Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of a Meeting of the Quality and Standards (Q&S) Committee

Held on 18 April 2017 at 1pm, Sandalwood Court, Swindon

These Minutes are presented for **Approval**

Members Present

Ruth Brunt (RB) Non-Executive Director and Chair of Committee
Sarah Elliott (SE) Non-Executive Director and Vice Chair of Committee
Charlotte Moar (CM) Non-Executive Director
Hayley Richards (HRi) Chief Executive Officer
Rebecca Eastley (RE) Medical Director
Charlotte Hitchings (CH) Trust Chair
Sue McKenna (SM) - Director of Operations
Andrew Dean (AD) Deputy CEO and Director of Nursing
Neil Auty (NA) Associate Non-Executive Director

In Attendance

Ivor Bermingham (IB) SU Involvement and Governance Facilitator, Swindon locality
Sarah Jones (SJ) Acting Quality Director, Swindon locality
Newlands Anning (NA) Medical Director, Swindon locality
Linda Hutchings (LH) Head of Project Management Office
Trisha Long, (TL) Service User Representative
Frank di Palma, (FDP) Service User Representative
Teresa Bridges (TB), Involvement Coordinator – Wiltshire Locality
Erika Tandy (ET) Corporate Governance Coordinator
Nigel Hopkins (NH) Member of the Swindon Service User Forum

Part One: Presentation by Swindon

1. The Chair (RB) welcomed members of the Swindon locality to the meeting and Nigel Hopkins (NH) who was a member of the Swindon Service User Forum.

2. NH explained that the Service User Forum was formally established a year ago with the aim to provide a relaxed environment for service users and carers, who set their own agenda for the meetings. The number of service users attending the meetings had increased to an average of 10 people.

3. NH was involved in collating the results from the Friends and Family Test. And providing feedback for the intensive service. A response rate of 15% had been consistently achieved. NH had observed that individuals could be wary of paper based surveys so the telephone calls undertaken by service user volunteers had been well received.

4. Ivor Bermingham (IB) explained that links had been made with the local MIND charity branch and this now coordinated with AWP on issues such as step down and peer mentoring which had been very productive. Service users and carers had set up a camera club, and photographs from this would be displayed in June. There would also be a Dungeons and Dragons session, and other shared activities such as dragon boat racing and half marathons.

5. CM asked how service users could be more involved with the work of the trust. Newlands

Anning (NA) explained that in Swindon, service users were being involved with such things as the complaints process. IB stated that they had also been involved in issues relating to dual diagnosis.

6. Sarah Elliott (SE) queried whether there had been much opportunity to engage with the media and IB stated that he had set up a media session which had aimed to look at such things as stigma surrounding mental health. However this had not been positive as the local newspaper had misquoted what he and other team members had said. NA stated that there had been service user involvement in trying to reassure the public following negative reporting of the proposals for changing 136 Place of Safety provision.

7. IB reported that there had been regular access to a local radio who regularly broadcast on mental health issues. There was also the aim to set up a Twitter account in the near future. Members of the Swindon team had been actively working with Black and Minority Ethnic (BME) groups, such as visiting temples, in order to raise the profile of mental health. .

8. Sarah Jones (SJ) presented the locality progress against the quality priorities for 16/17. Due to the implementation of Safewards there had been a 5% reduction in the use of restraint across the locality. There had been no instances of face down restraint for non-cogent reasons, and only 7 instances of face down restraint in total.

9. In relation to physical health and health promotion there had been liaison with Community Physical Health Clinics at Chatsworth House, joint working with Public Health Swindon Health Ambassadors, and work around Smoke Free Hospitals and Smoking Cessation. SJ stated that they were coordinating their go live for Smoke Free with Great Western Hospital (GWH). In relation to the community CQUIN, this had not been officially confirmed, but SJ thought that this had been achieved.

10. Quality priorities for safety had included the Chatsworth House Medicines Management Review which had taken place in February 2017. RB asked if the cultural issues had improved as at last year's Q&S meeting the locality were concerned about lack of ownership for medicines management issues and nurses and pharmacists blaming each other for problems. NA reported that he felt that the culture across Swindon had changed, and new ways of working had been implemented.

11. There had been no incidents of access to the roof of the Applewood building since implementation of the local environmental mitigation plan. The ligature risks at Hodson Ward had been mitigated through local clinical management. In relation to incident reporting, there were 11 incidents externally reported, which was a reduction from 20 in 2015/2016 and 629 low risk incidents reported which was an increase from 559 in 2015/2016. SJ felt that this was a sign of a more positive reporting culture. A significant proportion of the low risk incidents related to violence and aggression on the wards.

12. Response rate to the Friends and Family test was14.1% overall, with 91.3% saying that they would recommend Swindon Services and only 0.9% would not recommend (which equated to 1 in 104 responses). CM queried if there was perhaps a particular set of people who had issues, and it was explained that the telephone calls that service user volunteers had been carrying out had helped, as some service users had received multiple questionnaires through the course of their treatment.

13. SJ reported that there had been 19 formal complaints in Quarter 1 - Quarter 3 which was a reduction from 24 in same period in 2015/2016. The Intensive Team had significantly reduced complaints following actions taken to improve the service. 138 letters of praise had been received which was an increase from 123 in the same period in 2015/2016.

14. The committee requested that for future reporting, complaints were presented against activity, year on year.

15. Workforce priorities that had been identified from the Staff Survey, were that staff would like to be able to make suggestions to improve the work of teams/departments, and in relation to bullying and harassment, individual cases had been looked at and taken seriously and there was communication with teams and departments so that issues could be discussed and addressed.

16. Recruitment difficulties within the locality were ongoing, particularly for inpatient areas. There were currently 17.6 staff vacancies, of which 14.6 were for inpatient posts. This was being managed through bank use and more continuity of agency staff to ensure consistency.

17. CM queried the sickness level for the locality and NA explained that this had been the case for a while. He was assured that individual cases were being actively managed. Sickness was high in older adults inpatients and the small size of community teams could skew the sickness percentages.

18. In relation to statutory compliance CM queried if the CQC would be satisfied that the trust had made enough progress regarding Section 136 provision. Members of the Swindon team explained that a key delay had been due to the suitability of premises. All incidents on Applewood Ward were recorded but it had not been possible to isolate specific 136 incidents, which was a concern. AD would look into this. **ACTION: AD**

19. Good practice included:

- no out of area acute admissions for 23 months
- liaison service at GWH
- a reduction in non-compliant records from 37% in Quarter 2 to 4% in Quarter 4 within the Recovery Team Records Management**.**
- a new post was being piloted in inpatient areas to support medical staff
- capacity for PCLS prescribing was being developed so that the patient experience could be improved and there would be fewer repeat GP appointments.

20. Hayley Richards (HRi) queried whether pharmacies know of the plans for PCLS. It was reported that a meeting had been set up but this had unfortunately been cancelled. There had also been issues around the cost of the initial prescription and where these costs would sit. Negotiations were in place with the GP lead for the CCG.

21. CM asked the team what they thought their colleagues would say about them. The team felt that the significant improvements in the acute care pathway would be recognised as being very positive as there had historically been a fractured relationship with GWH. A large number of patients were now being seen within 4 hours. Work had also been undertaken with regard to the Perinatal service.

22. Neil Auty (NA) queried what could be learned in relation to the 5% figure for restraint. SJ felt that this showed that competence and confidence for staff using restraints had improved; a new matron had been assisting with training. There had been a new initiative created called a ‘safety pause’ which was time out each day for teams to identify risks and consider how they could address them.

23. Sue McKenna (SMc) highlighted that there had not been a formal Clinical Director in place for Swindon, so the high level of success of the locality should be recognised. The Chair echoed this and recognised the positive impact of service user involvement in the locality.

PART 2 MEETING

QS/17/001 Apologies

1. Apologies were received from Phil Cooper, Hannah Bailey and Val McElhinney.

QS/17/002 Declaration of 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. None were declared.

QS/17/003 Minutes of the Previous Meeting

The minutes of 21 March were agreed subject to the following amendment:

The sentence on page 5 (point 11) in relation to the Clinical Executive Report was amended to say that there were actions that needed to be taken in relation to the Well-led domain, prior to the CQC visit.

QS/17/004 Update on actions and matters arising from the last meeting

1. QS/16/042 Service User and Engagement Strategy: On agenda

2. QS/16/042 Social Work Strategy: The Committee was informed that this had not yet been completed and requested that Andrew Dean (AD) follow this up this with Phil Wilshire. **ACTION: AD**

3. QS/16/076 external comparative data on section 136: action on-going

4. QS/16/062 Quality Dashboard: this was in progress and would be produced in time for the May meeting. **ACTION:PC**

5. QS/16/094 Workforce plan: AD informed the committee that a new version would be produced but some information may not be present. CM queried if Whole Time Equivalent Posts would be mapped against the budget in relation to the workforce plan and SMc confirmed this was the case; all LDUs know what they needed and a review of finances had taken place the previous week.

6. SMc was reluctant to say that these figures were final, as SSG had yet to look at the information. She queried what the timeline was for the workforce plan and it was agreed that this would come to the Q&S meeting in May.

7. QS/16/115 Improvement in Safer staffing: to be included in the next Clinical Executive Report; action outstanding.

8. QS/16/121 Quality Improvement Plan: Prior to the meeting it had been agreed that this would be deferred to the May meeting. After discussion it was agreed that quality improvement information was present in other documents such as the quality accounts so it was agreed that the item could be removed from the action tracker.

9. QS/16/127 RB had reviewed the job description for the service user/carer representative and returned this back to Phil Cooper (PC). AD stated that this would be actioned through the service user forum so could be removed from the action list.

10. QS/16/133 Progress against CQUINs: action outstanding

11. QS/16/133 CQC preparation: on the agenda

12. QS/16/134 CAMHS: SMc reported that risks had been triangulated with the CAMHS team. Action complete.

13. QS/16/134 Acute Care Pathway/DToC: SMc reported that she would pass the feedback from the Stakeholder event onto Rebecca Eastley (RE) who would incorporate this into her paper on DTOC that would be brought to the May Q&S meeting.

14. QS/16/139 Bristol Suicide response detail: this item to be removed from the action list as

it was unclear as to what this related to.

15. QS/16/144 Staff Survey Results: a summary had been circulated for comment and would come back to the Q&S meeting in May.

16. QS/16/145 Work plan: on agenda

Horizontal reporting:

BD/16/277Staff Experience action plan: AD reported that the quality sub-group would be ratifying this and clarifying the criteria

BD/16/286 Well led: on agenda

Clinical Executive Report: the committee queried what the status was with regard to a new style of report being produced and AD stated that due to the high level of information that his team had to collate prior to the CQC visit, it had not been possible to produce one for the month's Q&S meeting.

CM also highlighted that there had been some additional items that should be logged as horizontal reporting:

a) Clarification on achievement of CQUINS; it was noted that there had been 2 separate results relating to CQUINS which made it unclear whether they had been achieved or not. HRi explained that this had been due to different markers. CM felt that 1 single report on CQUINS should be incorporated into the Clinical Executive Report.

b) Quality Impact of reduction in capital for anti-ligature costs; it was agreed that AD would pick up this action to ensure that no service user was put at risk, and that this should be brought back to the Q&S meeting in May.

QS/17/005 Clinical Executive Report

1. See under matters arising above

QS/17/006 Workforce Report

1. AD reported that a key issue had been the spike in bank and agency spend in month 12, due to a number of factors. The roster system meant that bank and agency were booked to cover vacancies well in advance and these shifts were not being cancelled if the ward could manage safely.

QS/17/007 Integrated Performance Report

1. The report shows Delayed Transfers of Care (DTOC) as the only non-compliant indicator on the NHSI Dashboard. The current figure was 11.6% against a target of 5% by April 2017. The required reduction (to achieve the target) would equate to around 20 service users being moved to locations more suitable to their needs. Whilst the average length of delay had reduced, numbers of individuals at any one time remained high.

2. The reduction in Out of Area Transfers (OOT) placements seen in recent months was being maintained, with c7 service users in facilities outside the Trust day by day, compared to c15-20 seen 3 months ago.

3. The report showed improvement in appraisal, statutory / mandatory training, and sickness rates, though there remained services that required improvement (including issues of non-

compliance for appraisals and statutory/mandatory in corporate functions).

4. The Committee noted the report.

QS/17/008 Internal Audit Reports

1. The Committee noted the report on Medicines Management. One of the key findings had been that in all six wards visited, the auditors found instances in which medicines fridge temperatures had not been recorded on a daily basis in accordance with policy. Additionally, they found instances across three wards in which recorded fridge temperatures were outside the acceptable range. Of these, for two wards they were unable to evidence that the ward had contacted the pharmacy to report the issue in accordance with the policy, presenting a risk that medicines were not stored at a suitable temperature and would be potentially unsafe to administer.

2. Members of the committee expressed concern, as managing and monitoring fridge temperatures should be a basic requirement. SMc would be putting an action plan in place to address this and would be meeting with ward representatives on 19 April so that this issue could be addressed. The Committee requested that SMc provide an update on this at the next meeting. **ACTION: SMc**

3. CM informed the committee that a summary internal audit report on unexpected deaths would be considered by the Audit and Risk Committee, which would then come to Q&S. RE reported that she would also be completing a paper on this and would confirm with Charlotte Hitchings (CH) whether this should go to the next Trust Board. **ACTION: RE**

QS/17/009 Service User & Engagement Strategy

1. RB welcomed Trisha Long (TL) Frank Di Palma (FDP) Teresa Bridges (TB) and Linda Hutchings (LH) to the meeting, to talk about the Service User and Engagement Strategy. Apologies had been given by Katie Legge who had a clashing appointment.

2. The strategy would apply to all people who use the services, as well as the wider community that the trust interacted with. It included the public as stakeholders who may not be receiving care but would have an interest in how care would be provided.

3. The draft strategy was currently out for consultation with localities and services and the consultation period would close at the end of April. Final adjustments would be made to the strategy and implementation plan by the steering group based on the feedback from the consultation. After some discussion it was agreed by the committee that the Executive Team (ET) should also review the document before this came back to the Q&S Committee for final sign off, potentially in May. The strategy would then be passed to trust board for their comment and approval and the implementation plan would continue to be monitored by the Q&S committee. **ACTION: ET/Q&S**

4. TL and FDP stated that producing the strategy had been difficult, due to various factors such as lack of clarity as to who would lead actions, the timelines for these, and if any budget would be available. Meetings that had been needed to discuss how to take the strategy forward had not taken place as often as they should. Trisha Long (TL) was still committed to ensuring that there was a strategy, but had been disheartened by the apparent disconnect with front line services.

5. TL stated that there had been some issues that had arisen over the past couple of days with regard to payment of costs to service users which might affect individual's willingness to be involved in Trust activity.

6. HRi thanked all for their work on this, and felt that the timing of the strategy was very

appropriate in relation to the wider NHS world. This year was a year of change for many NHS trusts who would be re-thinking their strategies.

7. The committee had no further amendments to suggest for the strategy, and looked forward to receiving the final version for approval, following the conclusion of the consultation period.

QS/17/010 Proposed Quality & standards work plan 2017-18

1. RB asked all committee members to review the proposed plan so that any gaps could be identified.

2. It was agreed that learning from deaths should be reported on a quarterly basis. RB felt that the committee needed to agree how often mental health legislation was reviewed and it was suggested that this should be quarterly rather than annually. It was agreed that Organisational Development (OD) issues should feature more prominently, for example a more consistent focus in relation to leadership. Equality and Diversity reports should incorporate patient information as well as staff.

3. Any further additions or amendments to the workplan should be sent to Erika Tandy (ET) who would update for the next meeting. RB requested that the locality visits were incorporated. **ACTION: ALL/ ET**

QS/17/011 Quality Account

1. All NHS Trusts were required to produce an annual Quality Account, to provide information on the quality of services to service users and the public and to identify its priorities for improvement which had been agreed in partnership with the senior leadership team, expert clinicians, service users and carers. The draft Quality Account had been shared with staff to give them the opportunity to comment.

2. Under the 17/18 priorities, RB was concerned that the metrics relating to risk assessment were misleading. SE felt that in the RAG rating section it would be more useful to have supporting narrative and AD agreed he would do this. SE also suggested that the information in the report on the Friends and Family test should be moved to the start of the document. **ACTION: AD**

The Committee agreed the paper subject to these amendments.

QS/17/012 Annual Operating Plan

1. Rachel Clark (RC) spoke to the plan and stated that there was the potential for this to be amended, as it would need to triangulate with the work of SSG.

2. The committee noted the inclusion of quality priorities and workforce information and approved the plan

QS/17/013 Annual Objectives

1. RC spoke to the Annual Objectives which had been amended to include SMART objectives; measurements had been refined. It was intended that monitoring of progress would be incorporated into the Q&S workplan, and the new style Clinical Executive report would reflect the key headings.

2. SE queried why there was no objective relating to patient and carer involvement. RC would review the Service User Engagement strategy to establish what elements could be

incorporated into the plan. **ACTION: RC**

3. The objectives were agreed subject to actions being put in place.

QS/17/014 CQC preparedness

1. AD highlighted issues relating to the CAMHS service and the physical environment. Also CAMHS staff didn't feel as if they had been fully integrated into the trust and have reported the perception that AWP sees CAMHS as a source of savings. SMc stated that this could be to some extent due to re-banding of staff positions to bring them in line with AWP grading.

2. RE went on to say that attempts had been made to address inherited problems, but this had not always been perceived as positive by staff. AD felt that a clear message could be sent to staff, in the form of a briefing to include information on agency spend, and quality and finance risks.

3. AD reported that there had been 1 breach of the 72 hour target for Section 136, which had been a system related one, so the mechanism of escalation continued to be effective. The target would be moving to patients spending no more than 24 hours in a 136 facility - at present there was still a significant number staying over 24 hours. It was agreed that the committee should receive a more detailed report, identifying the number of patients in different time ranges.

4. There were issues due to the regulation for the Daisy Unit, as this was a hybrid between a hospital and a care home, so traditional hospital regulations did not apply. AD will agree with the CQC before they visit which criteria will be used for the unit.

5. Other issues related to ensuring that all staff in the Bristol locality were able to provide a coherent account of quality improvements, as the CQC would be looking at community and inpatient services in the Bristol area. AD reported that he was monitoring the risks in Silver Birch ward and there were risk mitigations which staff could demonstrate were being used.

QS/17/015 Unregistered Career Progression Framework

1. This document set out an integrated career development framework for unregistered practitioners in AWP, and proposed mandatory minimum standards of training for key roles. The purpose was to improve care quality, staff wellbeing, consistency across the unregistered workforce and efficiency within the system. All members of the committee agreed that this framework should be adopted for use.

QS/17/016 Update on policies

1. There were currently 149 policies published in the policy library on Ourspace, and 82 were in date for at least another year. There were 12 expired policies and a further 35 had 2017 expiry dates.

2. The Committee noted that there were a significant number of policies which expired in May 2017. AD explained that he had put in place a process for extension of policies, to allow a 3 month re-write time limit for significant changes.

QS/17/017 Any other business

1. No other items were raised for discussion by the committee.

Comments on the meeting included the following:

The meeting was good but the papers needed improvement

There were concerns surrounding workforce issues in relation to culture and morale within the trust

The quality focus was articulated well and there was a good level of discussion

Service users had been looking to the committee for re-assurance which couldn't be provided

The chairing was of a very high standard but we cannot/should not rely on RB's knowledge as this is unfair and unsustainable

It was unacceptable that some papers had not even been provided

There was disappointment that at the start of a new financial year there had been significant issues with documentation for this committee

There was recognition from all of the committee members with regard to the high level of achievement from the Swindon locality.

The meeting closed at 4.40pm.

The next meeting of the Quality and Standards Committee would be on 16 May from 1pm, in the Conference Room at Jenner House.