Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

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

Held on 23 March 2015 at 9.30 a.m. in Conference Room 4, Jenner House, Wiltshire

These Minutes are presented for **Approval**

Members Present

Susan Thompson – Non-Executive Director (Chair)
Eva Dietrich – Clinical Director, BaNES
Claire Williamson – Head of Professional Practice in BANES
Newlands Anning – HoPP, Swindon
Toby Sutcliffe – Clinical Director, Wiltshire
Kristin Dominy – Director of Operations
Hayley Richards – Medical Director
Andrew Dean – Director of Nursing
Ann Tweedale – Head of Quality Information & Systems
Hannah Dennis – Deputy Company Secretary (in-part)

Staff In attendance

Alexander Lauder-Bliss – Governance and Risk Coordinator

QS/14/212 – Apologies

1. Apologies were received from Barry Dennington and Ruth Brunt.

QS/14/213 – Declaration of Members' Interests

1. In accordance with AWP Standing Orders (s7.1) members present were asked to declare any conflicts of interest with items on the Board meeting agenda. **No interests were declared.**

QS/14/214 – Minutes of the Meeting of 17 February 2015

1. The minutes of the meeting of 17 February 2015 were **approved** and taken as accurate.

QS/14/215 – Matters Arising From the Previous Meeting

1. The Committee had agreed that locality deep dives would review how localities had performed against previous years and against their current Quality Plans. It had also been decided that CQC, Quality Improvement and other plans were being pooled into the Check and Challenge process. This was a more robust mechanism by which assurance could be provided to the Committee.
2. The Swindon Week in Focus had been completed. The Wiltshire Week in Focus started on the current date. The Bristol Week in Focus was scheduled for 14 April.
3. The Health and Safety Report had been removed from the previous

meeting's agenda due to a lack of clinical oversight. KD confirmed that a complete review of health and safety work over the course of the current year had been called for. The Committee agreed to bring the report to the April meeting.

4. The Committee had asked for better indications of comparative data and performance trajectory analysis from the Learning from Experience Report. This message had been fed back to Lynda Hutchins. Subsequent to the current meeting, Committee members will discuss how best to design the report, and how to feed the Check and Challenge process into the report. The action will be closed following the discussion.

5. The Committee agreed that it had been taking too long for them to be sighted on the Mental Health Survey Report. ST will meet with AD and Alan Metherall to discuss how survey results are embedded in Quality Improvement Plans. HR proposed that survey results be collected more quickly, so that they could be embedded into the planning process for Quality Improvement Plans. ST asked how it was possible for the Committee to measure whether the Trust had improved. KD replied that progress was measured against CQC action plans, records audits on IQ, Weeks in Focus and Executive and locality walkarounds.

6. The localities fed back that there were robust structures in place to enable them to be sighted on issues raised in the survey. On that basis, AD proposed that quarterly audits be undertaken, to evidence whether or not localities' plans were effective and leading to measurable improvements. He confirmed that he would take responsibility for the action.

7. ST asked that AD bring a response to the Committee in April, in respect of item 11.

QS/14/216 – Week In Focus Report

1. CW fed back that BANES had implemented some actions from the Week in Focus into their CQC action plans, around recording standards and learning from incidents. BANES had created a new action plan which included actions from the Week in Focus, Quality Improvements and the Inpatient and Community Mental Health surveys. CW clarified that the action plan was a work in progress and would be monitored over the coming months.

2. CW said that the BANES would benefit from focused support around, for example, medicines management. BANES' pharmacy had been reduced, and consequently there were concerns around the teams' ability to demonstrate consistency. HR stated that medicine management on-ward was a nursing task, and that pharmacy support was limited to checking, challenging and advising. CW replied that BANES were struggling with these processes, particularly within Community services. NA relayed feedback from the Swindon pharmacy that there were challenges around clinical discussions on the prescription of medication.

3. The following issues had been identified during the Week in Focus and the CQC inspection: checking drugs into services; storing drugs appropriately; keeping drugs in date; disposing of drugs appropriately, and utilising correct

processes around fridge temperatures, etc. These issues were not Pharmacy actions. HR added that, following the CQC response, consistent and repeated advice had been issued through central Pharmacy to give guidance on medicine management and to reissue and review policies and guidance. KD agreed with HR that medicines management was a nursing responsibility and suggested that the issue pertained to a gap in the skill set of the locality's Community Services. **– ACTION AD**

4. NA added that the medicines management issue had also been raised in Swindon. He suggested that the actions generated from the CQC action plan needed to be reviewed.

5. ST asked suggested that peer checking could be adopted, so that wards and teams could undertake checks on other wards and teams.

6. AD understood that some of the issues outlined by CW constituted 'nursing competency' issues. He stated that he would review all medicines management subsequent to the current meeting. Further, AD proposed to review the benchmarking figures by which the Trust's progress was measured.

7. KD proposed that AD undertake a review of the audit tool which was being used to assess medicine audits. This was an executive action. HR understood that the issues around medicine management that had been raised would be reviewed by AD, as Clinical Directorate, alongside the support of localities.

8. ST understood that BANES had built in their learning from the Week in Focus to their Quality Improvement Plan, to enhance their action plan. KD stated that the actions from the Week in Focus needed to be fed through the CQC action plan.

9. KD proposed that the post-Week in Focus reporting be amended, so that it followed regular Committee templates rather than exception report templates. Localities were asked to detail the findings of the Week in Focus visit and what actions they planned to take. AD added that exception reports could be utilised in the future, if localities' plans were not on-target. The Committee agreed.

10. On Swindon, KD updated that the review team had undergone several changes.

11. Medicines management, Learning from Experience and Inpatient ward training had been identified as areas of improvement for Swindon. The rehab ward had performed well, and Later Life services had also been assessed as good. Care planning and crisis recording required further improvement, as did medicine storage.

12. NA stated that Swindon had expected several of the issues which had been identified, such as the problems with record management and crisis contingency relapse plans. He confirmed that a plan was in place to address the issue. Further, NA had attended the Locality Medicines Assurance group.

13. AD asked NA what actions were being undertaken to address the

inconsistencies in Swindon's crisis planning. NA confirmed that he would add the issue to the Quality Improvement Plan.

14. AD asked ST if a report was produced to triangulate common locality issues into Trust-wide issues. ST replied that the Week in Focus process was very new and that triangulation had yet to occur. She anticipated that common themes would be raised as part of KD's Quality and Performance Report to Board.

15. ST was dissatisfied with the fact that the Trust encountered so many difficulties with crisis and contingency planning, which she described as a 'basic' element of service. She proposed that the records management process within IQ needed to be reviewed, on the basis that it did not provide sufficient, qualitative information. AD updated that he had agreed to review the process. He said that he would provide an update on the progress of the review at the next Committee meeting. **– ACTION AD**

16. ST asked how positive feedback from the Weeks in Focus was being communicated to ward staff. CW, ED and NA confirmed that this communication was occurring. CW noted that it had been helpful for teams in BANES to be updated on the improvements made to the Sycamore ward.

17. HR asked that localities proactively work to assist each other, in preparation for a CQC re-inspection.

QS/14/217 – SDU Quality Plans

1. ST noted that Quality Improvement Plans had been received from each locality.

2. ST asked for assurance that Quality Improvement Plans had been informed by the Trust-wide plan and service user input. The Clinical Directors confirmed that they had. NA noted that a Local Care Forum was held on a monthly basis in every area and ED added that Community Care Forums were held for friends and families of service users. ST asked Clinical Directors whether communities would recognise the quality improvements that their localities hoped to achieve. TS replied that his community may not be aware, and stated that he would address the issue.

3. ST reminded Clinical Directors that the Trust expected to see evidence that localities were reflecting on their previous plans and that they were measuring their achievement of targets that had been set in previous years.

4. ST highlighted the importance of localities' Improvement Plans being in line with Trust-wide quality objectives for the year. She asked if the plans were subject to Executive-level scrutiny. HR stated that localities' plans needed to demonstrate that they were relevant to the Trust's key issues. It was confirmed that localities would present their Quality Plans during the Committee's locality deep dives.

5. NA proposed that the Quality Board Terms of Reference be reviewed and updated if necessary. The Committee agreed. AD expected that the locality plans would be dealt with at the Quality Board.

6. ST highlighted that the Quality Improvement Plan review should constitute business as usual, going forward.

7. KD asked who was currently managing the process. AT replied that the process was aligned to the development of the annual objectives, as had been agreed by HR and Alan Metherall. She assured the Committee that a review of localities' performance had been undertaken earlier in the year. The local plans had been collated and fed through the development of the annual Trust plan.

8. The Committee **noted** the Quality Plans and agreed that the Plans would be reviewed by the Quality Board. The Committee expected that the Quality Board would report to the Committee any incidents of non-alignment with Trust objectives, and would be clear about how Quality Plans would be monitored. **– ACTION AD**

QS/14/218 – Mental Health Dashboard Presentation

1. The Dashboard had been updated, following conversations between ST and Dan Meron around how the Committee would maintain oversight of the Trust's performance against certain Mental Health Act parameters. The Dashboard was a work in progress and could be continually updated.

2. HR reported that the Dashboard could be found through IQ. It was possible to interrogate the data by LDU, ward and other factors. The Dashboard gave information around the current status, as well as the trend over time for any given metric. Data could assist with analysis around quality and diversity, and could be used by Service User Groups and Inpatient Development Groups, etc.

3. HR asked localities to suggest extra metrics that could be added to the Dashboard.

4. AD read from the Dashboard that acuity was going down, which was contrary to his understanding from previous meetings. HR confirmed that, throughout the previous 30 days, 96 Mental Health Act detentions had been started and 103 patients had been discharged from detention.

5. HR clarified that she was not proposing that the Quality and Standards Committee be required to have regular oversight of the Dashboard. ST suggested that key metrics such as seclusion, restraint and 136 could be identified and monitored, so that the Trust could have thorough oversight.

QS/14/220 – Quality and Performance Report

1. KD noted that the Equality and Diversity piece, as was outlined in the executive summary of key issues, was being presented in a different report by Emma Robert's team.

2. In February, 90% of service users reported that they would recommend the service to their friends or family. AT added that national data submitted by the Trust was due to be published on 27 March.

3. Two teams in Banes and one team in North Somerset had failed to submit

their records management through IQ.

4. It had originally been anticipated that CQC changes into IQ would be online by the end of the current financial year. The process had been delayed due to additional development work.

5. In relation to the Acute Care Pathway, the current situation in respect of closed beds remained unchanged.

6. KD proposed that, following presentations to the Board and Financial and Planning Committees, next steps were taken to: review the Personality Disorder Pathway; improve the Ward Inefficiency Programme; review and manage bed pressures and the escalation process and begin the Community Services review. All issues were internal to the Trust and therefore did not rely upon Commissioner agreement.

7. There were significant staffing challenges in Secure and Wiltshire. Wiltshire and Secure Services were undertaking a number of recruitment efforts.

8. HR added that Clinical Directors would be written to on the subject of records management and failure to submit. She suggested that a more proactive approach could be taken to ensure that localities did not fail to submit before deadline.

9. ST asked how many out-of-locality and out-of-Trusts placements the Trust currently had. KD replied that there were 32 out-of-area placements. She noted that the Trust was operating at 85% occupancy. Work was being undertaken to improve the process by which patients were returned to their home localities.

10. The Committee **noted** the report. KD confirmed that she would continue to report on the Acute Care Pathway in the Quality and Performance Report on a monthly basis.

QS/14/221 – Caseload Management

1. The paper had been produced in response to a CQC comment that some caseloads in community teams were higher than national guidance and Trust policy. The paper analysed national guidance, which suggested that the figure of 35 was acceptable for community teams. There was no policy within the Trust to state that there was an absolute number for caseloads.

2. The Trust benchmarked in the lower quartile for both face-to-face contact for Community Mental Health Team (CMHT) members and caseloads per 100,000 population. A number of measures were being adopted, at a locality and Trust-wide level, to gain further understanding of the issue.

3. The paper proposed that a greater and more thorough analysis of caseloads was undertaken, so that sufficient assurance could be provided.

4. ST asked if caseload analysis was being managed at local level. The Clinical Directors confirmed that it was. ED added that her locality had introduced a tier system, to reduce the caseloads for Care Coordinators who dealt with particularly complex patients.

5. HR proposed that a discussion be held with AD to address the questions raised by the paper. AD agreed. He proposed that a further paper be presented that provided more detailed information around locality caseloads. The Committee agreed.

6. The Committee **noted** the paper. AD confirmed that a report would be put to the Committee around whether or not the Trust's caseloads were acceptable, and what the next steps would be. **– ACTION AD**

QS/14/222 – CQC Updates on Progress With Compliance Actions

1. KD asked that AD comment on the heat map, to give assurance that it was fully compliant in terms of how action plans were closed down. AD agreed that he would hold the discussion with KD subsequent to the current meeting.

2. AD emphasised that staff needed to have a clear understanding of the definition of its different ratings. The Committee agreed that definitions of ratings needed to be standardised across the Trust.

3. ST noted that Juniper had been given an 'amber' rating. ED confirmed that the rating should be 'green', and would be given after building work had been completed and the central nursing point had been improved.

4. ST asked if progress had been made, according to the overall heat map. TS updated that Wiltshire had seen positive initial results. Further, the recent recruitment effort across Ireland, London and UWE had been positive. KD agreed that early results were positive. KD and AD agreed that that further assurance was needed, led by the Clinical Executive, to finish the process.

QS/14/223 – Terms of Reference and Work Plan for 2015/16

1. HD joined the meeting.

2. AD updated that he had reviewed both the Terms of Reference and the Work Plan. AT added that some amendments had been made, in light of the feedback given in 2014.

3. KD asked that an amendment be made. She asked that her deputy, or a nominal deputy, could be present as an attendee in her place. The Committee agreed.

4. HD reported that Tony Gallagher had asked for the future quorum to be two NEDs, rather than the current quorum. The Committee agreed that two NEDs were necessary for Committee meetings. HD said that the Committee's view could be put to Board.

5. The Committee agreed the Terms of Reference.

6. AD asked if he could undertake further work around the Work Plan before it was presented. The Committee agreed that the Work Plan would be deferred until April. **– ACTION AT**

ESEC/14/226 – Any Other Business

1. There was no further business.

ESEC/14/225 – Agree Any Items to Escalate to Board, or for Horizontal Reporting to Other Committees

1. ST said that she would take to Board the subject of how Quality Improvement Plans and quality objectives were to be decided, on an annual basis. **– ACTION Chair**