Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of a Meeting of the AWP NHS Quality and Standards Committee

Held on 17 February 2015 at 1.30pm, Conference Room, Jenner House, Chippenham

These Minutes are presented for **Approval**

Members Present

Susan Thompson – Chair

Barry Dennington – Non-Executive Director
Ruth Brunt – Non-Executive Director
Hayley Richards – Medical Director, AWP

Staff in Attendance

Kristin Dominy –Executive Director of Operations
Sally Wood - Patient Experience Manager
Paul Daniels – Head of Health and SafetyJohn Owen – CD, South Gloucestershire
Ann Tweedale – Head of Quality, Information and Systems

Phil Cooper – HoPP, Secure Services
Anita Hudson – HoPP, North Somerset
Clair Williamson - HoPP, BaNES
William Bruce-Jones - Clinical Director, BaNES
Tony Gallagher – Chair of Trust
Liz Bessant – Acting Deputy Director of Nursing and Head of Infection Control

QS/14/195 – Apologies

1. Apologies were received from Alan Metherall, Tim Williams, Simon Manchip, Liz Hardwick and Pete Wood.
2. It was noted that the Swindon and Specialised Localities were unable to have a representative present to present their quality plans.

QS/14/196 – Declaration of Members' Interests

1. The members of the Committee did not declare any interests.

QS/14/197 – Minutes of the Meeting 20 January 2015

1. The minutes of the previous meeting were approved as correct with the following amendment:
2. Liz Bessant to be added to the Staff in Attendance record.

QS/14/198 – Matters Arising from the Previous Meeting

1. Wiltshire had been asked to review their CQC Action Plan as the majority of actions were highlighted as amber, which they had identified at the Locality Governance Meeting. After review WIL06, WIL05, WIL09 and WIL17 would remain amber due to outstanding issues with care planning, which are currently being addressed. Substantive appointments to

Band 7 are still to be made, which meant some issues were taking longer to resolve. KD confirmed that appropriate actions were in place. Wiltshire would be subject to the Week in Focus in March 2015 and would shortly announce the appointment of a Clinical Director.

2. RB asked if there were any residual concerns around clinical quality in Wiltshire that the Committee should be made aware of. HR said that there were no significant concerns other than delayed discharges on Imber Ward. A very effective Ward Manager had left Imber Ward, but there was a recruitment process in place to replace them.
3. It was confirmed that the updated Quality Impact Assessment had been completed. The establishment of the Patient Safety Team and the Mobile Working Project would go to F&P this week.
4. Work Plan and Terms of Reference: the work plan for the next year had been discussed with the Chair and lead Executives and NEDs at a separate meeting and the terms of reference would be approved at the next meeting. The Acute Care Pathway Project paper had been withdrawn after being uploaded in error; it would go to F&P on Friday. TG explained that F&P had asked for an interim report, and subsequently any associated Quality Impact Assessment would come to the Committee for review. The Chair requested this be removed from the action list currently as it would come through the work plan at an appropriate stage.
5. The Actions were noted with the above amendments.

QS/14/199 – SDU Presentations on Quality Plans

Secure Services

1. PC presented an overview of the 2014/15 Quality Plan for Secure Services. Clarifying roles for leaders through optimising training pathways had been completed: lead roles for dual diagnosis, physical health care, service user and care, experience champions and medicines were now in place. There had been an increase in supervision from 47% to around 86%. PC explained that there had been a clear improvement in practice and ward environment where staff had taken on specialisms.
2. The in house talent management section had been partly completed and the remainder would be rolled over to 2015/16; the intention was to increase motivation and progression for staff who demonstrated potential. PC said that they had a significant recruitment strategy in place and the ILM5 Leadership Programme had now started. They had noticed that the senior leadership team were now leaving at a slower rate.
3. The goal around corporate image was almost complete; a polo top with the corporate logo had been ordered to give the appropriate image for a professional environment. The objective would be rolled over to 2105/16 for completion.
4. In regards to addressing concerns around the amount of reflective time for ward managers, this had been completed; there was a weekly Senior Nurse Management meeting every Monday morning where senior staff could share time together away from the ward. The feedback from the Senior Nurse group had been that this was successful and PC felt that it was supporting wards to move from a crisis environment to a proactive environment.

5. The engagement with friends and family objective was partly completed: there was a carers' strategy and the first carer satisfaction survey had been completed and sent out to all known carers. A carers' register had been compiled and would be used to promote carers as part of future pieces of work. PC felt the quantitative data would be around the reduction in unsatisfied carers who had previously been feeling uninvolved and increased involvement in future governance; there was a hope there would be a reduction in complaints and improvement in the satisfaction survey markers.
6. The objective to monitor clinical detail had been completed; the forensic peer review continued as a commitment, and they had established a quality and performance team. This was a national process and this meant that the service was benchmarked against other secure services in the national peer review process; the service had been rated 'poor' at the previous benchmark.
7. As part of the objective to increase the use of social media, they had begun to use Skype allowing service users to contact loved ones elsewhere. They were also using Twitter and were on the programme for Wi-Fi within the unit.
8. Increasing access to specialist supervision for nursing staff; this objective had been rolled over to 2015/16.
9. Explore models for challenging behaviour and enhance forensic skilling on the LDUs; a single mode of methodology had been considered and RAID, a de-escalation process, had been rolled out on acute wards. KD asked whether they had considered the application of Safe Wards, which PC said they needed to pick up. It was hoped that the continued implementation of RAID would reduce the need for restrictive practice.
10. In addressing concerns about the quality of collaborative engagement in the CPA process, they had focused on My Shared Pathway, a process of collaborative assessment, planning and review, and the objective was partially complete. It would be rolled over, and in 2016 there would be a further push on MSP.
11. The objective to redesign service model was partially completed; they had redesigned, but they had not yet achieved an embedded multidisciplinary team. Each ward now had its own allocated staffing group including OTs, Psychologists and Social Workers, but they had more work to do on embedding an MDT culture, and would be facilitating away-days to promote this.
12. The first priority for 2015/16 was supporting and developing staff: introducing a coaching and leadership culture, running a programme for supervision improvement, training and mentoring.
13. An audit of current supervision satisfaction would be carried out alongside work on supervision skills, and there would then be a re-audit to demonstrate improvements. The Chair asked if there were any hard targets. Reduction in violence and aggression was a key objective: supporting staff to feel fit for their job would lead to a reduction in violence and aggression. KD recommended they give themselves a current benchmark and percentage reduction to aim for, which would help them to measure objectively.
14. TG noted concerns around the level of agency staff use, and suggested zero tolerance for the use of agency on secure wards. RB asked if there was data showing more violence and aggression when agency staff were used. PC commented that they would usually pull permanent staff into secure wards and agency staff would work on rehab wards.

15. Continuous improvement; embedding My Shared Pathway was the process for collaborative working. PC explained that they were engaged around auditing the number of participations and had designed systems that would measure the quality of the collaborative processes. There would be quarterly evening sessions for carers' education and engagement and carer satisfaction would be surveyed twice a year. PC explained that they would write a Care Pathway journey producing one document that would detail everything that happened on that journey.
16. Improved governance; the governance process had been revised, so that every member of the senior team met monthly to go through cost improvements, finance and efficiencies. They intended to have an electronic referral system in place by the end of Q4 and an electronic checking system by Q2.
17. Future focus; there was a commitment to provide monthly and quarterly reports to commissioners to demonstrate the benefits of the service. The feedback forms had been redesigned, and a working group was producing a glossy brochure for the service.
18. Integrated MDTs operating at ward level, was an objective that had moved over from 2014/15: PC explained that everyone was in place, but they had not fully embedded the MDT culture. The Chair confirmed that Secure Services was working towards an externally accredited secure performance benchmark. PC said that this gave the benefit of benchmarking the service against other secure services. A delivery plan quantifying the objectives for 2015/16 was in process.
19. BD noted that due to national pressures, Secure Services were having to retain more violent patients, and asked what the impact of that was on staff. Clinical Director, Pete Wood, was aware of this issue and was in discussion with NHS England around the provision of high secure services. The impact was that service users were staying in the service longer than usual with this being facilitated through restrictive practices.
20. The Chair asked to what extent the quality benchmarks mirrored the commissioner requirements. PC asserted that core objectives matched areas for improvement highlighted by the data; he felt they had identified more objectives than had been highlighted by commissioners.

B&NES

21. BBJ introduced a short paper of progress against the 2014/15 plan and plans for 2015/16. In 2014/15 they had looked at medicines management and optimisation in the locality, and had established a quality and standards subgroup to focus on this; there had been a delay developing the medicines optimisation plan, but this was now close to completion.
22. Improvement in quality of safeguarding reports; to meet this, the triumvirate had implemented training and ensured that safeguarding supervision took place. The improvements had been confirmed by feedback from the subgroup of the Children's Safeguarding Board in BaNES and favourable CQC report of safeguarding in BaNES.
23. Improvement in quality of written communication with GPs; they had introduced a standardised format for letters in collaboration with GPs. There was an audit process looking at the embedding of the letter template.
24. BBJ said that much of the year had been spent preparing for the CQC inspection and its aftermath, particularly relating to inpatient services and Sycamore Ward. The work on Sycamore Ward had gone very well, resulting in the lifting of the enforcement notice

following the September inspection.

25. Standardising and improving assessment process; currently there was an audit looking at this based on the SBAR assessment process, and this would produce result at the end of February.

26. Developing an open learning culture in the locality; BBJ felt they were still on a pathway to learning what this meant in practice. Currently, there was a review of incidents at the three monthly Risk and Safety Meeting where actions were shared. Incidents and RCAs were discussed regularly with commissioners and the Head of Quality for the CCG, and the perception was they had become a more transparent organisation.

27. Improvements in care planning; training had been held around care planning and writing crisis plans, but there was more work to be done. They had instituted a case load supervision tool; the feeling was that this was an interim measure while awaiting the Trust-wide tool.

28. Service User and Carer Experience; regular meetings were now held with service users and carers and a carers' lead had been put in place. They were working on the implementation of the Carers' Charter, which had been developed by the carers' voice in Bath and Somerset.

29. Best Practice; the locality-wide CQUIN was around monitoring and interventions of alcohol use. This was on track to achieve using a standardised assessment tool for use of alcohol.

30. Care Pathways; there had been limited progress on this apart from completion of the Eating Disorder Pathway and a pilot Personality Disorder Pathway. There had been limited progress on improvement for pathways with people with severe mental disorder. Barry Dennington asked how the improvements had been quantified and William Bruce Jones noted this was something to be considered carefully for the next year's plan.

31. In 2015/16 most priorities would remain around the CQC action plan and the actions that arise out of the week in focus. BaNES was leading in terms of the inpatient ward becoming smoke free with a good smoking cessation worker. Physical health interventions were a key quality improvement initiative of the Trust, and the Chair asked if the non-smoking pilot was BaNES contribution to that. They had found a hospital worker to lead on physical health liaison into the mental health unit and were working with GPs to transition patients back into primary care in terms of their physical health care.

32. Confidentiality Conference in partnership with Keep Safe and Keep Sane; this would try to find common ground with carers in the area of confidentiality. RB noted that this was a key feature of the Deep Dive in the development of the charter with carers. CW thought that this was a good collaborative project to identify the tensions on both sides, and she was sure it would produce actions.

33. Service User Charter; there was an objective to produce a charter along the lines of the carers' charter, which would be adopted by all key providers in BaNES. BBJ felt that one of the most important quality improvement developments over the year was in terms of service user and carer involvement.

34. Pathway for Patients on Cluster 11; this was a CQUIN objective. Cluster 11 comprised patients with chronic psychosis with low disability and low needs. RB requested that the plan be incorporated into the Trust format. BD felt the list for 2015/16 did not demonstrate

enough rigour. BBJ stated that the objectives included the CQC action plan objectives and would also incorporate the week in focus outcomes. CW stressed their commitment to ensuring that they got the basics right.

35. **Action agreed**: The meeting confirmed that the SDU quality plans needed to be on the Trust-wide template for quality improvement plans and that they needed to include local actions to deliver the Trusts annual quality objectives. KD confirmed that the Executive Team have agreed there would be one overall quality plan for the Trust and for each SDU with three different elements: Compliance (CQC), Responsive (Patient Safety Development, complaints, PALs) and other quality more sustainable improvement plans such as actions from patient surveys, Trust quality objectives and clinical audit.

QS/14/200 – Operating Plan: Quality Section & Draft Annual Quality Objectives

1. HR presented the annual Operating Plan, which set out the Trust's plan for delivery with a high level summary of the Trust's approach to quality. The Chair said that it had been helpful to identify the quality priorities, but it had felt inpatient focused and questioned why they had dropped physical health as a key quality priority, given the emphasis on parity of esteem and its importance for mental health, and vice versa.
2. HR said that the quality objectives reflected the CQC focus on safety, but the Acute Care Pathway objective was very much end-to-end and not solely inpatient focused. Additionally, reaching the 'good' rating would encompass objectives focusing on physical healthcare. TG asked whether they could quantify the differentiation between 'average' and 'good'. HR said they could reference the key lines of inquiry and pull some of those issues out. She confirmed the plan was still at draft page.
3. **Agreed action:** Further work is needed to describe how we shall quantify and measure the quality objective "to achieve a rating of at least good in all 5 CQC domains" – particularly so that staff are able to understand what it means.
4. The Chair raised that the all objectives needed to be quantified across the report moving forward.
5. The Operating Plan and annual quality objectives were approved with recommendations provided by the Committee as outlined above.

QS/14/201 – Integrated Quality and Safety Plan Q3

1. HR presented the plan, which looked back at the improvement priorities and achievements to the end of quarter three 2014/15. There was a relatively low uptake of best practice around using the National Patient Safety Suicide Prevention Toolkit; they recognised the need to focus on formulation around best practice, and also that progress had been made.

QS/14/202 – Quality Accounts – Progress with Quality Priorities Q3

1. The paper reported the progress with the annual Trust quality improvement priorities to the end of December 2014 and was a status report. The Chair asked if there was a quantifiable data showing a reduction in the use of restrictive practices. AT referred the members to the report on restrictive practices received a the January meeting which outlined the challenging issues around the use of incident data to quantify the desired reduction. RB recollected that this report was clear, there was no reduction evidenced by

the data. HR explained however that we have made good progress with the implementation of the Safe Wards Model, which is the nationally recommended evidence based intervention for reducing violence and aggression on inpatient units; this was being implemented across all wards and was endorsed by commissioners.

QS/14/203 – Quality and Performance Report

1. The Report detailed performance against the three quality indicators. KD stated that point two focused on friends and family and the records management audit. During January, for the last three months, 88% of service users reported a positive score. Three teams had failed to submit their records management audits reports; an approach to non-compliance with records management audits was being developed, which would establish whether teams required further support or sanction.
2. The Committee was aware that they had suspended the current CQC self-assessment process against the previous regime. There would be a rollout of the new IQ system aligned to the CQC intelligent monitoring approach in March set around the five CQC key questions.
3. The number of Out-Of-Area Patients was currently at 34. It was noted that the TDA would visit the following week to provide support to understand systems-issues contributing to bed pressures, with a particular focus on detox. Wiltshire had particular concerns, including difficulties with repatriating overseas patients. For Older Adults, four beds remained closed temporarily on Laurel. In PICU, three beds were temporarily closed on the male PICU Ashdown. Therefore, focus remained on inpatient bed pressures and the CQC action plan, as well as recruitment, with particular focus on Wiltshire and Secure Services.
4. TG highlighted phrasing around permanent bed closures and asked for more understanding on these issues. AH said that there would be a further 18 beds once building work had finished on Juniper Ward. The Chair asked when a significant improvement could be expected in the number out-of-area placements. KD responded that the Trust had decisions to make regarding the efficiency of the inpatient environment.
5. HR commented that there was no tolerance for out-of-area placements at all; the number had reduced from a peak some months ago, but she could not make a prediction. TG noted the downward trend and encouraged that a fact-based narrative should continue to be communicated to the TDA. He had met with the TDA who understood the issues, and that the trust had zero tolerance for out-of-areas, and also the actions that were being taken by the Trust.

QS/14/204 Updates on Progress with Compliance Actions & Other Issues as Required

1. KD gave an update on Week in Focus. KD stated that it was fair to say that BaNES was a trial for the methodology and they had made alterations as a result of that work. They had undertaken a comprehensive medicines audit and interviews with staff across all services. KD commented that turnaround in Sycamore was exceptional as the environment was pleasant and the staff were calm and well-coordinated, with service users being treated with compassion and respect. They had requested improvements around the provision of psychological therapies to be more in line with what was used in secure services.
2. Ward 4 was found to be clean and well run, and they had been impressed with the care and treatment of service users; there was also a requirement around improvement of

access to psychological therapies. IAPT was embedded into the locality and was a credit to the leadership of the locality and the staff. There was a question around staff undertaking their clinical work in other people's environments and how the organisation maintained their safety.

3. There were some challenges for the intensive team in terms of workload and recording good care as crisis and risk management plans were not as good as they needed to be, and they were disappointed with the quality of the pharmacy record.
4. The complex intervention team provided a well-run service; it was identified that not all service users and carers were always involved in care planning, and the health and safety returns were slightly out of date.
5. On Primary Care Liaison; there were issues around a standardised approach around interventions offered to service users. They could not get a picture of consistency in relation to the number of interventions that people were offered and there were differences in the way that adults and older adults were managed through the team. The Care Home Liaison was impressive and reported being well-supported. The Recovery Team reported staff shortages, and there were challenges in care planning, risk management, and medicines management. There were relationship issues between Intensive and Recovery that required sorting through. The Acute Liaison team was exceptional in a difficult environment.
6. KD said that on the whole it was a challenging review and validated a lot of the things that were coming through the CQC action planning process. She said that they had been impressed by the improvements seen in BaNES services.
7. The Chair requested that they align the Committee presentations with the previous month's Week in Focus. BBJ commented that the teams had found the process challenging, but it gave them the leverage to accelerate changes that needed to happen. CW felt the process had confirmed the need for good systems and processes.
8. TG commented that there was a need to have a transparent relationship with the external agencies. He requested that they think about consequences to estates issues; if the environment prevented staff from doing their job properly they should put resources in to fix the issue immediately. This would show that the visit was not just to critique, but also to put issues right.
9. **Action agreed:** Work plan to be revisited to align the week in focus with the locality presentations to Quality and Standards. WIF verbal briefings to Q&S same month as visit and written report and improvement plan to following month's Q&S to coincide with locality presentation.

QS/14/205 Annual Infection Control Report

1. LB presented the report, which was an overview of the six-weekly infection control reporting process throughout the Trust and infection control activities undertaken in 2014/15. There had been no incidents of MRSE, CPE or clostridium difficile, and there were very effective monitoring procedures. There had been no influenza outbreaks and four outbreaks of norovirus, which had been managed very effectively. There had been 11 needle stick injuries over the past year with no further complication. There were communication issues with the emergency departments regarding such injuries, although

this had been addressed with PAM the Trust's occupational health provider.

2. Six monthly infection control audits were averaged 94% for inpatient and 80% in community, an increase from 50% two years ago. The audits were supported by the infection control nurse and facilities representatives, as well as the infection control practitioner from the ward. Training had improved greatly at 94%. Overall there was a low risk to the Trust and they were compliant with the hygiene code. RB requested more reference to whether targets were met and tables to demonstrate this in the report. The Chair felt that in the future reports would only need presenting if there was a deviation from plan.
3. The committee noted the report.

QS/14/206 Annual Health & Safety Report

1. PD presented the Health & Safety Report for 2013/14. The annual self-assessment process had shown a drop in overall performance by 0.2% attributed to safety inspections and manual handling, which had produced actions incorporated into the health and safety action plan. Fire Safety had been found compliant with the Fire Code; more operational staff would be required as fire marshals in each building, and the next round of fire risk assessments were now underway.
2. Statutory risk assessments were being monitored monthly; there had been a drop in activity since the Trust scorecard had stopped. There would be a focus on increasing the quality of risk assessments during this year's audit work.
3. Pressure continued on improving training rates, but it was not yet at the 80% target. There is a Trust-wide review being undertaken on statutory training by the Learning & Development Team.
4. H&S Risk Management procedures varied across the Trust, raising concerns in some areas. KD asked how these concerns escalated to the senior leadership of the Trust and Paul Daniels responded that the issue had been on the risk register for some time. HR asked who in the leadership team had accountability for ensuring health and safety assessments were completed, as she had not seen it on the Clinical Executive Risk Register.
5. KD commented that it was not acceptable that localities did not have sight of health and safety compliance; furthermore non-compliance had not been escalated through the Trust. Paul Daniels stated that was not the case. **Action agreed:** The Chair requested clarity about the accountability structure and process to manage gaps in compliance. It was felt this should come from the Director of Nursing.
6. RB confirmed they were looking at the 2013/14 report, and asked if they would see the 2014/15 report quite quickly this year. PD hoped to provide the next report in July. TG said that he was not comfortable with the report due to the mix of data; he said that there should be an over-arching Trust policy that each of the localities referred to. He requested that the report go back to the Executive for a review, because he was not prepared to endorse the current report coming to the Committee. **Action noted.**
7. BD suggested a matrix for each location and ligature action required in each area, because that was missing from the report. TG said that there should be a clinical and estates joint view on ligatures in the report; he reiterated how uncomfortable he was with

the report. The Chair said they would withdraw the current report and request clinical oversight of the data; additionally there should be one report to show progress on targets. The Board should support PD to pull the localities together to facilitate reporting to the Trust. It was agreed the report would be deferred to April. **Action noted.**

8. The Committee resolved to withdrawn the Health and Safety Annual report and review again at a future Committee meeting.

QS/14/207 Learning from Experience Report

1. HR presented the report focusing on information about incidents, reporting and actions in terms of responsiveness. Inpatient Development Plan: this was being scrutinised through CIOG and progress would be presented by Clinical Directors twice yearly. There was a spike in complaints around privacy and dignity linked to the removal of en suite bathroom doors; it was recognised this would happen and they had improved communication around reasons for the action. Complaints regarding attitude of staff would be further investigated.
2. HR noted that the report was a collation of information and missed an analysis of the meaning of the complaints, and proposed to include that in the next report. The Chair did not feel they were getting a comparative picture with the report; what the trajectory was and performance against national benchmarks. HR confirmed they could include benchmarking data. **Action noted**.

QS/14/208 Patient MH Survey Report and Actions

1. SW, Patient Experience Manager, presented the report, which summarised the feedback from the Annual Community and Inpatient surveys. An extended sample for the community survey giving data by area had enabled detailed improvement planning as service area level. The Trust remained 'average' in terms of results; they had worked on information about medication and had remained 'good' for working with carers, although despite last year being better than other Trusts we were now 'average'.
2. There was a need for awareness around peer support and crisis care. The results for psychiatrists from inpatient wards had improved from last year. SW felt that the results acknowledged that nurses were caring, kind, professional, but under a lot of pressure. The local actions provided for each service should be included in to SDU Quality Improvement Plans.
3. The 2015 surveys would go out shortly; this year there would not be a breakdown by locality as we are not doing the larger sample. RB raised a concern at seeing the report so late, as it had been presented to the Professional Council in September; they were going into another round of surveying shortly giving little time for improvement actions to take effect. The Chair would take the point to the new Director of Nursing.
4. The Chair thought the key thing was how they moved from 'average' to 'good'. The advice from Quality Health was for a Trust to focus on one or two issues. TG noted that there were some very specific questions that required specific answers; he agreed there should be executive focus on the key priorities identified by our service users. The Chair felt they needed quality initiatives that reflected what service users wanted and questioned how the survey results and other patient experience information had been triangulated to

inform the Trusts development of the annual quality objectives. It was requested that a narrative be provided by the Executive to the Committee on this process. RB wanted the survey results to be triangulated with complaints and service user groups, rather than being addressed in isolation. It was agreed the clinical executive would be asked to identify two or three themes to form part of the Trust-wide quality improvement plan and ideally linked to the Trust annual quality objectives. **Actions noted**

5. It was requested that the information was broken down into localities in the future, because there were huge differences in areas. Sally Wood agreed; she hoped that they would be able to return to a larger sample broken down geographically. A discussion relating to reporting of quality improvement plans at the Committee resulted in an agreement to review two at the next meeting, and then to take a view as to the frequency of reporting during meetings.

QS/14/209 – Policies

1. PD presented the Security, CCTV and Protection of the Health, Safety and Welfare of New and Expectant Mothers policies. TG noted that the changes on the tracking document were quite minor. PD agreed; the only significant change was Section 5.3, where there had been a request to include details around unescorted visitors, and this had been checked with Safeguarding.
2. The CCTV policy had been reviewed in response to the NHS Protect tools for assessing practice against the 12 principles of CCTV. The Committee requested that the CCTV policy be included with the Security policy. The Chair asked whether they needed to think about covert recordings by visitors within this policy. PD explained that there was work going on currently; he would speak to Alan Metherall to ascertain where that work should sit. The Chair requested matters arising be returned to the Committee in six months.
3. The Protection of Mothers policy was due for a review; they had clarified the links to the HR process and amended wording around employee-specific assessments. Paul Daniels had checked that there was no conflict or confusion between this and the HR policies. The Security and Protection of Mothers policies were approved subject to retifications by HR and Alan Metherall.
4. The CCTV Policy was approved as above, with the policy to return in 6 months.

QS/14/210 AOB

1. TG said that the previous year they had not given service users and carers sufficient scrutiny of quality accounts, so he wanted to ensure they were given that ability this year.
2. Finance & Planning had tabled a pharmacy issue relating to a Deep Dive: Tony Gallagher felt that due to the organisational issues between what was the responsibility of the operations executive versus medical executive this was more properly the proviso of the Quality rather than Finance Committee. Ruth Brant agreed that Deep Dive issues should come to this Committee.
3. The Executive Team would write a paper when they had concluded their work in progress.

QS/14/211 Escalation to Board

1. TG raised the issue of quality of papers It was felt that the Health & Safety Report did not provide sufficient assurance. Ruth Brunt agreed and felt the Committee should be more

sighted of H&S issues. The Chair questioned the effectiveness of the Health & Safety management working group. TG commented that locality clinical and medical directorates were working well, but there was conflict in the overlap between other directorates and clinical functions.

2. RB stated that neither the escalation processes nor the reporting accountability to the management team were well understood. BD thought there was an opportunity for some report training to provide a mix of more quantitative data and less qualitative data. It was felt there was an issue with the quality of report writing and that reports should provide more meaning and quantification to facilitate Board decision-making.