Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

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

Held on 16 May 2017 at 1pm, Jenner House, Chippenham

These Minutes are presented for **Approval**

Members Present

Sarah Elliott (SE) Non-Executive Director and Vice Chair of Committee
Rebecca Eastley (RE) Medical Director
Malcolm Shepherd (MS) Non-Executive Director
Sue McKenna (SM) - Director of Operations
Neil Auty (NA) Associate Non-Executive Director
Matthew Page (MP) Deputy Director of Operations

In Attendance

Phil Cooper (PC), Associate Director, Governance, Improvement and Quality
Anthony Harrison (AH) Consultant Nurse - Suicide Prevention
Chris Ellis (CE) Consultant Nurse for Intensive Services
Claire Williamson (CW), Head of Psychological Therapies
Erika Tandy (ET), Corporate Governance Coordinator

QS/17/018 Apologies

1. Apologies were received from Ruth Brunt, Val McElhinney, Andrew Dean, Malcolm Shepherd and Charlotte Hitchings. Sarah Elliott (SE), Non-Executive Director (NED) and Vice Chair of the Quality and Standards (Q&S) Committee would be standing in as Chair on this occasion.

2. Charlotte Moar (CM) had also given her apologies as she was no longer officially a member; but would attend meetings on occasion. Sue McKenna (SMcK) informed the Committee that she had now been appointed as Chief Operating Officer, so she would like Matthew Page (MP) to attend as her deputy, and he would provide the focus on performance.

QS/17/019 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.

2. None were declared.

QS/17/020 Minutes of the Previous Meeting (18 April 2017)

The minutes of 18 April were agreed subject to the following amendments:

That point 1 on page 6 is amended to read that ‘KL could not attend due to a clashing appointment’.

The Chair requested that an action is added to the tracker that had arisen from the discussion on the Annual Objectives: 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**

QS/17/021 Update on actions and matters arising from the last meeting

1. QS/16/042; Clinical Executive Report (Social Work Strategy); The Committee was informed that due to a delay this would not be ready until the June Q&S meeting. See also agenda item QS/17/031.

2. QS/16/042; Clinical Executive Report (Service Users and Carers Strategy); see agenda item QS/17/030.

3. QS/16/062; Quality Dashboard; The Committee was informed that it had not been possible to produce this in time for this meeting. This was a work in progress and would be included in future versions of the Integrated Performance Report. The Committee was reminded that there was another action linked to this; in that there was the future aim for the Integrated Performance Report and the Clinical Executive Report to be amalgamated.

4. QS/16/076; Clinical Executive Report; the Committee noted that work on the external comparator data across the trust for S.136 was in effect on-going, so this could be removed from the action tracker.

5. QS/16/122; Suicide Prevention Strategy Work-plan; the Committee was informed that this would come to the Q&S meeting in July as was not yet ready for scrutiny.

6. QS/16/133 a) Clinical Executive Report (CQUINS); progress against 2017-19 CQUINS is discussed under agenda item QS/17/032.

7. QS/16/133 b) Clinical Executive Report (CQC) is discussed under agenda item QS/17/033.

8. QS/16/144; Staff Survey Results; this is discussed under agenda item QS/17/034.

9. QS/16/145; Any Other Business (Q&S workplan); Phil Cooper (PC), Associate Director, Governance, Improvement and Quality informed the Committee that this was ready for sign off.

10. QS/17/004; Quality impact of reduction in capital for anti-ligature costs; this had been deferred until the June meeting.

11. QS/17/008; Internal Audit Reports (Medicines Management); SMcK informed the Committee that she had a forthcoming meeting with members of the Operational team, so that findings could be addressed in relation to fridge maintenance, and progress could be mapped.

12. In relation to the incidents on Applewood Ward, and that specific 136 issues could not be identified, the Committee was informed that there was no update at present, but this was being taken forward as a serious priority. It was also noted that these problems arose from the Electronic Staff Register (ESR) and were not just specific to the Swindon locality.

Horizontal Reporting:

April Board: BD/17/208 (CEO Overview; BNSSG-STP) the Committee was informed that SMcK had met with other Chief Executive Officers and Hayley Richards (HRi) had met with the Turnaround Director. HRi had also been involved in discussions with Rebecca Eastley (RE) and Simon Truelove (STr).

Ultimately SMcK had not had sight of the strategies so had not felt assured, and there was also a risk due to double counting. She stated that it was hard to say how plans would be addressed, as the plans had not yet been received. She also had some concern from with

regard to the levels of staff involved in the decision making on the STP plans. SE requested that a short paper is produced in time for the June meeting which would show what Q&S should have sight of and the impact of these elements. **ACTION: SMcK/RE**

Audit and Risk Committee: AR/17/015 (Report on Information Governance) in relation to clinical risks potentially arising from coding issues, SMcK informed the committee that she had requested feedback on this, but it had not yet been received so she would chase this and liaise with Toby Rickard from IT. **ACTION: SMcK**

QS/17/022 Clinical Executive Report

1. RE made the Committee aware that the document was a work in progress so would evolve over the coming months. Members of the Committee thought that it was very useful to have the inclusion of the narrative relating to serious incidents.

2. 72 hour reporting had generally been adhered to, with only approximately ¼ of breaches for RCAs. SE queried if best practice was being looked at and, and RE confirmed that the central risk team would be looking at acute.

3. RE highlighted that were gaps in staff and training but plans are in place to address this: staffing and training would be scrutinised on a weekly basis so that momentum is not lost.

4. There had been issues with water pressure due to a legionella filter being used. The Committee queried as to how this problem had been escalated? MP stated that he had been informed that this had been resolved. The water system that has been built into the Applewood facility was no longer suitable for the building. SE queried if SMcK was happy that this was in the workplan.

5. The Committee requested that the narrative relating to South Gloucestershire on page 3 is amended as this was not clear.

6. The Committee noted the Guardian of Safe Working which had been provided as an appendix to the Clinical Executive Report. Recommendations had been made by Dr Wilkie, such as an upgrade of IT for reporting purposes, which RE stated was on the IT workplan. It was clarified that this was a non-urgent action. RE would give the author feedback on style before this went to Trust Board on 31 May.

QS/17/023 Analysis of Community Deaths

1. SE welcomed Anthony Harrison (AH) Consultant Nurse for Suicide Prevention, and Chris Ellis (CE), Consultant Nurse for Intensive Services to the meeting.

2. During 2016, a number of concerns had been expressed regarding the number and nature of the deaths of service users known to AWP, so Rebecca Eastley (RE), Medical Director, had commissioned this report. AH and CE stated that they were looking for the Committee to approve the recommendations that they had identified:

2. Establishment of an incident review panel: RE agreed that this was a good idea so would be taken forward. AH hoped that the creation of this panel would bring objectivity.

3. Improve the quality of initial incident management reports: the recommendation was that there is a framework – e.g. clarity of expectation. The template for the managers' report had also changed which had not helped staff when completing reports.

4. CE stated that this would also then feed back into the incident review panel. SE asked SMck as to how and what feedback is communicated and SMcK stated that it was hard to get feedback of a good quality; this is a mixed bag. She supported the idea of the framework, as long as PC was involved on the quality side. PC felt that communications need to be shared across the trust for good practice which had been identified in clinical areas. In relation to

training staff, senior staff perform the 72 hour checks, so the quality should be there.

5. AH informed the committee that he and CE had been producing a bulletin entitled 'Safety Matters' which had been a refresh of a previous newsletter which had been long-winded and not particularly exciting. They had cut this down to 2 pages and showed the key messages, and they had been considering whether this should be circulated every week or twice a month. There was the suggestion that this document could be 'live', so would be amended as and when changes happened.

6. Different levels of investigation: The current options for the level of investigation available for the incidents review panel to commission should be reviewed. Consideration should be given to establishing a three-tier process – the first being a mandatory 'management review', the second being an enhanced 'desktop' review of care (such as the developing *structured judgement review for use in mental health settings*), and the third a comprehensive, in-depth investigation, such as an RCA. This was agreed in principle by the Committee.

7. Use of Ulysses: IT had looked at the current use of this, and what could be improved on. Ulysses had stated that they are happy to be involved with this.

8. Establish a formal mortality review process: AH/CE felt that a mortality review group should be established which would discuss Mazars. It was agreed that this should be taken up by quality and clinical sub-groups.

9. Cease commissioning ad hoc commissioning reviews: it was felt that adopting the above recommendations would improve the overall robustness of the Trusts' governance and assurance processes associated with patient safety and learning from incidents. In light of this, there should be no further ad-hoc commissioning of thematic reviews. Thematic reviews had not brought forth fresh information but confirmed what was already known. SE queried as to how realistic this would be, and AH/CE stated that the mortality review would set the framework.

10. Link with 'Zero Tolerance' pledges within Sign-Up to Safety: The Committee supported this.

11. Expansion of the existing patient safety review team to ensure capacity to handle all Level 3 investigations (SUIs/RCAs): PC informed the Committee that he had been preparing a paper which supported the idea to have staff in his team doing more caseload reviews. He had been setting this out and included timings and involvement of individual staff. The Committee endorsed this and requested that PC works up a proposal. **ACTION: PC**

12. Cross-organisational incident reporting: review of governance process in respect of incident reporting and management, regarding partner agencies – e.g.: IAPT. This would ensure clarity and consistency in relation to incident management and learning. It was suggested that this should be put back to the communications team to raise, and SMcK felt that the many different strands of learning should be shared.

13. All members of the Committee commended the report that AH and CE had produced as being very thorough and with some positive thinking behind it. PC queried as to whether there was any intelligence around using service users and AH felt that this was anecdotal, but agreed that this should be considered.

14. RE stated that the Duty of Candour internal audit should be encompassed and AH and CE agreed that they would speak to Carla Carter (Acting Clinical Audit Manager) with regards to this. SE queried if suspected suicides were followed up and CE would check this, to see where the referral came from. As an aside the Committee was informed that Mark Dean was doing some additional work around this. Members of the Committee queried as to if this could be shared with commissioners, and this was agreed, but would need to be thought out beforehand, such as by Commissioning Quality Performance Meeting (CQPM) or the quality sub-group. The learning could be shared once an action plan had been produced.

QS/17/024 Workforce Report

1. The Chair informed the Committee that a workforce report had not been prepared for this month's meeting, but noted that workforce information had been included in the Integrated Performance Report. The Committee requested that a report is ready for the Q&S meeting in June. **ACTION: AD**

QS/17/025 Integrated Performance Report

1. SMcK apologised to the Committee for the delay in the production of the report, and handed over to Matthew Page (MP), Deputy Director of Operations. who highlighted the key issues for the attention of the Committee. Summary information had been provided due to the large amount of data available, but MP would take guidance from the Committee if they felt that a different format would be better. A fuller report would come to the next Q&S meeting.

2. In relation to Delayed Transfer of Care (DTOC) a standard operating procedure had been completed which had pulled in different areas, there is also a weekly operations meeting with regard to DTOC. Letters are going out to CCGs this week; there are process issues around placement and in-flow for DTOC. There is the aim to get workforce quality performance resolved.

3. RE was continuing to working on her DTOC focus, and this would be taken to commissioners. There is always the aim to consider how the workforce can be triangulated more effectively, and action would be taken to consider if not over staffing was linked to the issues within the Trusts' Electronic Staff Register (ESR).

4. For compliance in safer staffing, different plans had been put in place, and levels had increased but to the cost of the Trust, so the process will be reviewed. SSG Health are also carrying out a piece of work on agency spend.

5. HRi had asked the operations team to review the Key Performance Indicators (KPIs) in section 7 of the report. The report that would come to the Committee in July would include more KPIs.

6. SMcK felt that a separate discussion should be had with regard to workforce, and as an aside, stated that CAMHS and Bristol still had issues, which was still a priority that would need to be considered.

7. SE queried as to the records management issue; how assured are we that we have got the evidence? PC feels that the process is satisfactory but there was no particular guidance that was being followed. It was agreed that this should be re-launched as a learning opportunity.

8. In relation to the recording of smoking status, members of the Committee struggled to understand why there are problems: why is there no practical place to record this?

9. NA felt that in relation to bank staff, there was the potential that some people would work low hours, but just enough so they could stay on the bank. MP stated that if people do not work for 3 months or more, then they are not offered shifts. He also felt that nuances needed to be considered, as it would be detrimental to penalise someone for doing low hours, but if that staff member was providing a high level of care.

The Committee **noted** the report.

QS/17/026 NHS Benchmarking Networks Annual Report (2015-16 dataset)

1. RE stated that this had originally an item that the Executive Team had considered and brought to light some of the possibilities and problems. Members of the Committee noted that in relation to community it appears that there was less activity but information on nurses was not given. All members of the Committee agreed that the data was useful so would be shared and used when appropriate.

The Committee **noted** the report.

QS/17/027 Internal Audit Reports

1. The Chair noted that there had not been any internal audit reports for discussion at this month's meeting. PC informed the Committee that the Unexpected Deaths audit had been sent through to AD in the morning of 16 May, and this audit would be used in conjunction with other work that was taking place on deaths.

QS/17/028 Update on Early Intervention

1. The Committee noted that the report had been requested by Sue McKenna (SMcK) to inform a discussion about how to take a more strategic and co-ordinated approach to the delivery of national standards, for Early Intervention (EI) services. This had been set against the context of current financial pressures for Clinical Commissioning Groups (CCGs).

2. Claire Williamson (CW) stated that compromises had been considered as to where the changes should be focused, due to the funds trickling through for EI, but also linked to the increasing demand on reporting due to National Institute of Clinical Excellence (NICE) guidelines. Longer term there would need to be a sustainable way of training and funding could potentially evaporate. CW did hope that collaboration with other trusts would help, but this could not be guaranteed.

3. Neil Auty (NA) sought clarification as to whether the cash shortfall had already had an impact and CW confirmed this was the case: staff were passionate but had been finding that caseloads were too high. Also staff that had been undertaking the training for Cognitive Brain Therapy (CBT) with psychosis had been dropping out as they hadn't had the time to complete the academic requirements. SMcK would be carrying out a review of what skills and qualifications that staff have, so that good staff would not be lost to the Trust.

4. RE queried if CW felt that the Bath and North East Somerset (BANES) locality was the best performer? CW stated that this may have changed since last year: however the BANES lead on EI was of a very high standard and staff were in place in BANES who had had the CBT training. An audit was due to take place during July-September of this year.

5. The Committee were asked to support the following recommendations:

- That discussion takes place with CCG's and NHSE re the standard of service to be delivered based on likely funding with an agreement about priorities. The suggested priorities had been CBTP, family interventions, Clozapine and physical health with expansion in age range and ARMS dependant of funding.
- That the collection of performance data for Early Intervention is considered as a priority within the IT work plan.
- In relation to the sustainability of training and supervision there were a number of recommendations:

  a) All opportunities for taking HEE funded training places are taken up.

  b) Encourage national discussion re alternative models for training e.g. Apprenticeships as is happening in IAPT.

  c) Encourage any staff trained to the appropriate level in CBT to apply for BABCP

accreditation (to be able to act a supervisor).

d) Use expertise (especially supervision) across CCG's / STP footprint.

e) Ensure all staff currently engaged in training have support to complete training to academic level required by course.

f) Ensure any additional training places in CBTP and family interventions commissioned by HEE in 2017/18 are taken up.

The Committee **agreed** to all of the recommendations set out in the report.

The Chair requested that CW could extend her thanks to all staff involved for their input and dedication.

QS/17/029 Update on Polices

1. The Committee noted the update report on policies and strategies that had been submitted by the Information Governance team and expressed some concern as to the amount that will expire before, or at a similar time when the CQC arrive at the Trust to carry out their inspection.

2. PC stated that the all policies had the Red, Amber, Green (RAG) rating of green at present, and there was the 3 month extension system in place which served to provide some flexibility. The Committee agreed that it would be useful if the policies that had been given a 3 month extension, had been specified on this document.

3. Other work was being carried out in order to streamline the amount of policies, PC would provide further assurance to the Committee on the status of policies at next month's meeting, and would also seek the opinion of Andrew Dean (AD) on the Trusts' policy on policies.
ACTION: PC

QS/17/030 Service User and Carer Strategy

1. PC clarified that the next step required for the strategy would be to ensure that the Executive Team (ET) had the sight of the implementation plan; as this had not happened yet. The ET needed to view this as there were significant considerations that needed to be thought about, due to funds, timelines and the staff that would be needed for implementation.

2. It was clarified that the proposed plan actions would form the implementation plan, so it was agreed that PC and RE would work up the implementation plan ready for ET, as soon as was possible, but if this could not happen then SE would discuss the strategy and the plans with Charlotte Hitchings. **ACTION: RE/PC/SE**

QS/17/031 Social Work Strategy

1. The Chair informed the committee that communication from Phil Wilshire (PW) had indicated that the final strategy would not be ready until the Q&S meeting on 20 June. PW had confirmed assurance via email that there were no gaps whilst the outdated strategy had run out, and the new one was being produced. **ACTION: PW**

QS/17/032 Progress against 2017-19 CQUINS

1. PC stated that this document needed to be viewed in the light that it was not progress against CQUINS, but rather what was being done to ensure that CQUINS were achieved. He reported that all was going well, and RE added that learning from last year had been that the advice of members of the operations team should have been sought earlier in the process. This learning would be carried forward. SMcK stated that there was the correct focus being applied to the new CQUINS, but these would be closely monitored by her and her team.

2. The Committee noted that the 2 year CQUINS relevant to the Trust were:

1a - Improving staff health and wellbeing
1b - Healthy food for NHS staff, visitors and patients
1c - Improving the uptake of flu vaccinations for front line clinical staff.
3a - Improving physical healthcare to reduce premature mortality in people with SMI: cardio metabolic assessment and treatment for patients with psychoses
3b - Improving physical healthcare to reduce premature mortality in people with SMI: collaborating with primary care clinicians.
4 - Improving services for people with mental health needs who present to A&E.
5 - Transitions out of Children and Young People's Mental Health Services (CYPMHS)
9 - Preventing ill health by risky behaviours – alcohol and tobacco.

The Committee **noted** the report.

QS/17/033 CQC Preparation

Phil Cooper (PC), gave the Committee the key dates relating to the forthcoming CQC inspection.

1. The CQC would start to have involvement in collecting information from staff from 12 June 2017, inspection of services start would start from 19 June and the inspection would conclude on 30 June 2017.

2. There would be 6 Must do's and Should do's off target, and these relate to Trust seclusion facilities (5) and staffing (6). In relation to the CQC Project Plan, there are 8 areas of the CQC work plan that are off target. They are related to CAMHS services (3), Bristol (3) and Seclusion (3). Lead Executives had been made aware of the concerns through the CQC Board escalation process.

3. SE queried as to what kind of evidence had been looked at for on track elements? PC had been using the Quality Improvement Plan (QIP) process and this had included a section on compliance planning. The process sets out what to do and is a 'go-see' process. All areas of the Trust need a robust system of preparation in place for the CQC visit, and staff needed to be fully briefed. MP stated that this should be from 'board to ward', as what staff say in response to CQC questions is key. PC stated that he would be liaising with the Trusts' communications team later today, to ensure that the right guidance is sent out in a timely way, to all Trust staff.

4. In relation to the action plan, the Committee was informed that there had already been a meeting with CAMHS staff, which had culminated in a lot more assurance. SMcK would be meeting with staff from the Bristol locality on 17 May. PC felt that whilst progress has been

made, both CAMHS and Bristol will remain the key risk areas for the Trust.

The Committee **noted** the report.

QS/17/034 Staff Survey Actions

1. Katherine Dawson (KD), Organisational Development Manager, informed the Committee that an action plan had been produced which had been discussed at the quality forum. The action plan set out the proposed objectives, delivery mechanisms and the timelines for these.

2. Listening into Action (LiA) had been set against the objective of 'we will develop our culture to address issues described in the staff survey results, and Rachael Redman would be leading on this. This would be a 12 month programme commencing in June 2017.

3. In relation to 'we will improve the experience and well-being of staff working in AWP, Task and Finish Groups had been created to look at a number of themes, which included IT systems, communication and workload duplication. For IT systems, the group would consider as to why certain things cannot be carried out, and the reasons for this. Also if there were wins, then these should be shared. Reporting would commence for this on 31 May and would be led by Katherine Dawson.

4. Link Directors were in place as was the Freedom to Speak up Guardian; at present KD was unsure on the wider plans for this role. Further steps would be taken to finalise the staff handbook and there was a link on OurSpace asking staff give their input on the Staff Charter, and there was the aim to use this as part of the Trusts' training and appraisal process. It was noted by all that the current freeze on recruitment would have an impact on plans for training.

5. It was recognised that the last staff survey was published last September, so time was tight to put actions into place. The Committee requested that a clearer action plan reflecting the timescale constraints was provided, and that actions were mapped across the Trust. Locality action plans would also be required. **ACTION: KD**

6. Going forward, the Committee agreed that a quarterly update from KD on progress would be suitable. Future information provided to the Committee should also include how progress was going with the Freedom to Speak up Guardian.

7. RE queried as to when KD would be collating information on appraisals, and it was agreed that they would meet outside of the meeting to discuss this further**. ACTION: RE/KD**

The Committee **noted** the report.

QS/17/035 Equality and Diversity Compliance Report

1. Mayur Bhatt (MB), Equality and Diversity Advisor informed the Committee that the Public Sector Equality Duty (PSED) requires public bodies with 150 + employees to publish information on the diversity of their workforce by 31st January each year. The Trust had published this data within the stipulated time frame.

2. The report included data covering the period between 1st January 2016 to 31st December 2016 and gave an overview of workforce and Trust Membership data by protected characteristics. Also included was Service User data, showing access to services by some protected characteristics. RE queried if data wise we should be looking at protected characteristics, and MB stated that ultimately the he and the Trust wanted excellent service for all service users. Quantitative information could be problematic and qualitative was more useful.

3. Key headlines included that there had been a 7% increase in the workforce during 2016 in comparison to previous year and within the next 10 years 15% of staff will reach or be nearing retirement age. BME representation in the workforce dropped by 1% in 2016, and the

percentage of staff declaring disability was 4%, and increase from previous year.

4. Service User data also highlighted the need to improve Trust processes for profiling and the data contained in the report will support actions under the Trusts' workforce development and clinical strategies respectively.

5. Equality and Diversity had been the topic of the May Board Development session, and had raised many points for discussion, such as that it is important for the Trust to know about the Service User experience all the way through their journey; it's not just about the data but about people's stories. Specific cohorts (such as the south west veterans' group) have specific issues.

6. SE felt it was important to consider the delivery of elements; how can elements be moved into actions? SMcK requested that MB attends a future transformation board meeting, so he can share his learning and the information. SE suggested that the Equality and Diversity information could be incorporated into the patient experience segment of the Trust Board meeting. PC felt that patient experience was an on-going, key priority for the Trust.

7. Members of the Committee queried as to what MB thought the top 3 challenges were, and he stated that they were those relating to CQC performance and how the Trust was performing as a business.

8. In relation to how things could be improved, MB gave an example of when he worked as an advisor for the police force, a member of staff had said that they didn't know much about equality and diversity but 'they were willing to learn'. MB had felt that this was a great start. SMcK also commented that when she had worked in the prison system, equality and diversity had been flagged up, as needing to be considered, through all standard meeting agenda templates. This had helped to form people's minds and an increased awareness had been seen.

QS/17/036 Any Other Business

1. RE informed the Committee that there had been no IT issues that had had an impact on clinical work.

2. SE shared for information that the Director of Finance had raised at the NED call in the morning of 16 May that all senior staff needed to consider what the risk points were.

3. Committee Evaluation:

The meeting was scored as an average for 4, and comments on the meeting included the following:

There had been good discussions which reflected on the important issues

The meeting had been chaired very well

More comfort and assurance was being given

The pace of the meeting was good

We need to ensure that enough time is given on the agenda for the Integrated Performance Report as this is a large document, and this report needs to be correct as is only scrutinised by Q&S and F&P

It felt like a supportive environment and enough time was given to people to share their comments and suggestions

The meeting closed at 4.40pm.

The next meeting of the Quality and Standards Committee would be on 20 June from 1pm, at Green Lane, Devizes