Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

## Minutes of a Meeting of the Quality and Standards Committee

Held on 21st June 2016 at 1pm, Sandalwood Court, Swindon

These Minutes are presented for **Approval**

## Members Present

Susan Thompson (ST) – Non-Executive Director (Chair)
Tony Gallagher (TG) - Trust Chair
Mathew Page (MP) - Acting Director of Operations
Andrew Dean (AD) - Director of Nursing

## Staff In Attendance

John Leyden (JL) - (Wiltshire)
Toby Sutcliffe (TS) - Clinical Director Wiltshire
Carol Bowes (CB) - (Wiltshire)
Heather Cooper (HC) - HealthWatch Wiltshire
Jennifer Ward (JW) - Corporate Governance
Toby Rickard (TR) – Head of Information & Performance Management
Moira McMurran (MM) - Business Change Manager

## QS/16/016 Presentation by Wiltshire Services

1. The Chair opened the meeting and thanked TS and the Wiltshire Team for hosting. The Wiltshire Team was introduced and made a presentation to the Committee.
2. TS began by outlining some of the positive developments in Wiltshire.
3. He provided some information on the Care Home Liaison scheme in which Wiltshire CCG was working with Wiltshire Council to find ways to treat service users within their home environment to avoid unnecessary hospital admissions. The scheme had begun in March and indications were that it was working well. The initial focus was on a training piece for the care homes to encourage proactive management of issues so that there would be less need for hospitalisation in the future.
4. ST asked if the Care Home Liaison Scheme was working across all care homes. TS advised that there were some specific exclusions, but in general the service was available across the locality.
5. The Committee sought clarification on whether there was a cost and volume contract or a block contract and whether the scheme was identified a separate line item in the contract. The team was not sure if this was an addition to the block. The Committee asked if the funding was dependent on the number of referrals received. It was reported that it was not.
6. TS reported on the Meridian Productivity Project that was being run in Wiltshire. The focus had been on ensuring the right number of staff in particular teams. Early on, overcapacity had been identified. A savings plan had been identified for the year. It was noted that given the high number of vacancies in Wiltshire, there was no prospect of redundancies, but work was underway to determine which vacancies actually required filling, and which could be subsumed. Individuals working in current roles would be required to work at a higher rate, particularly in relation to patient contact. In the Assessment Team it had been established that one staff member should be assessing two people per day. A streamlined approach would need to be taken to reduce the time associated with each assessment.
7. TG considered the two hours on paperwork versus one hour face to face assessment ratio should be the opposite way around. He asked if the right level of resource was being invested to resolve

this. He also asked if the team had looked at clustering appointments in a more efficient way so that travel time could be reduced. CB advised that there was a culture in which the team tried to accommodate the needs of the service use. It was suggested that that this could be balanced by offering appointment windows. Initial appointments could also be offered on the premises rather than in a location designated by the service user. TG indicated that to run a more efficient system, a dedicated resource would need to be engaged who would own the logistics and paperwork.

8. It was noted that there was a project underway in Kettering where scribes were being engaged in GP surgeries who sit in on consultations and do the paperwork at high speed.
9. ST asked if mobile technology had been improved to enable assessment team members to input data on site. TS advised that there had been an increase in the use of technology. ST noted that Smartphone apps could enable staff to record information and suggested that more consideration should be given to using technology to improve data input.
10. ST asked if the team was feeling confident about the changes that had been recommended by Meridian. TS indicated that some of the savings had already been made and there was confidence about the estimations that had been made. CB considered the recommended staffing numbers to be appropriate. The concerns the Wiltshire Team had were about transitioning from the current way of working to the new approach. TS advised that Meridian had been encouraging in identifying there should be ongoing review and were open to the revision of targets (either up or down) if required.
11. TG asked if the CIPs that Wiltshire had committed to were deliverable. TS and CB both confirmed that they were. ST asked if there would be any impact on quality. CB advised that there should be a positive impact on quality.
12. ST asked how the team was tracking progress and success on the project. TS advised that the team was using dashboards that provided information on face to face contact within teams or groups of teams. A timetable had been set out that would track the financial realisations.
13. TS advised that Week in Focus visits had flagged issues at Amblescroft in the previous year. Healthwatch had recently made an unannounced visit and had provided a positive report. He summarised that while the Week in Focus had implied there may be cultural difficulties on the ward, this had not been evident to Healthwatch.
14. TG asked if there had been feedback from the CQC about Amblescroft. It was noted that there had been no major concerns raised, and those concerns that were raised were issues that the Wiltshire team had already flagged (e.g. placement of assisted bathrooms, maintaining the single sex accommodation standards). CQC had been more interested in Amblescroft North given the level of incidents and the level of acuity of the service users there. Overall positive feedback had been given to the wards and the standard of care observed.
15. TS reported on some of the challenges facing Wiltshire.
16. The Quality of Care provided at Imber ward was related to staffing issues (numbers and morale). The other area of concern raised by the CQC was around provisions. The blink alarms had also remained an issue on the risk register.
17. ST noted that Imber Section 136 had been flagged as a concern at the previous two Quality and Standards Committee meetings and advised that they had been briefed. She asked whether mitigations had been put in place that would resolve the problems. MP advised that longer term temporary staffing had been put in place in Imber ward and a number of recruitment initiatives were underway. An action plan was being regularly followed up and medical leadership was

being addressed. The Deanery had indicated they are happy with the current arrangements.

18. JL introduced himself as the Lead Nurse for ECT in Wiltshire. He made a presentation on a project that had been picked up by Wiltshire which had looked at aligning nurses as well as doctors to administer ECT. It was reported that there were some very experienced nurses around the country. Rotas for ECT often involved junior doctors who felt uncomfortable about undertaking the treatment. The training/experience to qualify a doctor to administer ECT was also quite limited.

19. A six month pilot had been run by two teams, one in Wiltshire and one in Northampton. The project had involved senior nurses carrying out 50 treatments. The outcomes of the project had been written up in a paper which had been published in a world journal of ECT. Since it had been published, nurse training was being carried out in Sweden, Australia and USA that would enable them to administer ECT.

20. The paper identified that having a nurse administer ECT would enable consistent treatment for service users. It was not the intention to have nurses take over this function, but rather to be an alternative option available. The paper had identified that nurses were safely able to give ECT and had also identified no impact on Junior Doctor training.

21. The Committee asked if there was a danger of ECT doctors not being involved. JL advised that doctors needed to remain involved.

22. The ECT Accreditation Service was supportive of this and considered that nurses who had achieved excellence through regular audits would be competent. JL had written the ECTAS standards for nurses to administer ECT. He tabled these for information purposes. Training was significantly more intensive for nurses than for Junior Doctors. Nurses would not be prescribing or making decisions about treatment. The NMC, the RCP and the RCA had also been presented with the project findings and had indicated that if the right governance was in place they would agree that nurses could administer ECT.

23. The proposal paper requested that AWP adopt the standards. JL noted that he would be the only nurse qualified at this point to administer ECT, but anticipated that in the future there would be nurses in all departments who would be able to administer ECT.

24. ST noted her support for the proposal. She asked JL to provide some information about the outcomes for patients as a result of implementing this change. JL considered that there were outcomes that should be achieved with a course of ECT (seizure response, clinical response, CGI response). It was difficult to get consistency when there was a different person administering each time. Another benefit was suggested to be the development of confidence of trainee doctors in their administration of ECT because they would have someone assisting who was familiar with the procedure.

25. AD asked if a traditional ECT nurse would support the ECT nurse who was administering. JL confirmed that this would be the case. There would need to be two staff members present and the second nurse would need to be an ECT specialist.

26. There was a discussion about the pathway for approving the change to the administration of ECT. AD advised that he had not been provided with a briefing as Lead Nurse. He also noted that the Clinical Executive would need to sign off any clinical changes. Any policy would come back through the Quality and Standards Committee for assurance. **ACTION**.

27. CB provided a briefing on how the CCG was working with Healthwatch Wiltshire.

28. Healthwatch Wiltshire was an attendee of the Wiltshire Care Forum, a bi-monthly meeting for service users, carers and other care organisations. This had helped each organisation understand

the services offered in the area.

29. Healthwatch and the Wiltshire CCG had worked together on the Have Your Say consultation about accessing services, and had the CCG had facilitated Healthwatch Wiltshire to provide information stands at Green Lane and at Fountain Way.

30. It was noted that the Better Care Plan was about how services could work closely together and become more integrated. The Wiltshire team had been focussed on how acute hospital care in the district hospitals linked with social care, but were also now focussing on mental health. They were working closely with providers to reach out and talk to people who were using the services.

31. HC advised that some regular meetings were now held between Healthwatch Wiltshire and the Wiltshire CCG. A carer from Wiltshire Services had done some training on a Healthwatch volunteer training course and people involved in Wiltshire were being encouraged think about becoming Healthwatch volunteers.

32. Healthwatch had a role around promoting user involvement. Support was provided through provision of volunteers and running carer forums. AWP had facilitated a forum at Amblescroft as part of the follow up work from the Charter House decision and the specialist beds in Salisbury. AWP was also supporting Healthwatch by providing information for the Your Care, Your Support website. In summary, the engagement between Healthwatch and Wiltshire CCG had provided support in both directions.

33. Healthwatch England had completed a piece of work about complaints handling and Healthwatch Wiltshire had also done some work locally. AWP had been identified as being comparatively better at handling complaints than other Trusts. The PALS team was proactive and sought to diffuse situations before they reached the complaints stage. Healthwatch had been involved in recruiting the lay member for the complaints review panel. A Complaints Liaison Group had been set up by Healthwatch, and the PALS Manager for AWP was an attendee.

34. TS would be attending a Healthwatch event to give a speech on the dementia strategy.

35. ST asked what AWP should focus on in terms of quality and experience of service users and carers in Wiltshire. It was noted that the top issue related to people accessing mental health services at primary care level. It was hoped that some of the remodelling being done by Commissioners would address this issue. Wiltshire had recently changed from a Lift model to an IAPT model which should provide a better service for those who were eligible. There was still work to be done on identifying how services would be provided for those people who had been eligible for Lift, but were not eligible for IAPT.

36. ST thanked Wiltshire Services for their presentation.

## QS/16/017 Questions from the Public/Attendees

1. Questions had been asked throughout the presentation as recorded above.

## QS/16/18 Close of Public Session

1. The public session was closed at 2.05pm.

## QS/16/019 Apologies

1. Apologies had been received from Linda Hutchings, Ruth Brunt, Tim Williams and Emma Adams.

## QS/16/020 Declaration of Members' Interests

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

## QS/16/021 Minutes of the Meeting on 19th April 2016

1. The minutes were reviewed for accuracy page by page.
2. The Committee **approved** the minutes.

## QS/16/22 Matters Arising from the Previous Meeting

1. On item one, it was reported that a meeting had been held to discuss changes on the work plan. AD had undertaken to work on the structure for Clinical Executive and this would come back to Q&S in July. This item was noted as **ongoing**.
2. In relation to item two, monitoring of Rapid Tranquilisation had been added to the risk register. This item was noted as **complete**.
3. Items three and four were noted as **complete**.
4. In regards to item five, the Pharmacy Case had not been accepted by Finance and Planning and it had gone back to Executive for further discussion. This was withdrawn from the agenda. It was agreed that this should be added to the September agenda. This item was noted as **ongoing**. **ACTION**.
5. On item six, the suicide benchmarking item was deferred until July. This item was noted as **ongoing**.
6. On item seven, the out of area information had been included in the Performance Report. This item was noted as **complete**.
7. Item eight, (the Clinical Audit plan) was noted as **complete**.
8. Item nine, (the Draft Quality Account) was noted as being on the Committee agenda for discussion. This item was noted as **complete**.

**Horizontal Reporting**

9. On item one, it was noted that the DTOC numbers were in the Performance Report. This item was noted as **complete**.
10. In relation item two about service user and carer involvement strategy, AD advised that a dashboard was being developed. A meeting had also been set up to discuss the strategy with users and carers and would take place on 7th July. One of the outcomes of the meeting would be to identify measurable outcomes. It was agreed an update should be provided in September. This item was noted as **ongoing**. **ACTION**.
11. On item three, the work had been done to identify roof risks and these had been mitigated. No issues had arisen in relation to roofs as a result of the CQC inspection. This item was noted as **complete**.

## QS/16/023 Clinical Executive Report

1. AD presented the highlights from the Clinical Executive Report.
2. The CQC had identified 87 issues during their visit. Many of these issues had been indicated via verbal feedback to AD or to the teams. Fifty two of the issues had already been resolved. The outstanding 35 issues would require longer term solutions.
3. One warning notice had been issued on Section 136. The feedback from NHSE and NHSI had been that the CQC were disappointed to have given this warning notice because overall the inspection had been positive. However, AD advised that they would have been remiss if they had not issued the warning given that several service users had been held for over 72 hours (illegal detention).
4. It had been agreed with the CQC that if the main issues of the Section 136 could be resolved between the end of the visit and the writing of the report, they would consider lifting the warning notice. He advised that the Health Community would need to provide an adequate response for this to happen.
5. ST asked what issues had been raised in relation to Section 136. AD undertook to circulate the warning notice to the Committee members. He advised that the main issue was the lack of central coordination. Each LDU had its own method of reporting. The data recording had been remiss in that it did not record when someone was referred, when they arrived and when the 72 hour period began. Furthermore, there was no escalation process when the end of the 72 hours was approaching. There were issues relating to bed management which had led to patients being held for longer in Section 136. Issues had also been raised about ligature points, lack of testing of emergency response and the absence of the Section 12 doctor. **ACTION.**
6. ST asked if the rating would be downgraded from 'Good' if the warning notice remained in place. AD advised that he believed the Trust would score 'Requires improvement with a good narrative'. He advised that this had been regarded as a positive improvement in comparison to the report provided following the previous visit.
7. TG asked when the draft report would be received. AD advised that it was due at the end of July, with a view to having the Quality Summit in September.
8. TG asked if it would be usual to give a warning notice for a system issue. AD acknowledged that others should be held to account, but advised that it was not unusual for a Trust to be issued the warning notice even if a CCG was responsible. TG asked if the CQC had any mandatory power over a CCG (e.g. a warning notice). MP advised that they did not.
9. TG noted that some of the issues that had been raised in relation to the Section 136 may be defensible. AD advised that the lack of an escalation process was indefensible and a process had since been drafted. MP was working on the bed management issue. The Wiltshire Group were working on the issues. Rebecca Eastley was working on the Section 12 doctor issue. Alan Metherall was developing a screening tool. The recording issue was being addressed in RiO.
10. TG asked if there was anything else that was supposed to be coordinated in localities but potentially was not. He asked how the Board would receive assurance that escalations in general were being scrutinised appropriately. AD advised that the team had been sighted on the 136, but had not prioritised it prior to the CQC visit. AD advised that the localities did not have a set of standards to work to, and these were being developed centrally. Nothing else had been identified from a central perspective that had been missed.

11. TG asked if it was clear where the ownership of Rio records lay in relation to the Executive. AD advised that he was.

12. ST asked if there had been a failure of policy, recalling that she had recently reviewed the Section 136 policy. She noted that she would have expected the policy to set out the processes. AD suggested that the policy was not good enough. He noted that the policies often provided broad stroke ideas and left the details to the localities, and he considered that the Section 136 policy had fallen into this category.

13. MP advised that the Section 136 policies were multi-agency and suggested that this could have caused some confusion. ST noted that there was also a multi-agency approach to child protection and asked if the policies around this were fit for purpose. AD advised that there was work being done on centralising Safeguarding functions. He advised that when writing new policies, AWP was being clear on setting the standard rather than allowing the localities to develop their own processes.

14. ST suggested that the Committee should review which policies needed to come back to Quality and Standards. It was agreed that the Section 136 policy would be reviewed in July. **ACTION**.

15. AD reported that a deep dive had been carried out on Safer Staffing and assurance had been attained about those wards recording below 95%. Valid reasons had been provided for not bringing staff in. The same level of assurance had not been attained about those wards recording above 105% with some strange reasoning being provided. ST asked when the Trust would come to the point where they would understand when levels moving above 105% were doing so for the right reasons. AD suggested that the procedures should be embedded enough by Christmas to be confident about the data.

16. AD reported that the blank boxes for Medicines Management had increased rather than decreased. He expressed his frustration about this issue and considered that his next approach would be to meet with the matrons and the locality management teams to ensure this poor practice was eradicated. The Committee sought to understand the reasons why this practice continued, and AD simply noted that bad practice seemed good enough.

17. AD advised that pre-Rapid Tranquilisation monitoring had shown improvement pre-tranquilisation, but monitoring post tranquilisation had reduced. The Associate Director for In-patient Nursing was now focussing specifically on this issue.

18. AD reported that the Acute Trust was not happy with the response that had been made in regards to the Southmead Legionella issue and had elected to withdraw their services from Southmead and not to continue to provide infection control advice to AWP. The Acute Trust had recommended a complete renewal of the water system at a cost of £2m and was not happy with AWP's decision to make a more measured response. AD advised that there was a discussion underway about whether Southmead would be an ongoing proposition in the longer term. He advised that there could be a decision made to continue current monitoring rather than to upgrade the water system.

19. There were three central areas of focus on the workforce - Planning, Development and Staff Engagement and Culture. Workforce planning involved looking at the safer staffing model and career frameworks. Development involved looking at competencies and centralising non-mandatory training agreements. Staff Engagement and Culture involved implementing the Culture of Care Barometer and setting up Staff Experience Groups.

20. It was noted that recruitment was being centralised so that staff could be engaged and directed to the locations where they were most needed.

21. There was a discussion about the safety incident/alerts. TG asked how the Board could be assured that when a safety alert came out that it would be actioned. AD advised that there were sometimes situations in which operational managers were second guessing decisions made by the Clinical Director. It was noted that the setting of standards was the role of the Clinical Director, and the Operational Manager must then implement as directed. The Committee recommended that all Operational Managers were made aware of this expectation. **ACTION**.
22. There was a discussion about screening people who were brought in under Section 136. It was noted that the purpose of the 136 was to take a person to a place of safety for an assessment. It was noted that Mental Health Assessments required 2 doctors and a social worker. Concerns were raised about a person being discharged having seen only one doctor who had screened him/her as not needing an MHA. AD advised that where the doctor was not certain about discharge, then the process toward having the MHA would continue and the escalation process would be followed as per the updated policy. He noted that there was only a 17% conversion rate for identifying a mental health issue.
23. TG asked if the consultation exercise in relation to the Nursing Director was complete. AD advised that it was complete and in place.
24. The Committee **noted** the Clinical Executive Report.

## QS/16/024 Pharmacy Business Case

1. This item was deferred until September.

## QS/16/025 Quality and Performance Report

1. MP provided an overview of the Quality and Performance Report.
2. It was noted that in the future, the Performance Report would be presented at the Performance Meeting and only variations and exceptions would be escalated to Q&S.
3. TG asked how the Committee and the Board would be assured they were seeing the right information. ST advised that a Quality Dashboard would provide the assurance in relation to the services being provided. AD advised that the Performance Meeting would be seeking improvement on red areas within one month. In the second month there would be escalation. It was suggested that where no issues had arisen, a report should be provided from the Performance Meeting that indicated there were no issues (for assurance purposes). **ACTION**.
4. DTOC had improved slightly on the previous month. A Task and Finish Group had been set up involving the Commissioners and Local Authorities and was due to meet early in July. ST asked what outputs were anticipated from this group. MP advised that specific plans would be set for specific areas. He reported that part of the brief was for the meeting to identify what AWP could do themselves to reduce/improve the DTOC position.
5. ST recalled that she had asked for some information to be provided about DTOC numbers in terms of length of stay. She noted that she would like to understand the impact on individuals.
6. Bristol had achieved a significant improvement on the Service Users with a Carer identified indicator. Wiltshire had also managed a small improvement which was slightly below the planned trajectory.
7. Claire Williamson was leading on the Movement to Recovery- IAPTs to ensure there was a clear

understanding of levels of compliance on the different commissioning models and within the different cohorts of individuals receiving treatment. A programme of work would be set out to improve compliance.

8. Bristol had recorded a dip in service users with a carer identified having improved on the indicator over a sustained period. This was a focus area to ensure this did not become a sustained issue.
9. Swindon's ongoing issues relating to Memory Service were affecting several of their metrics. MP had met with the interim CD in Swindon to discuss some specific work around this. The focus would be on process rather than resource. TR advised that the CCG and the Locality had agreed to temporarily relax the four week standard to a six week standard which was more indicative of the average wait for service users. It was noted that there was no national standard at this time.
10. Issues were reported in recording for the Settled Accommodation indicator in Bristol and Wiltshire. Work was underway to address these.
11. Bristol was now 95% compliant with the Referral to Assessment indicator which was a significant turnaround from their position at the beginning of the year. It was noted that there was still some temporary staffing in place which had been used to achieve this improvement, but work was being done to substantiate those in post to carry out the work that had previously been done by temporary staff.
12. ST asked about the number of people who were waiting beyond the four week period, and how much longer were they waiting. MP advised that there was a Dashboard Report that outlined this information. ST asked that this be provided to the Committee going forward. It was noted that the three month rolling report would require narrative so that the Committee would be aware of the actual position at the time of meeting. **ACTION**.
13. S Glos had resolved the issues with clinical resource in the primary care service doing the assessments. Wiltshire had also revised processes. There was a more chronic staffing problem in Wiltshire. TS spoke to this issue advising that high levels of sickness meant there was high reliance on bank staff. The system in place meant that Referrals were stratified and RAG rated. Breaches were generally resolved within a few days.
14. There had been a dip in Appraisal and Supervision. This had been raised by HR at the Extended Executive Team meeting.
15. Four beds were temporarily closed.
16. The new KPIs for 2016/17 contract were identified in the report and would be included in the Performance Report moving forward.
17. ST thanked MP for the report and for his contribution to the Committee.
18. The Committee **noted** the Quality and Performance Report.

## QS/16/026 PLACE Assurance Report

1. ST asked why the Quality and Standards Committee needed to see this report. AD advised that this should go to the Infection Control Group (ICG) and it could be included in the ICG's Annual

Report which Q&S would receive for information.

2. It was agreed that this Report would be removed from the Committee's agenda. **ACTION**.

## QS/16/027 Quality Account

1. MM presented the Quality Account.
2. It was reported that there had been further consultation on the Quality Account with CCG Health Groups, Healthwatch, and Service User and Carer Groups.
3. The Trust Auditors had been engaged to check the quality and accuracy of data. A draft audit report had been included in the appendices.
4. HR's introduction letter had now been included.
5. MM sought approval from the Committee to recommend the Quality Account to Board pending the final audit report.
6. It was noted that a final report would be presented to Trust Board within the next week and would include the final signed audit report and one more piece of feedback from the Wiltshire Health Group Committee.
7. ST suggested that a brief summary of the report would be helpful to make the data more accessible for the reader. It was agreed that this would be appropriate and MM undertook to prepare this. **ACTION**.
8. TG noted the feedback from N Somerset Healthwatch and suggested that relationship issues should be addressed. **ACTION**.
9. The Committee **approved** the Quality Account.

## QS/16/028 Clinical Audit Plan

1. The Clinical Audit Plan was presented for approval.
2. It was acknowledged that the Plan had been approved by the Audit and Risk Committee and had been presented to Quality and Standards to ensure that it met the quality priorities. ST advised that having read the report, she was satisfied that the quality priorities were being met.
3. The Committee **approved** the Clinical Audit Plan.

## QS/16/029 Learning from Experience Assurance Report

1. The Learning from Experience Assurance Report was presented for noting.
2. ST noted that the report was thorough and outlined the relevant activities. She asked AD if he was satisfied that the report appropriately addressed the learnings from the CQC visits.
3. AD considered that the report was beginning to demonstrate the learning within the organisation, but acknowledged that there was still work to do in this regard.
4. ST considered that this was a helpful report which identified how the organisation responded to incidents, but was concerned that it did not demonstrate that the learnings were being embedded in practice and did not indicate how the localities were responding to this.

5. AD considered that there was still some work to be done on the quality aspects of the incident investigation processes and the learnings from them.
6. TG considered that this report should be one of the tools used for supervision at the triumvirate level rather than just being a report that needed to be presented for compliance purposes.
7. CB noted that the report was useful from the perspective of triangulating local themes with those of the rest of the Trust. She advised that she used the report for this purpose.
8. ST asked if there was good support in terms of learning from incidents at locality level. TS advised that the feedback in his locality had generally been good.
9. ST sought confirmation that the report would be shared with the triumvirate Directors of Quality for their overall learning and development of quality plans. AD confirmed that the report would be circulated to the Quality Directors. **ACTION**.
10. The Committee **noted** the Learning from Experience Assurance Report.

## QS/16/030 Sustainable Transformation Plan

1. It was noted that there was an STP submission date coming up in June.
2. TG advised that all AWP committees were being appraised of progress.
3. AD advised that the three work streams had been working on their areas and the intention was to write the submission in the upcoming week. Mental health was to be involved in all of the work streams.
4. The Committee **noted** the Sustainable Transformation Plan update.

## QS/16/031 Quality Impact Assessment Update

1. ST asked for an update on Quality Impact Assessments. MP advised 8 QIAs had been approved. There were 49 QIAs screened and likely to be approved. There were 21 QIAs that were insufficient (these amounted to [£200k]). All QIAs would have been reviewed in time for the Board Meeting.
2. ST asked if there had been anything adverse to report relating to QIAs. AD advised that there had been no QIAs presented that had been rejected because of high risk.

## QS/16/032 Acute Care Pathway

1. The Acute Care Pathway project work was reported to be ongoing and on-target. It was agreed that an update would be provided in September. **ACTION**.

## QS/16/033 Any Other Business

1. No other business was declared.

## QS/16/034 Policy Approval

1. AD tabled his notes on the policies that had been identified for approval. Other committee

members were asked to provide feedback/approval by email.

**P148 Performance & Quality Management Strategy**

2. TR advised that the Performance and Quality Management Strategy had been updated. Changes included clearly linking performance management to the Annual Objectives. A chart had been constructed to show the flow of information from team level through to Board.
3. TR suggested that there needed to be a stronger oversight of the performance of non-clinical services.
4. ST asked how the quality metrics linked into the performance metrics. It was indicated that there needed to be strong links between people, finance, quality and performance. TR agreed that there was a need to work toward producing an integrated report. It was noted the new Director of Finance and the new Director of Operations should set this as a target and work with TR accordingly to achieve it.
5. The Committee approved the Performance and Quality Management Strategy subject to the inclusion of the development of an Integrated Quality Report.