Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of the Quality and Standards Committee
Held on 9 May 2013 10am -1pm in the Conference Room Jenner House, Chippenham
These Minutes are presented for Information

In attendance	
Susan Thompson (ST)	Chair & NED Member
Emma Adams (EA)	Project Manager Operations
Carol Bowes (CB)	Clinical Director, S&SS
Liz Bessant (LB)	Head of Nursing, NCAS
Ruth Brunt (RB)	NED
Denise Claydon (RB)	Wiltshire Interim Area Director
Mark Dean (MD)	Head of Safeguarding & Deputy Caldecott Guardian, NCAS
Eva Dietrich (ED)	Clinical Director, North Somerset
Kristin Dominy (KD)	Director of Operations
James Eldred (JE)	Clinical Director, Bristol
Tony Gallagher (TG)	NED
Katherine Godfrey (KG)	Trust Lead Occupational Therapy
Linda Hutchings (LH)	Head of Risk and Compliance, NCAS
Sarah Jones (SJ)	Lead Nurse NCAS
Hayley Richards (HR)	Medical Director
Ann Tweedale (AT)	Head of Quality Information & Systems
Tim Williams (TW)	Clinical Director SDAS

			Action
1.	**Apologies**		
	Bill Bruce-Jones Alison Griffin Julie Hankin Alan Metherall Paul Miller Bina Mistry Hazel Watson Phil Wilshire	Clinical Director B&NES Head of Engagement & Responsiveness, NCAS Director of Service Improvement, General Adult Psychiatry - Medical Deputy Director of Nursing Executive Director of Finance & Commerce Chief Pharmacist, Pharmacy Director of Nursing Team Manager, Social Care/Work Lead	

		Action
2.	**Minutes of the Quality and Standards Committee held 9 April 2013**	
	Approved.	
3.	**Review Matters Arising and Action Log from 9 April 2013**	
	AT took the Committee through the Matters Arising: Item 3 (6 November 2012) Clinical Directors Safety Risks - will come back to the June meeting after it has been through the Clinical Systems Group. Completed on Matters Arising log as added to the Work plan. Item 3 (13 March 2013) Wickham Unit - HR is to complete a case mix review. This item will come back to the November meeting. Completed on Matters Arising log as added to the Work plan. Item 3 (13 March 2013) Wickham Unit - All posts are recruited to but are not all substantive. This is expected by end May 2013 and CB will report back to the committee once all posts are confirmed. Item 4 (13 March 2013) Safeguarding Report is being presented at today's meeting (Agenda Item 5). To close on log. Item 7 (13 March 2013) Quality Impact Assessment Policy. The three amendments to the policy are completed and approved by the Chair. Item 11 (13 March 2013) Integrated Quality & Safety Plan is not yet on Our Space, AT will inform the Committee when this is shared. Item 12 (13 March 2013) two items relating to updates to the committees terms of reference. AT will follow these up. Item 7 (9 April 2013) Quality Dashboard – this relates to Specialist and Secure, and SDAS additional reporting; this is still outstanding. CB to meet with AT to discuss and give clarity to which elements of commissioner quality reporting may need reporting to the committee. Item 8 (9 April 2013) Quality account 2012/13, the amendments have been made and the two items are now completed. Item 9 (9 April 2013) Service User and Carer Engagement Strategy update is being presented today (Agenda Item 9). Item 10 (9 April 2013) MH Act visits lessons learned, a report is on the agenda for this meeting. Item 16 (9 April 2013) Draft Quality and Standards Work plan 2013/14 to be discussed under Any Other Business. Item 17 (9 April 2013) Quality Impact Assessments. HR had spoken with HW and have confirmed that they have approved the quality impact assessments reported to date. The process will be discussed today under Any Other Business. Item 17 (9 April 2013) Training and Development Standards and Provision. No	

	update received, carried forward to June meeting	
4.	**Review Action Log and Matters Arising outstanding from the Mental Health Legislation Committee**	
	AT talked through items on the action log: Item 4 (September 2012) completed. Item 5 (September 2012) completed. Item 9 (11 October 2012) this item will be considered at the July MHL & S Group and brought to the next Q&S meeting after that. Item 10 (11 October 2012) Dashboard to be presented at the June meeting. Item 4 (10 January 2013) will be addressed today (Agenda Item 6). Item 5 (10 January 2013) s136 update will come at the end of the first quarter, once progress can be seen with contract negotiations. To be revisited at the July meeting. Item 6 (10 January 2013) Admission Detention Rate. A report had been requested to look at sections 2 and 3, looking at trends. This goes to the Management Group before approval at this meeting in July. Item 7 (10 January 2013) MCA/DoLS - completed. Item 9 (10 January 2013) Count me In Census - completed. Item 10 (10 January 2013) – AWOLs, feeding in to national reviews of CQC MH Act management. Post meeting note – agreed with Chair that this has now been completed. Item 11 (10 January 2013) Exception Report - PW to bring to June meeting	
5.	**Annual Safeguarding Report**	
	The Chair and Committee agreed with RB in thanking MD for an extremely comprehensive report taking into consideration the Committee's comments from the April meeting. Appendices 1 and 2 were now combined reflecting where the safeguarding team sit within the reorganisation of the Trust. The short report picked up the headline issues and described the systems around safeguarding activity, internal governance and protection of data. The Safeguarding Team has refocused, providing advice to local managers and teams. Level 1 training remains included in the MOT training day, mandatory for all staff. Level 2 deals with practitioner updates and Level 3 around safeguarding children. The Trust is on target to deliver all safeguarding training by the end of 2013/14. RB asked if the Trust was happy with the 80% target for Level 1 and 2 safeguarding training. MD said the 80% target was set on a 2 year re-training basis and acceptable within the MOT with 90% set for those on a 3 year cycle. The Trust was working towards the 3 year training cycle for all appropriate staff.	

6.	**High Dose Prescription and Rapid Tranquilisation Assurance Report**	
	This report was prepared by Harvey Rees in response to a request from the committee. HR presented the report which included the findings from the National POMH Audit of prescribing high dose and combination of anti psychotic drugs. AWP performed less well (in some areas) than other mental health Trusts and the report describes actions in place and progress to date. Hazel Ward had been chosen as the pilot site, examining the issues around high dose/combination prescribing to help change process and culture on the ground. Findings are multiple, explaining reasons why and initial reactions around PRN (pro re nata) prescribing and as required prescribing. Environmental, educational, knowledge and routine behaviour factors were looked at. A communication exercise with multi disciplinary staff was undertaken and the work is revisiting the vigilance of pharmacists to scrutinise the high dose prescribing cards. New audit standards are now in place and prescribing decisions are kept under review. The key recommendations are stated in the paper. JE – asked if there was any sense of where Hazel Unit lay in relation to all acute units as this issue has not been flagged for other Bristol acute units. Is this issue relating to just males, as males seem to be heavily prescribed when discharged from Hazel unit. HR will have to look into this, unable to respond at this point. HR confirmed that Hazel Ward was selected because it would capture all the variables identified in the audit (eg PRN prescribing) in light of level of acuity of illness. it was targeted for necessary improvements. Steps needed to be taken to reduce high dose prescribing and this will be tested when next audited. A broader discussion will take place on this between HR/HW. The organisation needs to show an understanding of why this happens and introduce safeguards to continue on a more downward trend when looking at comparable Trusts. Two clearly defined areas were: a) E-prescribing will be introduced later this year and will help identify high doses, flagging up to pharmacists and Clinical Directors where this was occurring b) Where appropriate, identify where clinicians were not filling in the correct form which is needed to justify high dose prescribing. HR will bring a further update report to the June meeting. The Chair emphasised that assurances were needed that the Clinical Directors have addressed and are sighted on the issues that the audit had identified.	**HR** **HR**
7.	**Mental Health Act CQC Monitoring**	
	MD - this paper reflects how the CQC Mental Health Act visit reports to the Trust are managed, however it does not show what happens within the wider governance framework. It was confirmed that issues raised are collated thematically from all visit reports across the Trust and reviewed by the MH	

	Legislation and Safeguarding Group. The Chair felt in terms of process that exceptions should be reported to this committee; either through the MH Legislation and Safeguarding Group or through clinical directors own reports from localities.	
8.	**Procedure for Recruitment and Retention of MHA and Lead MHA Associates**	
	MD presented the procedure which does include significant changes. The appendices are still being developed. The Chair explained that this had been an outstanding issue for some months with the Mental Health Legislation Committee asking that this procedure should be refreshed and a robust process instigated for the recruitment, retention and training of Mental Health Act Associates. It was confirmed by the Chair that the procedure and all its appendices are required to come back to the June meeting for approval. This was of importance as there is a lack of clarity on the Trust processes and several concerns have been expressed by associates regarding training and support. The paper was withdrawn and will be brought back with appendices in June for final sign off. TG expressed concern around the experiences of associates with the administration and paperwork for this area of work. An update was needed on how issues were being resolved. Associates' comments seem to have a lack of action and follow-up by the administration team and this had become a reputational issue for the organisation. The Chair asked for an update on what the administration team were doing to address issues. Any comments please to be fed back to AM or MD and this will also be an item for the MHL &S Management Group to address further.	**MD** **MD**
9.	**Service User and Carer Engagement Steering Group Report**	
	EA presented the report from the steering group. The group had received a presentation from the Trust's research and development team and discussed the approach to service users being invited to take part in research projects via opting into research or opting out. It was noted that the groups Terms of Reference need some further refining. As this is tied in to the next Agenda item, any comments or points raised will be addressed in Item 10.	
10.	**Update on Delivery of Service User and Carer Engagement Strategy**	
	EA presented her paper providing an update to the committee on the draft strategy that was taken to the SU and Carer Steering Group last week. This helped crystallise all previous feedback gathered from the engagement events held earlier this year including the recommendations from the internal Audit	

	and NSUN the external review reports 2012/13. This work identified three key mechanisms for engagement: 1. Day to day involvement in your care 2. Being able to give feedback and for services to capture, understand and act upon it 3. People being engaged in the design and delivery of new services and improvements in current services In turn these areas have been translated into the core levels of engagement involvement – strategic/Board, local, ward and individual level. A diagram has been added to describe the framework for ensuring engagement as well as progression of actions and setting of standards. This is a local strategy using SU involvement and SU networks on a local level and this is believed to be its strength. Mechanisms will be provided to engage with current teams and a Trust-wide engagement body will report into this committee. SU Involvement Workers are being appointed into each locality. This is key to the delivery of SU involvement; particularly using experienced based design methodology and the use of peer mentoring. The group will connect developmental practice across the Trust to deliver engagement; working with Clinical Directors and HoPPs. This will be the structure to drive the Engagement Strategy forward. A set of assurance standards are being developed across the Trust along the lines of the new CQC guidelines to enhance the way people work with localities to reach the standards required with engagement and involvement. It is planned that this would be best done at induction via involving SUs and carers. A working group is starting within two weeks, however some more engagement work may be needed to consult on the plans to deliver the strategy; the strategy is going to Board by end of May. HR commented that good progress had been made on this and all agreed. JE asked if a network of good practice for engagement workers was in place? KD responded explaining that Gareth Sharman was leading on this. EA added that she was looking at the methodology and standards that would be used. JE said each area is bespoke, depending on population, locality and needs. The Chair asked if FT membership would be involved. EA said that local working relationships would be in place but needed looking at. TG requested any actions (not an actual paper) could come to the Board to gauge the work going forward. He had attended a recent carer meeting which had been very positive. EA suggested there will be separate SU, Carer and Healthwatch groups, asking them to express feedback on services received. The groups will operate as sub groups of this committee. KD reported initial conversations had taken place, part of that being peer mentor engagement. TG highlighted that SUs/carers needed to be kept involved. This was agreed. RB said decisions had to be made particularly around what key measures and success indicators are in place for monitoring. EA explained that more time was needed to agree the right measures and to set up the groups. The Chair	

	and RB requested EA develop a 'proposal' to frame the way forward, what measures will used and the key actions to be taken and how often this will be reported to the Committee. EA was asked to bring a proposal to the June meeting, that it would be understood that not all would be agreed at that time but to ensure that the committee and the CDs were sighted on this as it progresses. The Chair summed up confirming that the Strategy is going to the Board and that the committee would need to agree any changes to the Terms of Reference of the SU and Carer Engagement Steering Group.	**EA**
11.	**Policies:**	
	• **Safety Alert Policy** LH presented the updated policy, now in a new format and hyperlinked so as to be fully accessible through Ourspace for all AWP staff. The policy was approved. • **CPA Policy** Sarah Jones presented a review of the existing policy. Amendments had been made to ensure all additional national guidance is fully reflected; including NICE standard 136 SU experience in adult mental health. The policy includes liaison within triage, screening and brief interventions. A new guidance document, approved by HW (Acting as an Appropriate Adult) is now referenced on page 7. Pages 8 and 10 include changes made on crisis relapse and contingency planning to support rapid access for SUs to re-access AWP services quickly once discharged and reflecting SUs individual needs. The following amendments were agreed: P11 19.2 Localities needs to be amended to Service Delivery Units. – Raised by TG. P4 To include in section 5. an explicit statement that service users are to be given a copy of their care plan. The Chair stressed importance of SUs receiving copy of their own care plan. This is an important aim worth expressing early on within the policy. P5 Section 7.4 Assessment – to make a statement in relation to the procedure for risk assessment and management and provide a link to appropriate documentation. - The Chair asked if there was a standardised approach to risk assessment? SJ agreed to add a direct link to the Risk Management Procedure which is very explicit about this. P13 Section Monitoring and audit para. 22.2 - to reword as follows: Compliance with this policy will be monitored by the quality information system 'IQ'. This will be through the completion by wards and teams of local audits of the care record, self assessment of the CQC essential standards for quality and safety and service user and carer feedback. JE expressed concerns in reference to the requirements about completing certain areas of RiO and is aware policies such as this tie in a system of	

	practice and ways of working that 'bind' the users to using a cumbersome system, not allowing much flexibility. Talks were being held with a view to a possible move to a lighter version, with a view to reducing unnecessary information entry. HR suggested that it would be helpful if sensible recommendations to streamline the system could be made whilst still maintaining the integrity of the clinical record. This work would then need to be brought forward for agreements to be made to change any policies that specified RiO data entry protocols. • **Engagement and Observation Policy** This is a review of an existing policy in response to feedback from clinical staff. Key changes are: a) Clarification of recording levels within RiO - this has now been clarified through the Clinical Systems Management Group b) Inclusion of guidance on user engagement, observation and managing physical health risks/falls especially within older peoples' services c) The requirements for staff involved in assessing and reviewing engagement and observation levels, to reflect the different clinical environments worked in d) Forms reviewed that allow staff to clearly document who has recorded what observation and the appropriate information to record. This policy was approved with the amendments.	
12.	**Management Group's Exception Reports**	
	None to report.	
13.	**External Reports**	
	AT reported that the CQC have been carrying out a follow up review of the Community Services. They had visited North Wiltshire and Bristol Recovery and Intensive Teams and the Bristol Central Recovery Team. Apart from a few minor details feedback was very positive on improvements made. JE said the Intensive Team Manager came in for special praise for the work undertaken implementing a management structure, filling vacancies and ensuring detailed care planning for all activities. Further visits to other teams are expected. TG - noted that at the last Board meeting there was an issue about unallocated cases. Is the root cause now understood and are fail safes now in place? Do clinical directors have visibility on these areas? JE gave a verbal update: yes there is absolute visibility on what is happening and is at the top of the agenda. The issues within the Bristol Central Recovery Team have been massive and multi factorial. Issues related to only having interim/acting up managers in post in previous months. A strategy is now in place to address these issues and vacant posts have been difficult to recruit into with the threat of a tender of Bristol services. It is recognised that agency staff is a short term unhealthy solution. TG welcomed a brief paper to be seen by this committee on the issues faced. This was agreed by all. KD said this was a uniquely difficult area	**JE**

	for the teams to deal with but had been hugely impressed by staff members still delivering care and continuity to SUs. The Chair asked that TG would raise the Bristol staffing as a concern to the Employee Strategy and Engagement Committee (ESEC). TG will give a verbal feedback to this committee after he has spoken to JE, considered the issues and raised at ESEC. AT reported that the formal CQC verbal feedback session will be 21 May.	**TG**
14.	**Draft Quality and Standards Committee Work plan 2013/14**	
	The Chair asked the group to consider how this committee will seek assurance to the Board on all services and local areas via the local area presentations? What issues need to be brought to this committee on behalf of each of the delivery units? CB answered this and will be first to present from the SDU perspective. Noting that there is such a wide range of issues and the whole structure is not yet in place, with lots of 'unknowns' and areas in development. The Chair confirmed the committee will be looking at three of the seven quality indicators from the IQ system: a) CQC compliance b) Friends & Families test c) Records Management The Committee will need to develop an understanding from each of the delivery units on their performance against each of the key indicators. Within the report a narrative from the clinical director would be helpful gathered from collected data and what it is telling them about their services in relation to the three indicators - positives, negatives and actions being taken. Significant plans Trust wide will be implemented against the Quality Improvement Strategy. This will have a substantial impact on delivery units identifying positive and negative areas and what the aspirations are for each unit. What is being tackled against the 2-3yr plans? As an organisation we want to push towards being in the top five in the country. RB said the committee wanted to know where the hot spots are; high performers and successes as well as concerns, areas that need improving and what measures are being taken to address the issues. What do the Clinical Directors want to flag that they are proud of? What challenges are they facing so the committee can give support. As this committee will start to focus on a different locality each month, it gives opportunity for Clinical Directors to showcase what is happening in terms of quality within their units as well as the challenges. JE welcomed the dialogue today and was greatly encouraged that the Clinical Director slots within future meetings will be more narrative than question and answer sessions. He felt more supported knowing help can be asked for. KD added that there are 'people' behind the numbers on the scorecards. If units are not hitting the targets then it is important to provide the story behind what is	

	happening on the ground. The Chair said is was important to include the SU/carer voice, possibly via the mentoring system and can be part of the public section of the meeting which will be about 45 minutes at the beginning. Eight of the twelve monthly Committee meetings will be used as a platform for a nominated locality to present. Otherwise at each meeting Clinical Directors will still need to present by exception against QI data for the chosen three areas; this should be fed from the local monthly governance meetings. AT will send out a briefing document to all Clinical Directors listing what will be expected from them at each Committee meeting. HR mentioned that when the open part of this Committee meeting had been discussed by the Executive Team, it was felt that there should be ownership by the relevant User and Caring Steering Group and service user involvement worker to host this part of the meeting within their own locality. All agreed this was a good idea. HR asked the Clinical Directors that when bringing their regular reports, they should be tested through the Quality Assurance Framework on how the information flows through management groups and onto the Board. This will help test internal systems such as; does an issue get escalated at the right point by the right people in the right way and actioned. HR will speak with the Clinical Directors about this. The Chair agreed that this was an assurance Committee and it would be a good way to check if the system was working. The Chair decided the 4 June meeting will be held in the Conference Room, Jenner House 1-4pm. All locality presentations will push forward one month with Specialised and Secure Services hosting the 2 July meeting, venue to be confirmed. Revised venues for host localities will be on the June Agenda and reflected in the Work Plan. The reporting requirements for the management groups were confirmed and the work plan will be amended as follows: • only CIOG and MMG will be required to report quarterly • all SDUs and management groups to report monthly by exception and annually	**AT**
15.	**Any Other Business**	
	The Chair led a discussion on the Quality Impact Assessment process in relation to the Cost Improvement Plans in the budget and how the committee needs to have assurance of this . The first round of Cost Improvement Plans' quality impact assessments have been considered by this committee and the Board and are approved by HR and HW according the to policy. However an additional CIP is in development for the shortfall in the savings target that is not met by CIPs already agreed. It was agreed that it was a matter for the SMT to establish the status of the current additional CIP plan and to ensure that the QIA process was being adhered to. The QIA for this scheme will come back to the Committee once completed.	**HR**

	Medicines Management - TG highlighted that he had seen two red internal audit reports on medicines management and that he felt that this Committee needed to understand any quality implications. The Committee are looking for a recommendation from the Executive Team. HR will bring this to the next meeting. The Chair said that if committee members were unable to attend that it was important to send representation especially when needing to address items such as Medicines Management.	**HR**
16.	**Date of Next Meeting:** **4 June 2013 1pm-4pm** **Conference Room, Jenner House, Chippenham**	