Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of a Meeting of the AWP NHS Trust Board - Part 1

Held on 25th May 2016, Jenner House, Chippenham SN15 1GG at 10.00am to 4.00pm

These Minutes are presented for **Approval**

Members Present

Tony Gallagher (TG), Chairman of the Trust
Susan Thompson (ST), Non-Executive Director and Vice Chair
Mark Outhwaite (MO), Non-Executive Director
Mathew Page (MP), Acting Director of Operations
Tim Williams (TW), Acting Medical Director
Hayley Richards (HR), Chief Executive
Emma Roberts (ER), Company Secretary
Ruth Brunt (RB), Non-Executive Director
Barry Dennington (BD), Non-Executive Director
Charlotte Moar (CM), Non-Executive Director
Sue Hall (SH), Director of Resources
Ernie Messer (EM), Associate Non-Executive Director

Staff In Attendance

Gary Bryant, Interim Director of Finance
Z. Millington, Development Worker
Brian Courtney, Interim Deputy Company Secretary
Jack Bancroft, Communications Officer
Simon Gerard (SG), Head of Communications
Franki Halliwell, Administration Assistant
Emma Bye, Media Communications Specialist
Julie Musk, Senior Communications Officer,
Chrissie Newton, Compliance Officer
Abbie Davis, Compliance Apprentice
Julie Benfell, Head of Compliance
Martha Kane, CQC Inspection
Graham Nice, CQC Inspection
K. K. Singh, CQC Inspection
Toria Nelson, Manager of Workforce Planning
Gordon Folkard, Acting Head of Operational Finance
Karen B-W, CQC Inspection
Rachel Clark (RC), Director of Organisational Development

Members of the Public in Attendance

Mr M D Ody

BD/16/033 Apologies

1. Apologies were received from Peaches Golding (PG) and Andrew Dean (AD).

BD/16/034 Declaration of Members' Interests

1. In accordance with AWP Standing Orders (s8.1) members present were asked to declare any conflicts of interest with items on the Committee meeting agenda.
2. There were no declarations.

BD/16/035 Patient Experience Story

1. SG introduced a film that had been compiled by the Communications Department as part of the Mental Health Awareness Campaign.
2. Rachel Clark described a wider body of work that was being done around Wellbeing. She advised

that the staff survey results had indicated three priorities related to the wellbeing of staff that required focus. Quality of supervision was being addressed through ensuring clarity of roles and providing access to training and support for staff development. Dignity at work was being addressed through staff recognition via awards and leadership development programmes. Health and Wellbeing initiatives had included the design of a manager's wellbeing Toolkit so that Managers could feel confident to in detecting signs of distress and would feel able to provide support as required. Rachel Clark advised that a ''Culture of Care'' barometer focussed on the team environment had been trialled in Secure and Specialised during the previous year and would now be rolled out throughout the Trust. She also advised that wellbeing roadshows would be held on the 14th and 15th July at the main sites.

3. HR was working on methodology for measuring the success of the wellbeing projects and would be reviewing the projects on a regular basis.
4. EM congratulated the Communications Team on the development of a good short film, noting that it illustrated what could be achieved with a small budget using media. He noted that the team had clearly gained the trust of staff to be able to produce such a film. SG acknowledged that the process of gaining trust had been a long one. He recalled that in the past AWP had avoided putting service users in front of the camera, but now they felt confident that there could be positive results when using media in this way.
5. HR asked how managers would know if staff had been injured or traumatised at work. Rachel Clark advised that the toolkit had been developed using some of the tools that had been identified in the Leadership and Management Programme and during the Leadership Conference.
6. RB asked how the Trust would evaluate the quality of the wellbeing programme as opposed to measuring the numbers of staff who had engaged with the process. Rachel advised that an evaluation would be built into the Supervision Project. A new method of conducting the appraisal process was being developed which included a feedback mechanism which asked staff to evaluate the quality of the appraisal. Appraisal training would aim to improve the quality of the appraisal experience.
7. ST indicated she would like to see some key measures in the Workforce Report that provided to Quality and Standards Committee that showed that the link between supervision and appraisal was clear and that development of staff was a focus. RC advised that part of the appraisal process identified the skills required to deliver objectives. Evaluation would also be requested from staff about the value of the skills and training that had been received within the Trust.
8. RC advised that the development of a Career Framework would also show a clear pathway along with the skills, competence and training that would be required for staff to progress. ST requested that a metric be identified that could be reviewed at the Quality and Standards Committee that would evidence that the steps being taken were improving outcomes for staff in this regard. **ACTION RC**.
9. The Board thanked SG and RC for their presentation.

BD/15/036 Questions from Members of the Public about the Work of the Trust

1. TG summarised two questions that had been received in writing from Mr Ody as follows:
2. Firstly, during the April Board meeting, the term ''Data Cleansing'' had been replaced with ''Data Quality Checking''. Mr Ody asked if these two terms had the same meaning. MP advised that this had simply been a revision in terminology. It had been concluded that the term Data Cleansing did not clearly articulate what was being done, whereas the term Data Quality Checking was a

clearer indication of the process that was actually being undertaken.

3. The second question had been about the type of phones that were issued to staff and whether they had camera capability. ER advised that Nokia mobile phones were issued to staff. AWP also supplies mobile computing devices which have camera capability. ER advised that the relevant area of the Policy had been highlighted in the copy of the Policy that had been sent to Mr Ody in response to his question. She invited Mr Ody to discuss any underlying issues that were related to this question with her directly.
4. Mr Ody indicated that he had wanted to know which social workers carried camera phones. ER advised that it would vary from person to person. Staff could request mobile phones; some of which were camera enabled. She advised that there was a record of each staff member's mobile phone type. Mr Ody asked if he could find out what type of phone a particular staff member had. ER invited him to discuss this with her outside of the meeting.
5. Mr Ody advised that he had not received written replies for previous questions that he had asked at March Board. ER advised that duplicate replies had been sent out to Mr Ody but undertook to provide additional copies as required.

BD/16/037 Minutes of the Trust Board Meeting on 27th April 2016

1. The Board reviewed the minutes page by page for accuracy.
2. BD/16/013 Item 2: RB asked that the wording to be changed to ''She advised the committee had received assurance that people who had not been seen within the target time were not waiting for an extended period for assessment''. **ACTION ER**.
3. BD/16/037 Item 15: a dollar sign had been used instead of a pound sign.
4. The minutes were **approved** with the corrections noted above.

BD/16/038 Matters Arising from the Previous Meeting

1. Item one was deferred. This item was noted as **ongoing**.
2. Item two was noted as having incorrectly used the word ''Incident'' rather than ''Incidence''. MP advised that a psychiatric intensive care unit (PICU) report had been provided to the Quality and Standards Committee. This report included information related to female PICU. This item was noted as **complete**.
3. In relation to item three, TW advised that he was happy to support Mr King's travel claims and this would be done through the CCG. ER undertook to send Mr King the relevant claim form. This item was noted as **complete**. **ACTION ER**.
4. In relation to item four, SH advised that the quality impact assessments (QIAs) would be presented at Quality and Standards on 21st June 2016. This item was noted as **complete**.
5. Items four to ten were noted as being covered in the HR Report and were noted as **complete**.
6. In regards to item eleven, it was noted that there would be a deep dive report into the top clinical executive risks during this meeting. This item was noted as **complete**.

Horizontal Reporting

1. It was noted that items one, two and four, five and six would be reported to the relevant committees in June.
2. Internal audit would be reviewing item three.

BD/16/039 Chair and Chief Executive's Actions

1. No actions had been recorded.

BD/16/040 Chair's Report

1. TG took his report as read. He highlighted the following three issues:
2. TG advised that there were two sustainable transformation plans (STPs) within the footprint of AWP. HR would update the progress of these during her report. The Chair of Bath, Swindon and Wiltshire and the Chairs of the Trusts and the CCGs of that STP had met to ensure that there were no blockages in relation to the progress of the STP.
3. TG advised that AWP had been successful in getting accreditation as being one of twelve genomics management centre (GMCs) in the UK. The West of England GMC included a partnership of five acutes, five CCGs, five academic organisations and five other organisations. TG advised that the GMC had moved into the phase of implementation and normalisation. The GMC had now been able to take test samples from patients, put them through the process, have the samples analysed and return the data to patients and NHS England. They had been commended as being an effective GMC and would commence taking their first real samples in June. The Board had also been expanded to add two people with lived experience.
4. TG sought approval for RB to be appointed as a Senior Independent Director as a conduit for Board members or others to reflect on Chair or Board performance. The Board **approved** this appointment. MO was being nominated later in the meeting as the Whistleblowing Lead and Board approval would be sought for this appointment at the relevant agenda item.
5. The Chair's Report was **noted** by the Board.

BD/16/041 Chief Executive's Report

1. HR took the report as read. She highlighted the following points:
2. An agreement had been made on the junior doctor contract although the British Medical Association (BMA) intended to ballot for acceptance. There was an awareness of specialties that may attract pay premiums, one of which was psychiatry.
3. TW advised that AWP was 100% recruited for core psychiatric trainees for the third year running. This reflected the work that had been done in supporting junior doctors. One of the AWP trainees had come second in the National Award for Quality Improvement Programme.
4. HR advised that AWP had won an Excellence in Diversity Award following the work of the Diversity Board on promoting diversity in the workplace.
5. Dr Tina Malhotra was welcomed as the new clinical director for Swindon. HR also thanked Simon Manchip, who would now focus on clinical work in Swindon as a consultant psychiatrist. HR also reported that Sue McKenna had been appointed as the new Director of Operations.
6. HR noted that the executive reports were providing a more robust view of clinical and safety issues through the Clinical Executive Report. This was being triangulated with the Performance Report and previously stubborn indicators were beginning to move. The Finance Report format had changed and would continue to improve.
7. HR advised that a large amount of her time had been spent working with the two STPs. Mental health was being established as a priority in the upcoming submissions. The STP was providing

good networking opportunities.

8. ST asked if the Board would have an opportunity to look at the STP plans prior to them being submitted. HR advised that the timeframes may not allow for the information to be presented to Board but advised that she would endeavour to share the information through a seminar or via email. **ACTION HR**.
9. CM asked about what would happen post submission checkpoint. HR advised that after the first checkpoint, the STP leaders and a small team had been called to an interview with Simon Stevens, Jim Mackie and Bob Alexander where they had received written and verbal feedback on progress. It may be that there would be another round of feedback after the next submission.
10. TG welcomed the mix of the operational and strategic information contained in the CEO's Report.
11. The Chief Executive's Report was **noted** by the Board.

BD/16/042 Clinical Executive Report

1. TW noted that there had not been a Quality and Standards meeting since the last Board meeting and therefore he undertook to provide more detail on the report to the Board.
2. On safer staffing, one ward had been under 95% (Applewood due to two bed closures) and 19 wards were over 105% Safer Staffing. A deeper dive had been provided in the report on the wards that were over 105%.
3. CM sought reassurance that the safer staffing levels that had been signed off by Clinical Executive were in the budgets. SH advised that the current standard board establishment for basic safer staffing levels were in the budget. If wards needed to have additional staff acuity over and above the budgeted levels, this would be charged separately to the CCGs - i.e. this was not in the budget.
4. TG asked if there was a charging mechanism in place where there was additional acuity and sought confirmation that there would be an equal and opposite charge. TW advised that there was a process in place. It required monitor and review to ensure that acuity was there. TG suggested there should be an automated process to ensure charges were raised to the CCG at the time of additional staff engagement.
5. HR assured the Board that the clinical need determined the staffing requirements and the funding issues were resolved at a later stage in the process.
6. ST noted that a safer staffing standard had been set, but understood there were still issues around skill mix to be resolved in some areas as a result of recruitment issues. She advised that within Quality and Standards, the Committee continued to monitor the variation and the reasons for it. Where any slippage was identified on the impact on finances, this was referred to Finance and Planning or Audit and Risk Committee.
7. TW spoke to the nursing audits advising that two wards had not submitted information for April. Fairfax had not submitted for four months in a row and the clinical director was being challenged to provide a report the following month. Despite a focus on the Modern Matron Network, there had been an increase in the number of blank boxes reported on the drug prescription and administration record (DPAR) checklist.
8. RB noted that the narrative described an increase in the number of blank boxes for April, but the numbers appeared to indicate a reduction. TW advised that there was an increase in the percentage of blank boxes but a decrease in overall numbers.
9. TW advised that there appeared to be some incidents being reported as rapid tranquilisation

which would not necessarily be considered RT. Clear standardisation was required around the definition of rapid tranquilisation. Bristol and South Wiltshire were particular areas of focus in terms of physical health monitoring.

10. RB asked what was being done about areas that were not compliant with medicines management requirements. TW advised that there was recognition of estates issues and the lack of available space to ensure compliance. They continued to actively look for solutions in those areas.

11. RB asked to what extent the rapid tranquilisation statistics were related to recording issues, and to what extent they were related to training issues. TW advised that there was an element of reporting issues, but the focus of the clinical executive was on improving practice which was not to the standard required. The next Quality Forum would be devoted to seclusion and restricted practice which included Rapid Tranquilisation. In the longer term, there would adaptation of the RiO process to ensure more accurate recording which would provide more prompts to staff dealing with RT.

12. ST noted that the report identified that the matrons had developed a quality improvement plan and it was anticipated that improvement would be delivered by the end of Q2. She asked if TW was expecting full compliance by the end of September or progress along a trajectory. TW advised that it would be a trajectory report rather than full compliance. The most challenging aspects would be around improving the recording of seclusion, restricted practice and RT so they could clearly evidence improvements in performance. A trajectory would be defined after the Quality Forum.

13. ST asked for an update to be provided back to Quality and Standards in June. She asked that some information be provided about how AWP was benchmarking against similar trusts. TW advised that no benchmarking had been done, but undertook to approach comparable trusts to share data. TG asked that the improvement expected by Q2 be quantified. **ACTION TW**.

14. Safewards had been a positive intervention and had improved staff morale and ward integration.

15. BD noted that appraisal rates of 95% had been set (taking into consideration exceptions). He asked by how much Bristol, Swindon and Wiltshire had missed and asked what action was being taken to address this. MP advised that 90.6% compliance had been reported in March, 89.8% in April. TW advised that the challenge was for localities. Monthly reviews of performance would be completed and action plans would be developed to improve appraisal rates. Part of the Extended Executive Committee would be looking at best practice in some areas. Bristol and Wiltshire were challenged in terms of staff engagement which was acknowledged as being an issue.

16. EM asked about the supervision rates which were at 85%. He noted that the staff survey action plans focussed on improving on quality of supervision and appraisal and asked why the target had been retained at 85%. TW advised that the next stage of the focus was on improving the quality rather than the recording of supervision.

17. HR advised that supervision had been sustained at 90% for a long time, but appraisal had dipped in the last month and this would be addressed.

18. TG asked for some quantification of statutory and mandatory training which had been described as poor. TW advised that in fact there had been a steady improvement in training rates for bank and agency staff which were moving toward the high levels that had been achieved for substantive staff. **ACTION TW**.

19. MP advised that staff were paid to complete the training and methods of delivery were being considered. The Bank App provided staff with full access to their MLE accounts.

20. Five SUIs had been reported.
21. The 2015-16 Quality Tracker was now closed and the 2016-17 tracker was under development. New items had been added to reflect new areas of focus.
22. RB asked that the Quality Tracker pick up the elements identified in the Quality Account. TW undertook to check this. **ACTION TW**.
23. The Clinical Executive Report was **noted** by the Board.

BD/16/043 PICU Report

1. It was noted that the PICU Report would be reported to Quality and Standards Committee in advance of any update to the Board.
2. TG asked that Quality and Standards Committee address Female PICU which was a national issue. **ACTION ST**.

BD/16/044 Performance Report M1

1. MP advised that the Performance Report had been provided to Finance and Planning, but had not yet been presented to Quality and Standards. He provided the headlines as follows:
2. The Monitor Dashboard showed an overall level of good compliance.
3. There were specific issues around delayed transfers of care (DTOC) that were being addressed with partner organisations. MP advised that he had met with the Commissioner Support Unit and representatives from the CCGs in preparation for the CQPM meeting. They had agreed to ensure the attendance of a Local Authority Representative to look at DTOC.
4. The indicator, service users with a carer identified, continued to be an issue in Wiltshire and Bristol with both reporting only slight improvements. An overhaul of the action plan would be undertaken.
5. MP advised that consideration was being given to different metrics that could provide the Board with assurance around carers in a more sophisticated way than the current tick box metric being used.
6. TG noted that the DTOC indicator trend for South Gloucestershire was quite erratic. He asked what the cause of this was. MP advised that he had met with the South Gloucestershire Commissioner who was aware of the issues. She advised that being a smaller locality it tended to be more volatile.
7. EM noted that information was presented based on CCG and the actions and resolutions were made by locality. He asked if this created any disjoint or mismatch when following through actions. MP advised that it did not. The decision had been taken to report by CCG because the local delivery unit (LDU) reporting had been a complicated process. TG advised that the Commissioners had welcomed this method because it also gave them direct visibility of data.
8. ST noted that it would be useful to have visibility on the actual numbers of people affected rather than the percentages. MP undertook to bring them to the next Quality and Standards meeting. **ACTION MP**.
9. MP noted that the variance of levels of investment in improving access to psychological therapies (IAPT) impacted levels of compliance for this target. He advised that Claire Williamson was leading a trust-wide group to look at this. He reported that AWP delivery of service indicators showed a high level of compliance for the areas over which AWP had control.
10. CM asked if the six week waiting time target for Swindon would bring it into line with other

localities. MP advised that elsewhere there was a four week referral to assessment target. He noted that there was a larger client base in Swindon. HR advised that this sort of contract issue would be discussed during the STP conversations.

11. TG noted that it was encouraging to see that AWP was working with the clinical commissioning groups (CCGs) to resolve the issues and that there was recognition that there was a funding and resource issue. TG acknowledged the improvement that had been recorded between May 2015 and May 2016 in Bristol.
12. MP noted the diversity within the ''settled accommodation'' indicator specifically in relation to the type of accommodation where service users could be placed, some of which did not count as settled accommodation. TG suggested AWP could consider working with a partner or a nominated provider in Bristol noting that AWP could not effect change in this indicator on its own. HR advised that this was how the AWP would be positioning itself and there had been discussion about how they could improve the system during partnership conversations in the new tenders.
13. MP noted the improvement of Bristol on the Referral to Assessment indicator advising that Bristol was closer than they had ever been to the 95% target. Issues continued to be recorded in S Glos and Wiltshire, both of which had specific action plans in place and improvements were forecast over the next two months.
14. RB asked if the average wait in days was median or mean. MP undertook to qualify this. RB advised that she would prefer the measure was median. EM advised that he would also like to see the range so the Committee could identify whether the variation was wide or not. **ACTION MP**.
15. EM asked about how episodes were being measured by Health and Social Care Information Centre (HSCIC) and asked if there had been any resolution with the differing interpretations between HSCIC and AWP. MP advised that he was confident in the Head of Business Intelligence who was in touch with HSCIC about this, but did not believe it had been resolved other than HSCIC acknowledging that there was a difference.
16. TG asked that Cove and Juniper be removed from the bed pressures table now that they were permanently closed. SH advised that in contractual terms, AWP had the liability to provide those beds. TG suggested that if AWP was taking the financial hit, it would become part of base business. If they were re-provisioning they would need to show a plan. **ACTION MP**.
17. MO asked about what progress was being made on the staffing issues at Imber. MP advised that there had been a turnaround response with a new Matron pulling together the action plans working alongside the Nursing and Quality Director to do some detailed work around nursing practice and culture. In terms of staffing in the medium term, some agreements had been made with framework agencies to provide fixed contract staff for three months to provide some continuity. This could also reduce agency costs for the ward. This period of stabilisation should improve things. Accommodation for staff was also being considered.
18. RB noted that in the areas where localities were off trajectory, it would be useful to have some narrative in the report. She noted that the report did not currently indicate what actions were being taken to move the localities back onto trajectory. She suggested that the Board could be provided with an exception report.
19. MO asked why distance from AWP HQ was used in the chart on Page 19 noting that given the geographical range of the Trust this was not an accurate reflection of a carer, family or service user experience. MP advised that this had been taken as a central point. He suggested it could be done individually from service user homes but considered that this could become quite

complicated. TG advised in the interests of gauging patient experience it could be worth checking the individual data given there was only a small number of users. **ACTION MP**.

20. The Board **noted** the Performance Report M1.

BD/16/045 Mazar's Report

1. TW advised that the report provided in the pack was a response following the Mazar's Report which had looked into the level of deaths in Southern Health and the reporting around the investigations into those deaths.
2. The report detailed the key findings and provided an AWP analysis. Discussion from the Board on the report was as follows:
3. EM asked how the Board would monitor near misses. TW advised that an external report from the national reporting and learning system (NRLS) had been received. This had reviewed the AWP process and there were a lot of low level green and yellow incident reports indicating that the Trust was capturing a lot of potential near miss incidents. He advised that Pharmacy actually reported separately on near misses and the Care Quality Commission (CQC) had indicated that this process was capturing a lot more near misses within Pharmacy than many of the trusts they had visited. He summarised that he was confident about AWP's ability to capture near misses.
4. ST commended the work that had been done on understanding and reflecting on Mazar's Report. She advised that there had been significant scrutiny of the report and the resulting actions at AWP Committees. She added that she was pleased to see that AWP was partnering and learning from Solent which had a large community and primary care base.
5. ST noted that Mazar's had focussed on the lack of scrutiny around learning disability and older people's services. She suggested that AWP must focus on those areas in conducting their reviews. They needed to ensure they investigate appropriately in those situations and learn from Southern Health's experience.
6. ST noted that the other area which had not been addressed in AWP's response was the need for independent advocacy. She noted that AWP did well in listening to families in their SUI responses. She considered that some of the best root cause analysis reports had been seen where families had wanted to be fully engaged in the process because there was a level of detail that would not be found if they looked purely from an organisational perspective. She suggested however that there was a gap in relation to advocacy.
7. ST asked how AWP would engage service users and carers in the work, in the learning and in the development of improved practices. She asked what the plan was for locality engagement.
8. TG suggested these questions be reviewed by Quality and Standards. He also noted that they needed to communicate to their staff that they were confident in the robustness of the AWP process. He also suggested that there was an external community relationship issue that needed to be addressed in order to assure the public that AWP had a rigorous mechanism in place. **ACTION Q&S.**
9. MO suggested it would be useful to have some indicators they could track over the next year that would enable them to demonstrate externally that the situation was under control. TG suggested this could be discussed by Quality and Standards. **ACTION Q&S**.
10. The Board **noted** the response to the Mazar's Report.

BD/16/046 Safer Staffing Update

1. The Safer Staffing Update had been provided as part of the Clinical Executive Report.

BD/16/047 Finance Report M1

1. SH presented the Finance Report in its new format and thanked MO for his assistance in designing the report. She advised that it remained a work in progress and noted it would develop over the next couple of months. The report was designed to be read on the iPad.
2. A small underspend was reported for M1, but SH cautioned that all budgets were not set and changes would be recorded as the contracts were signed.
3. SH noted that the Annual Operating Plan had been submitted with a financial plan to report a surplus of £50k which was not in line with the Trust Development Authority's (TDA's) request for a control total of £1.7m. AWP was still waiting for a response about their enquiry to the TDA about what happens to trusts that do not accept the control total.
4. EM advised that this report had been reviewed at Finance and Planning. That Committee had identified that a couple of the red/amber/ green (RAG) ratings on the first page should be amber (e.g. temporary staffing, non-pay overspends). SH advised that they had agreed a rating methodology whereby they would show amber if they were not at the expected budget in month, but would show green for the full year if they still anticipated making the budget by year end.
5. CM noted her surprise at cost improvement plans (CIPs) being rated as green indicating that the full CIP program was not in the budget. She noted that the final QIAs would not be presented until 21st June which would mean the CIPs programme was back-ended.
6. BD advised that this had been discussed extensively at Finance and Planning and the Committee had been advised that all of the QIAs related to the CIPs would be reviewed by 25th May and approved by the next Quality and Standards meeting. Any QIAs that could not support a particular CIP would then result in a circulating back and identification of new CIPs to quickly replace them thus ensuring there was always a firm plan on CIPs that could be measured.
7. CM asked if Finance and Planning had looked at the profile for CIPs for the year noting that if it was back ended, they could get a long way through the year without progress being recorded. SH advised that a separate paper had been presented to Finance and Planning by the Future Focus Programme Board which detailed the CIPs schemes and their start dates. The Project Management Office (PMO) was working up schemes for more than the £6.1m needed and was beginning the process for 2017/18 already. The CIPs noted as green were those that had been carried forward from the previous year.
8. TG sought confirmation that the colour coding represented to the Board that the Executive had high confidence in achieving the CIPs. He noted that there had not been full scrutiny from Finance and Planning on those schemes and their timing, nor the QIAs associated with this. HR advised that this was the case. Some of the CIPs were two year schemes that had been carried forward. She noted that she was concerned about delaying the QIA sign off until 21st June. ST advised that the Clinical Executive had to be satisfied that the QIA was acceptable for the CIP to go ahead. Quality and Standards would expect to see a report on the QIAs after the Clinical Executive scrutiny. Quality and Standards should be informed about areas of concern that required further interrogation.
9. TG summarised that the current position was that there was a high degree of confidence from Executive. Finance and Planning had reviewed and considered that some of the CIPs should be amber. They were awaiting the QIAs to gain assurance that they were acceptable. BD noted that, further to this, Finance and Planning was seeking replacement CIPs very quickly in the event

any CIPs were rejected through the QIA process.

10. CM sought confirmation about when the full £6.1m of CIPs would be devolved to a budget holder. SH advised that the localities had their CIPs in their locality budgets (albeit not necessarily in the right cost centre until the QIAs were agreed). BD advised that Finance and Planning had sought assurance that all of the CIPs had been agreed by LDU, triumvirate and the other stakeholders. They had received assurance that the CIPs had been agreed.
11. MO agreed this should be amber and considered it probably should remain so until the end of the period. SH advised that the RAG rating showed the confidence in delivery. CIPs were not accepted unless they were deliverable and would be taken out of the budgets.
12. TG referred to the statement made about the run rate in Bristol having the potential to take Bristol £3m over budget. He noted that he would expect Finance and Planning to scrutinise this and for the Board Report to identify the mitigations either directly to address the issues in Bristol or elsewhere to make up the shortfall. He suggested issues as significant as this should be in the main body of the Key Messages. SH took this comment on board.
13. SH advised that not all contracts had been signed, but the financial envelopes had been agreed with all providers. There had been some adjustments to income (to AWP's benefit) as a result of negotiation with CCGs. This would be brought to the next Finance and Planning Committee meeting.
14. RB provided positive feedback on the report.
15. The Board **noted** the Finance Report M1.

Report of the Finance and Planning Committee Chair

16. BD provided a brief overview of the Finance and Planning Committee meeting held on 20th May.
17. Given that budget discussions were still underway, budget scrutiny had been deferred until the next meeting.
18. The new style of the report had been commended. They Committee had also asked for clarity on the RAG ratings and had asked that the actions and their owners be clearly identified.
19. A presentation had been provided on the Bath and North East Somerset (BaNES) procurement bid. The feedback from the Committee had been to alert them on any particular areas where there may be a threat to AWP winning the bid.
20. The Committee had previously alerted the Board to the risk of a £1.67m loss, but this appeared to have been neutralised through contract negotiations.
21. Cash and bad debts had been discussed. There was recognition that weekly cash meetings were being held and the Committee had recommended early and urgent escalation in any recovery of bad debt.
22. The Committee had recognised the good performance in agency reduction but had picked up that the Bristol and Wiltshire LDUs were underperforming and had asked for more focus on this at the next Finance and Planning meeting.

BD/16/048 HR Report

1. SH presented the new format HR Report.
2. She advised that a new recruitment system called TRAC had been introduced. This would provide more visibility about where people were in the recruitment process and would enable better reporting.

3. Work was being done on retention with a detailed plan being developed for each locality. This was being monitored by the Strategic Workforce Group. Targeted recruitment retention within Wiltshire included schemes to work with housing associations to offer key worker housing.
4. Staff had been successfully transferred from North Bristol Trust to AWP from the 1st April 2016. MP advised that work had been done to ensure that staff training was up to AWP standards. Being a Child and Adolescent Mental Health Service (CAMHS) service, there was a high level of part time staff which would affect how it would be managed and this would present some challenges.
5. HR advised that she had attended the Health Education England (HEE) Workforce Workshop. Information had been presented that indicated that retention was high on the agenda nationally and it would be important for AWP to benchmark themselves in relation to turnover, retention and reasons for leaving. The key issues for people leaving were around the lack of clear career progression. This would be key to the work that would be put into the sustainable transformation plans (STPs).
6. EM noted that 73 staff had left within their first year of employment. He suggested it would be helpful to have more detail on this. SH advised that analysis was being carried out on this statistic.
7. EM asked if there had been any financial implications as a result of the CAMHS Transfer of Undertakings (Protection of Employment) (TUPE) transfer that would change the business case from the original plans. MP advised that there had been significant challenges around receiving TUPE information from the previous provider. There was undertaking that because it was a lift and shift contract, the finance would follow precisely, therefore there was no financial exposure for AWP. There was work to be done by finance and payroll to ensure that this was the case.
8. CM requested that a deeper dive on recruitment and retention be provided by RC at a future meeting, particularly in relation to career progression. ST added that the Trust needed to have a much better grip on how skills and capabilities were being addressed within appraisal and supervision to ensure people were given the opportunities to learn and given the space to develop. **ACTION HR**.
9. ST advised that quarterly reports and monthly exception reports from the Strategic Workforce Group were being reviewed by Quality and Standards. She noted that there needed to be some improvement in the retention figures, particularly in Bristol.
10. MO noted that where people were feeling helpless, bullying and harassment could become an issue. Good training, good skills and the ability to use them was important in addressing this threat.
11. TW advised that AWP was seeking to become a leader in the Physician Associate Programme and would be offering placements within Bristol.
12. TG noted that one of the dominant reasons for nurses leaving was due to approaching retirement age which the Trust should be able to forward plan for. The other reason was work-life balance and staff had the ability to go to agency or use bank in a flexible way. He noted that AWP must continue to be creative about the work patterns and the different ways of working available to enable them to retain staff
13. The Board **noted** the HR Report.

BD/16/049 Annual Operating Plan

1. CM asked what would happen next on the Annual Operating Plan. She asked how the Trust

would measure whether they were delivering on the Plan or not.

2. TW advised that the Annual Objectives would be developed. These had been discussed with localities. The formal Annual Objectives Plan had not been formally compiled as yet, but the work had now been done to enable this compilation to proceed.
3. CM asked how progress would be reported to the Board. ER advised that there would be a quarterly review against annual objectives and the first report would be presented in July. In 2015/16 an Assurance Dashboard had been developed which measured performance against annual objectives and identified risks to the objectives. The intention for 2016/17 would be to monitor progress against objectives and through a separate document they would monitor controls against risks to the objectives. The Audit and Risk and Quality and Standards Committees would be reviewing these reports.
4. TG noted that the plan was more specific than it had been in previous years.
5. The Board **noted** the Annual Operating Plan.

BD/16/050 Annual Report

1. ER presented the Annual Reports and Accounts for approval noting that they had been produced two weeks ahead of the normal timetable. She advised that they had been reviewed in detail by the Audit and Risk Committee.
2. Over the last week there had been some minor grammatical changes made to the document.
3. CM advised that the Head of Internal Audit Opinion had been very clear that there were no significant issues to raise. The External Audit had gone smoothly and the Auditor had acknowledged how positive this was given that there had been a high turnover in the Finance Department.
4. CM advised that in future they should ensure the timetable was less pressured.
5. SH acknowledged the work of the team during a difficult time.
6. TG thanked the Finance Team for their work on the accounts.
7. The Board **approved** the Annual Report and Accounts.

BD/16/051 Annual Whistleblowing Report

1. ER provided the formal Annual Whistleblowing Report which provided assurance to the Board that there were sufficient and robust arrangements in place to cover whistleblowing arrangements. She highlighted the following points:
2. There had been some changes in relation to how AWP manages whistleblowing arrangements at a Non-Executive Director level with the roles of Senior Independent Director and Whistleblowing Lead being separated. RB had been appointed as Senior Independent Director. The papers sought approval to appoint MO as Whistleblowing Lead for the coming year.
3. The Annual Report indicated that there had been four significant whistleblowing concerns raised in the last year and these had been investigated using the whistleblowing policies and procedures. ER had provided support in her role as Company Secretary to the Whistleblowing Lead in carrying out the investigations in line with the Public Interest Disclosure requirements.
4. ER advised that there had been a need to raise attention of staff to the Whistleblowing Lead and relevant contact details. There had been communication in year to provide staff with information on whistleblowing. MO may consider making a blog or webcast for staff.

5. The introduction of the Speak-Up Guardian was also noted.
6. ST noted as outgoing Whistleblowing Lead that she had been involved in the investigation of incidents that had been raised anonymously. She noted the importance of continuing to welcome both anonymous and accredited whistleblowing. She thanked the Executive for their support in investigating incidents quickly and efficiently. Feedback had been received from individuals who had identified themselves and they had indicated that they felt they had been listened to and action had been taken.
7. The Board **approved** the appointment of MO as Whistleblowing Lead from 1st April 2016 for a one year term.
8. MO advised that he had already received two incidents for investigation, one anonymous submitted through TDA. Neither incident involved patient or service user risk. The first incident had been sent back to TDA and there had been no substance to support the allegations although there would be corporate learning. The second case was under review. There was substance to this allegation.
9. The Board **noted** the Annual Whistleblowing Report.

BD/16/052 Risk Report

1. HR advised that the Clinical, the Delivery and the Business Executive Risk Registers were called the Trust Risk Register. The Strategic Risk Register aligned with the risks identified through the Annual Governance Statement, Annual Operating Plan and IBP.
2. HR advised that the move to RiskWeb had been made and positive feedback on this had been received.
3. The Top Scoring Risks were identified from each of the Executive Risk Registers. These had been shared with the extended Executive Committee which had resulted in more exposure to risk conversations. This had also resulted in more challenge around what was represented in the registers.
4. The Strategic Risk Register had changed a lot in the last month as a result of the alignment work that had been done.
5. A significant risk had been added to the Clinical Executive Risk Register as a result of the benchmarking against the Mazar's Report and Southern Health.
6. TG asked about the new risk (roof space). He asked about the process by which this risk had been identified and asked about the 16 score which he considered to be high. ER advised that there were differing risk appetites depending on the type of risk. For Delivering Best Care there was a low risk appetite, which was why it was marked red and had scored 16. TG indicated that localities should be informed about this reasoning.
7. TW advised that he and AD had reviewed this risk and considered that not only was there a direct risk to patient safety, but there was also an element of systemic risk which would affect all elements of the Trust. The mitigation that they had previously considered effective had been proven ineffective. TW had visited Applewood and Juniper and an immediate structural mitigation had been implemented. He confirmed that this was the reason for the addition of this item to the register and the reason for the high score. TG noted it was important that localities understood why the scores were high do that they could have confidence that high risks would be mitigated. TW confirmed that this particular incident had been shared with each locality and they had been asked to review their roofs and garden spaces as a result.
8. ST noted that identification had been important, but sought assurance that the mitigations were

effective and sustainable. It was agreed that it would be presented to Quality and Standards as a key risk for interrogation. TW provided a brief overview of the actions that had been taken in regard to roofs and advised that the mitigations had been reviewed by the senior management teams and had been designated as effective.

9. MO asked if learnings from risk identification and mitigation were being transferred into Trust policies (e.g. in the case of roofs, was there an updated of the building policy?). TW advised that Estates had been informed and that a longer term roof strategy would be developed.

10. MO noted that although some risks would be retired, they should still be audited on a regular basis to ensure that they do not come up again. ER advised that this was happening. CM advised that the Internal Audit also reviewed the list of risks and flagged follow up in areas that had not been reviewed for some time.

Top Scoring Risk - Deep Dive

11. TW talked about standardisation across the Trust and sharing of good practice to bring up the overall standard. He noted that risk CE18 affected every element of patient care. He provided a detailed analysis of the risk mitigation measures and examples where standardisation work was being undertaken.

12. HR noted that opportunities should also be identified from the key risks. She noted that in regards to this risk there was an opportunity to improve communication and use this as a lever for standardisation. There would also be consultation with the workforce about IT platforms for communication that would allow exchange and best practice ideas. HR advised that realistic action dates had been set for 2017.

13. RB noted that during the recent Non-Executive quality improvement visits, staff seemed to value the structures in place for cross-locality sharing.

14. ST asked how progress would be monitored and measured. TW noted that while action plans were reviewed and assessed at AWP Committees and externally at the CQPM Quality Meeting, there was no one area where they could draw together the outcomes that had been checked.

15. MO suggested a case study would be useful in demonstrating spread and checking qualitative measures to check how people feel. ST suggested it would be useful to review Pharmacy and IAPT for measurable improvement across the organisation. TG also suggested that the Care Plan could be case study option and localities could be involved in identifying useful metrics. **ACTION TW**.

16. The Board **noted** the Risk Report.

Board Assurance Framework

17. ER noted that a more traditional assurance mapping arrangement was being introduced in 2016-17. There would be separation of measuring performance against objectives and measuring risks to objectives. This framework had been reviewed by Audit and Risk Committee. The performance dashboard would be retained albeit in a new format.

Report of the Audit and Risk Committee Chair

18. CM provided an overview of the recent Audit and Risk Committee. The major business of the meeting had been the approval of the Accounts, the Annual Report and the Quality Accounts.

19. The Head of Internal Audit Opinion had advised that AWP had adequate and effective framework in relation to risk management, governance and internal control, and that they could make further enhancements. This opinion had been queried by the Committee.

20. The Head of Internal Audit had advised that it was unusual to get a top score. He had also advised that the improvement they were reflecting were the internal audit reports that had been produced the previous summer around safer staffing and the approach to managing quality improvement (both of which had been critical). Because there had been scrutiny of the action plans since, the Trust was in a much stronger position around both areas. The further enhancements referred to those improvements that were already in motion.
21. The Board **noted** the report from the Audit and Risk Committee Chair.

BD/16/053 To Note: Minutes of Board Committees

1. The Board **noted** the minutes of the following Committee meetings:
    - Audit and Risk Committee meeting on Friday 15 April
    - Finance and Planning Committee meeting on Friday 24 March
    - Finance and Planning Committee meeting on Friday 15 April

BD/16/054 Any Other Business

1. TG thanked ST for her work as Senior Independent Director and as Whistleblowing Lead for the last period noting that she had supported both roles to good effect.
2. No other business was declared.
3. The Chair closed the meeting at 1.15pm.