Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of a Meeting of the Quality and Standards Committee

Held on 15th December 2015 at 1pm, Willow Room, Bath NHS House

These Minutes are presented for **Approval**

Members Present

Susan Thompson (ST) – Non-Executive Director (Chair)
Ruth Brunt (RB) - Non-Executive Director
Barry Dennington (BD) - Non-Executive Director
Andrew Dean (AD) – Director of Nursing
Paula May (PM) – Interim Managing Director, Secure Services [present on behalf of Acting Director of Operations]
Dan Meron (DM) - Acting Medical Director
Rachel Clark (RC) – Director of Organisational Development

Staff In Attendance

Bill Bruce-Jones (BBJ) – Clinical Director, BaNES
Claire Williamson (CW) – Quality Director, BaNES
Steven – (Service User)
Emma Roberts (ER) – Director of Corporate Affairs
Rachel Clark (RC) – Director of Organisational Development (present on behalf of Jenny Turton)
Richard Edwards (RE) – Consultant Nurse for Dual Disorder
Sarah Jones (SJ) – Senior Lead Nurse, Nursing and Quality
Mark Dean (MD) – Head of Safeguarding

QS/15/092 Presentation by BANES Locality

1. Steven talked about his experiences within the Art Therapy program. He spoke about participating in museum visits, and how he had challenged himself to take part in meetings at the Guild Hall and to present his work at an art exhibition. He had set personal goals to produce a set number of art pieces and had met this challenge. Being involved in the program had greatly improved his social skills.
2. Steven showed some of his artwork to the Committee; one of these pieces had been purchased and was being displayed at Bath NHS House. He summarised that being involved in this program had enabled him to find a new method of expression, and said he was thankful for the opportunity to be involved.
3. Steven was now on the Steering Committee for Fresh Arts and was working to deliver the service to others. He had also been involved in the EBD Project improvements.
4. Steven advised that since completing the program, he had been working on the World Mental Health Day. He was also looking into creating an urban art project with a local youth club. He had applied to volunteer with the AWP.
5. The Committee congratulated Steven on his work and the progress he had made.
6. BBJ referred to the Data Pack that had been submitted to the Committee in advance. He presented the Quality Governance Structure for BANES advising that there were monthly meetings/reviews of Quality and Standards and Risk and Safety. There were also monthly team meetings and meetings of sub-groups that covered Medicines, Health and Safety and Mental Health Legislation.

7. BBJ talked through the IQ summary and provided some commentary about the scores. He noted the data entry issues in relation to the Gatekeeping statistics. It was reported that BANES was piloting the Caseload Management Tool that had been developed by the Quality Academy. This had been helpful and was being rolled out to other teams. Timeliness statistics were noted to be affected by sickness in the administration team and data recording issues.
8. BBJ noted the struggle BANES locality had with inadequate technology. He advised that the booths for the Friends and Family Test had been 'frustrating' and noted that the receptionist now provides the form for completion by hand. Some FFT returns were not being recognised in Meridian. It was noted that there had been a dip in FFT results during the period in which bed management issues had been prominent, resulting in patients being moved around.
9. Junior doctor training and compliance checks had been put in place in response to the Records Management Audit results.
10. The BANES locality had been recognised as being an outlier on restraint. Upon investigation, it was considered that the BANES' reporting practice was such that the locality staff were reporting all incidents. It was suggested that other localities may not be doing the same. Following discussion with the matrons across localities, the sense had been that they were likely under-reporting in comparison with BANES.
11. In regard to incident reporting, work was being undertaken to ensure that restrictive practice reporting was being completed as well as the reporting of seclusion. Doing this would ensure that there was a clearer picture of the whole process.
12. An external audit had been completed by the RUH Falls Specialist, who had commended the practice on Ward 4 given that the patients were not confined to bed. Positive risk taking was considered to be of greater benefit to patient wellbeing overall than restricting movement around the ward.
13. ST noted the Trust objective to reduce the impact of falling incidents that result in harm. She asked if the balance was right between positive risk taking and placing a patient at risk. BBJ and CW considered that the balance was right, and highlighted that they were monitoring movements, taking advice from physiotherapists, using all of the safety equipment provided and reporting all incidents even though some were very minor.
14. The CCG had raised issues about the SUI process; meetings had been held to discuss the issue. The concerns were about determining when the CCG needed to become involved in the process and when service users' families should become involved. Other concerns raised were about the fact that some RCAs did not find root causes or did not identify lessons learned.
15. RB stated that the Trust had to demonstrate that it was satisfied with its processes. She highlighted that the expectation would be for a root cause to have been thoroughly investigated and that lessons learned had been thoroughly explored. A paper trail would also be required, to show that this had been duly considered.
16. It was acknowledged that some patients would be recognized as being likely to harm themselves or pass away. It was suggested that in the Care Planning, the Patient Agency Toolkit should be used for high risk service users, so that it could be demonstrated that the person had been recognised as someone who may eventually die.
17. The Committee acknowledged that it was important not to equate lessons learned with blame being apportioned.
18. CW spoke to the Patient Safety Development Plan. She advised that lessons had been learned from complaints as well as from serious incidents. It was noted that communication issues

between carers and clinical staff had been identified. As a result, carer training sessions had been carried out in all of the teams. The Confidentiality Conference had also provided an opportunity to discuss with carers about information could be shared in an open way.

19. The review of Bed Management protocols had improved the rate of complaints raised by service users. A new role had been developed to coordinate the response to complaints and SUIs. Part of this role would be to check that lessons learned were embedded.

20. It was reported that there had been two CQC visits, one to Ward 4 and one to Sycamore. Issues identified were related to evidencing, involvement of carers in DNR forms, personalisation of care plans for people with dementia, observation and gender separation at night. CW and BBJ fed back that the visits had gone well.

21. The BANES Week in Focus visit had been held in March 2015, following which a detailed action plan had been developed. This plan was being run alongside the CQC Action Plan and used to monitor progress. Generally there had been improvement, particularly in Intensive Services and the Recovery Team. Areas for focus were identified as being: clarifying short term interventions provided by the Primary Care Liaison Service, the interface between different teams, quality of record keeping and sharing learnings.

22. The CQC Task List had been reviewed during a visit by Rebecca to Ward 4 and Sycamore. A small number of issues had been raised, but BANES had generally performed well.

23. BANES had been piloting Sycamore as a smoke free environment. Limited success was reported.

24. The Confidentiality Conference had involved the AWP Carers Group and St Mungo's, and was described as being a 'collaborative event' on a difficult issue, resulting in positive outcomes. A statement about confidentiality was to be made across the Trust and Trust-wide training would be developed. Further, the written information related to confidentiality would be reviewed to encourage sharing of information while setting guidelines about what could and could not be shared. It was requested that IGG be involved in this process – **Horizontal Reporting to IGG**

25. A Service User Charter was being developed by a service user. This would be a 'multi-agency BANES charter', but AD had indicated it may be used across the Trust. The draft document was tabled for information.

26. Quality Improvement Initiatives were presented. It was reported that liaison work with the police had led to a CQUIN for the following year. It was noted that the postcard scheme had worked well although the data input was time intensive.

27. The risks and challenges for BANES were identified as follows: maintaining momentum around the new build, moving forward with Your Care Your Way and maintaining focus on local authority priorities.

QS/15/093 Questions from the Public and Attendees

1. RB asked whether there were any significant workforce concerns in terms of recruitment, turnover, bank and agency use. BBJ and CW stated that no issues had been identified, and that recruitment and retention were positive. It was noted that there were challenges within the 24 hour services (both on wards and in the intensive team), but there was an open recruitment process in place to address these. CW and BBJ reported that there were 12 vacancies within the locality. RB requested that LDUs provide information on key workforce issues in future presentations – **ACTION Governance Team**

2. The Chair asked how BaNES was sharing progress against quality metrics/tasks in the LDU. BBJ replied that the Patient Safety Development Plan was discussed in the Risk and Safety meeting

and that there was a pre-populated team agenda to ensure that issues were shared within teams. The Week in Focus and CQC Action Plans were being discussed in a smaller group with the Service Managers in a monthly meeting. BaNES also had good engagement with the Quality Forum, and a weekly huddle was held at Hillview during which key themes for the week were discussed.

3. The Chair thanked the BaNES Locality for their presentation and congratulated them on their progress.

QS/15/095 Apologies

1. It was noted that Jenny Turton was being represented by RC.
2. It was noted that PM was attending on behalf of Mathew Page.
3. DM was welcomed as Interim Acting Medical Director.
4. RC was welcomed to the Committee as a new member.

QS/15/096 Declaration of Members' Interests

1. In accordance with AWP Standing Orders (s8.1), all members present are required to declare any conflicts of interest with items on this agenda.
2. **None** were declared.

QS/15/097 Minutes of the Meeting on 17th November 2015

1. The minutes of the Committee meeting held on Tuesday 17th November were reviewed for accuracy page by page.
2. It was noted that AD had been present at the meeting. He was added to the list of attendees.
3. The Committee **approved** the minutes subject to the amendment made above.

QS/15/098 Matters Arising from the Previous Meeting

1. Items one to four, seven and eight, thirteen, sixteen and seventeen were to come back to the Committee in January 2016. These items were noted as **ongoing**.
2. Items five and six were noted as being **complete**.
3. Items nine and eleven would be discussed during the Clinical Executive Report. These items were noted as being **complete**.
4. Regarding item ten, AD reported that there would be a plan in place to check all water across the Trust by the following week. This item was noted as being **ongoing**.
5. The timeline for item twelve was moved into January 2016. This item was noted as being **ongoing**.
6. The Acute Care Pathway update had been provided in the Clinical Executive Report. Item fourteen was noted as being **complete**.
7. Item fifteen was marked as **complete**.
8. Item eighteen was covered in the Clinical Executive Report and marked as **complete**.

QS/15/099 Quality and Performance Report

1. It was noted that the main issue of concern in the report was the deterioration in the Delayed Transfer of Care indicators in Swindon and Bristol. The rise in Swindon had been anticipated, as a

result of a new process being put in place. This process ensured that service users with highly complex requirements, who could not be managed within specialised placement, were placed into suitable property and given access to bespoke services. There were six service users in the Later Life Ward who were to be subject to the process. It was summarised that DTOCs had risen and were expected to rise further in the transition period.

2. The Chair noted that, even with this specific process change, the DTOC indicators were getting progressively worse and mitigation measures had to be put in place. She asked for an update from Bristol about the mitigations that were being put in place around DTOCs – **ACTION MP**
3. The Gatekeeping of Admissions by the Crisis Service indicator remained below target. It was reported that Wiltshire had faced ongoing challenges, however had demonstrated some improvement in this indicator.
4. ST noted that the IAPT Moving to Recovery dashboard was also showing a worsening picture. It was noted that BaNES had performed well on this indicator.
5. Bed pressures had remained high and mitigations were in place to manage this. It was noted that the pre-Christmas build-up had been significant.
6. RB noted the red indicator for Secure Services, within the Service Users with Annual Review (non CPA) dashboard. She noted that Swindon was amber at 90%, and asked why Secure Services were marked red at 92%. AD highlighted that the Service Users (non-CPA) indicator did not relate to Secure Services. PM undertook to seek more detail and clarify whether the indicator was fairly represented – **ACTION PM**
7. RB suggested that the narrative in the report did not provide a real sense of the areas of concern. She noted that there were indicators in which the Trust had failed to make improvements, or where earlier in the year indicators had deteriorated and had remained at a low level. She asked if the report writers could provide a sense of what issues were critical for the Trust to address, what issues did not have a major impact and which issues were affected by data recording problems – **ACTION MP**
8. The Chair noted that the Referral to Assessment indicator for Bristol had been discussed at the last Committee meeting. She recalled being assured that the target of 95% would be reached by March 2016. She noted that there appeared to have been little movement between August and November. The Chair asked how confident the Trust could be that this target could be achieved. RB noted that the assurance needed to be provided in the report narrative; or, if assurance could not be provided, then the expected position would need to be identified – **ACTION MP**
9. AD did not consider there to be reasonable evidence that would support the suggested trajectory of improvement in many of the key indicators. He agreed that the Clinical Executive may need to provide more interpretation and feedback of the indicators for the Committee. RB noted that she was aware that some issues were data recording issues, and acknowledged that the Trust may accept poorer statistics as long as there was no impact on service user experience.
10. RB noted the assurance provided at the last meeting that the mixed accommodation breach was a 'one-off'. She noted that there was another breach had been identified in the dashboard report. It was advised that this was the same incident and that the dashboard showed the information on a three-month rolling basis. PM clarified that the indicator showed year to date statistics, and confirmed that there had been only one breach in the year.
11. The Chair asked about the Unallocated Cases Waiting for Treatment indicator. She asked how assured the Committee could be about the information supplied in Appendix D (Page 30). AD advised that the Committee should continue to challenge the numbers and noted that he did not

feel that they could be confident in any assurance provided at this point. AD undertook to look further into how the numbers had been compiled and to provide an update at the next meeting – **ACTION AD**.

12. The Committee **noted** the Quality and Performance Report.

QS/15/100 Clinical Executive Report

1. AD noted that there were two wards reporting above 80% staffing and a number of wards reporting above 120%. He advised that no wards had been deemed unsafe.
2. Water re-testing had been carried out in the interests of infection control and there had been no variance in the data. A meeting was to be held on the 21st December, during which a process would be put in place to ensure that the whole organisation underwent regular water testing in the future.
3. Ad outlined that Medicines Management Audits would be held monthly, until the Clinical Executive was satisfied that a ward was performing well on an ongoing basis.
4. It was noted that there had been a number of CQC inspections. AD noted that the task list was continually being updated. He advised that he would amend the report to indicate how many tasks the Trust had had, how many had been completed and what was new. The Chair noted that the Committee needed to know that where compliance issues were raised, they were being acted upon – **ACTION AD**.
5. AD stated that there would be compliance issues that could not be addressed other than by identifying mitigation plans. He noted that staff would need to be able to explain to CQC the reasons for non-compliance or indicate what had been done to gain compliance through mitigation measures.
6. It was noted that the CQUIN delivery statistic was up to 75%-80% rather than 60% as reported. AD confirmed that all CQUINs, both local and Trust-wide, would be reported going forward.
7. AD reported that the U18 Place of Safety strategy had not been working well during the year. A more robust contract was to be negotiated, which would clearly identify what should happen when someone under 18 is admitted. AD advised that, if this could not be achieved, the Trust may not offer this arrangement given the number of 'near misses' over the last year.
8. AD advised that the Acute Care Pathway Project update would look at all aspects of acute care and would look to identify the most efficient and effective delivery of care. Senior clinicians from across the organisation would be invited to refresh the clinical strategy in early February, and would feed into the project. It was noted that an outcome from the last Quality Forum had resulted in an integrated piece of work about Service Pathways.
9. The Chair asked if some of the issues around service users' experience in PICU had been resolved. The issues that had been identified were 'boredom', the level of qualified staffing on the wards and patient interaction. AD confirmed that he would provide an update on these issues to the next Committee meeting – **ACTION AD**. It was noted that the service user who had identified these issues to the Board was currently working with the Nursing and Quality Directorate and was helping to lead the Safe Wards project.
10. It was noted that Clinical Executive were reporting 80% to 120% safer staffing levels, despite the Trust Board having set objectives of between 95% and 105%. AD acknowledged this discrepancy and confirmed that the levels set by the Trust Board would be used in the Clinical Executive Report going forward.

11. The Committee resolved to **note** the Clinical Executive Report.

QS/15/101 Human Resources Report

1. RC provided the report on behalf of Jenny Turton. She advised that the first Strategic Workforce Group had met on the 30th November and noted that the Quality and Standards Committee would receive the minutes for this meeting along with a list of the key decisions that had been made.
2. It was noted that a piece of work was underway to resolve a discrepancy in how vacancies are described. This would likely be impacted by the Safer Staffing Review.
3. A significant amount of activity was taking place in every locality to understand reasons for staff leaving, and to determine appropriate interventions in order to reduce the staff turnover.
4. Sickness and absence rates had been discussed at the Strategic Workforce Group, who had identified the need for better data on the reasons for sickness and absence. The Committee noted that it was still possible for staff not to record why they were absent from work. Those present agreed that further analysis would also be needed to understand how training and other work related work could be developed.
5. It was noted that there was a significant number of staff members over the age of 50. A Workforce Strategy would be developed that would identify such risk areas and to develop specific interventions that would support younger staff to move through pathways into nursing roles. The Strategy would also consider how older staff could be supported to remain healthy and working. The Committee noted that the Workforce Strategy needed to reflect the skills required of the workforce and to address the common workforce challenges being experienced across the Trust. The Strategy would be developed in response to the Clinical Strategy development.
6. Nursing revalidation after a certain age had been identified as a risk area. Work would be carried out to understand and quantify the risks of nurses choosing not to go through revalidation. RB noted her surprise to see staff working at the age of 65-70, indicating that many Trusts retire staff at 65. It was noted that a Court of Appeal Case had enabled staff to carry on with work after the age of 65.
7. Disciplinary data had been provided about the time taken to resolve cases. Jenny Turton was working with Managing Directors to understand the common themes.
8. The Recruitment and Retention Strategy was an ongoing piece of work. The numbers of offers were outlined in the Human Resources Report appendices as evidence of this activity. Further, the report outlined the sorts of activities that were being undertaken locally, in addition to the Trust-wide programs such as the Leadership Development Program.
9. The Strategic Workforce Group had agreed the development of a Career Framework to outline how staff could progress within the Trust. This was intended to support talent management and workforce planning.
10. There had been discussion at the SWG about the Equality Delivery System. Focus was to be maintained on bank training compliance, which was the only remaining issue on the ESEC matters arising log. All other ESEC matters had been closed.
11. It was noted that the Locality Workforce Dashboard could be added into the Locality Reports, to ensure that workforce metrics were being reported to the Quality and Standards Committee. RB stated that she would like to see a clearer link between workforce and quality issues.

12. It was noted that significant gains had been made in many of the localities. The areas of concern were identified as Wiltshire, Bristol and Secure Services; these remained challenging from a workforce perspective. It was suggested that a more holistic approach should be taken to support colleagues in those localities.
13. AD noted that he had more concerns about retention than recruitment, identifying that skills and competencies were an area that needed to be examined.
14. It was noted that the Conduct Policy had been updated. This had had a positive effect on resolution timeframes, which in turn had impacted on absence reduction and recruitment processes.
15. The Committee resolved to **note** the Human Resources Report.

QS/15/102 Sign Up to Safety Plan

1. AD advised that Suicide Prevention, Falls Prevention, Use of Restrictive Practices and 'AWOL' (Failure to return from leave) would be the focus areas for the Trust.
2. AD requested that the Committee approve the Sign up to Safety Plan.
3. The Committee requested that the Sign Up to Safety be reflected in the Annual Objectives – **ACTION AD**.
4. The Chair asked how the focus areas had been determined. AD advised that these were Clinical Executive objectives.
5. There was a discussion about whether AWOL was considered an issue within the Trust. AD informed the Committee that the Trust was focussed on improving risk assessments to anticipate whether someone would fail to return.
6. The Chair asked whether or not a safety improvement plan would be developed that would include physical health. AD outlined that there was a focus on physical healthcare and acknowledged that it could have been included in Sign Up for Safety. He advised that the approach had been taken from a Harm Reduction perspective.
7. The Committee **approved** the Sign up to Safety Plan.

QS/15/103 Co-Existing Mental Health and Alcohol and Drug Strategy

1. RE updated that this was the third iteration of the strategy, which had built on existing standards and relevant work in this area.
2. RE fed back to the Committee that there had been some debate around whether there should be standard statements and/or target percentage rates set. It had been determined that standard statements were required but that targets did not need to be set.
3. Checking IQ assessment scores, auditing against guidelines for psychosis and substance misuse and carrying out analysis in relation to deaths with a drug and alcohol flavour could provide evidence about whether the strategy was being delivered in a timely and appropriate manner.
4. The Chair said that the Strategy was clear and the standards were easy to read. She noted that she would like to see some more information about how the Trust measured against the standards.
5. RB noted that operational targets should not be set against a Strategy. She suggested that underpinning the Strategy should be a work plan, showing the measures and timelines in relation to strategy implementation and delivery – **ACTION RE**

6. The Committee **approved** the Co-Existing Mental Health and Alcohol and Drug Strategy.

QS/15/104 Policy Approval

1. SJ provided an overview of the Medical Devices Policy update. She advised that there were no major changes. It had been reviewed by the Physical Health and Medical Advices and Infection Control Group. The main changes were: updates to hyperlinks, in order to provide readers with access to the most up to date information; the addition of a method of registering newly acquired devices; and a reminder that the responsibility to determine equipment needed, and the management of medical items, remained at the Departmental level.
2. The Committee **approved** the Medical Devices Policy.
3. MD provided an overview of the changes to the Mental Capacity Act including DOLS Policy. With the cessation of DOLS, Safeguarding and Mental Legislation Management Groups, the Policy would be overseen by CIOG. Revised guidance had been developed and procedural changes had been made around administrating DOLS applications and authorisations within the Trust. MD highlighted that he did not consider data capture around DOLS to be reliable, but believed the procedural changes would assist the Trust to have more confidence in the data collected. The updates also proposed the introduction of a specialist function in relation to DOLS in the Safeguarding team.
4. The Chair asked if DOLS was part of the checklist on the Record Management audit within the wards. MD outlined that there was a specific checklist in relation to DOLS, but said that he was unclear as to whether this was part of the audit checklist. The Chair advised that it should be evident on the care plan that DOLS had been considered, and that it should be noted which legal framework should apply. MD undertook to talk with AD about adding this to the record management checklist – **ACTION MD/AD**
5. MD was asked if there was a standard approach to using DOLS on the Acute Wards across the Trust. MD advised that he believed that the approach was better understood in older people wards, and less well understood in Acute Wards. He noted that the new procedures would provide better data.
6. The Committee **approved** the Mental Capacity Act including DOLS Policy.
7. It was noted that the Social Media Policy and Membership Strategy Policy review would be **deferred** until January.

QS/15/105 Any Other Business

1. No other business was declared.

Committee Evaluation

1. Those present scored the meeting, on average, as 3.5 out of 5. The Committee felt that the presentation from the BaNES locality had been very positive and well-presented. Those present acknowledged that more interpretation was required of figures, data and trajectories to ensure that they remained meaningful.