Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of a Meeting of the AWP NHS Trust Quality & Standards Committee

Held on Tuesday 15th April 2014

Venue:- Seminar Room 3, Jenner House, Chippenham

These Minutes are presented for **Approval**

Members Present

Susan Thompson (Chair) – Non-Executive Director
Ruth Brunt – Non-Executive Director
Emma Adams – Head of Academy
Kris Dominy – Director of Operations
John Owen – Clinical Director – South Gloucestershire
Eva Dietrich – Clinical Director – North Somerset
Newlands Anning – HoPP, Swindon (in part)
Pete Wood – Consultant Forensic Psychiatrist & Clinical Director, Secure Services
Dr Hayley Richards – Medical Director
Dr Dan Meron – Associate Medical Director
Tim Williams – Clinical Director, BSDAS (in part)
Dr Claire Williamson – HoPP, BANES
Ann Tweedale - Head of Quality Information and Systems
Liz Bessant - Interim Deputy Director of Nursing & Head Of Infection, Prevention & Control.
Norman Atkinson – HoPP, Wiltshire

Staff In attendance

Phil Wilshire – Head of Social Work and Social Care Pathways Lead
Alison Devereux-Pearce - Governance Support Officer (Minutes)
Ben Watson – Acting Consultant, BSDAS

Action

QS/14/001 - Apologies

1. Apologies were received from the following:

Alan Metherall – Acting Director of Nursing
Tony Gallagher – NED & Trust Chair
Emma Roberts – Director of Corporate Affairs
Dr Julie Hankin – Clinical Director, Wilts
Bina Mistry – Chief Pharmacist

QS/14/002 – Declaration of Interests

1. In accordance with AWP Standing Orders (s7.1) members present were asked to declare any conflicts of interest with items on the Committee Agenda.

   None were received.

Action

QS/14/003 – Minutes/summary from previous meeting on 18.3.2014

1. P3, Item 4 Chief Inspector Visit – Ruth Brunt reworded the paragraph as follows; '*The locality are developing a good understanding around service pressures and concerns and are developing plans address these and there's an awareness of issues around recovery team caseloads and inpatient beds, with some local issues relating to delayed transfers of care and inter-dependencies with other areas'.*
2. With this amendment, the Committee **approved** the previous minutes.

QS/14/004 – Matters Arising from previous meeting on 18.3.2014

1. The Group considered the Matters Arising and resolved to note progress and remove items completed.

QS/14/005 – Locality Quality Plans

1. BANES: Claire Williamson

Main actions identified were presented as follows:

- Improve the quality of Safeguarding Reports which has arisen from feedback from the Local Authority and sub-committee.
- Enhance GPs letters with a template developed and agreed with local GPs.
- Improve quality of Inpatient Services (including specific CQC actions for Sycamore Ward). Monitor and carry out and improvements from 'Lessons Learnt'.
- Improve assessment process by PCLS (taken from a complaint and piloting audit of ESBAR assessments used for diagnosis and formulation).
- Open Learning – the Management Team has established processes to learn from RCAs and complaints which have recommended a change within the Management governance process including a dedicated process/ risk meeting to address issues. The Team will continue with detailed performance discussions with commissioners.
- Improvements to care planning have been taken from the CQC Recovery Inspection which will be measured by IQ.
- Evidence based practice in the locality is to be embedded and will support skills to deliver interventions. This will be audited using NICE guidelines, as utilised in BANES as a main focus.

Questions:

'It was recently discussed in the Professional Council that BANES isn't writing to patients, only to the GP and CC'd to patient; this is alongside CPA policy recommending writing to the Service User (with the view taken that info that GP wants is specific). Is copying in to both parties stepping outside trust policy? Some localities write to the referrer and also involve the Service User'

KD suggested review of policy as any change would be in Service Users' interests and this could implement change as a consequence. NA stated that, according to

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the policy, ALL correspondence is to be addressed to SU and copied to others/ distributed accordingly.

Action Agreed: Policy Leads Alan Metherall/ Sarah Jones to discuss a review of CPA policy (difference of opinion and practice with professionals). The amendment will to come back to committee as appropriate.

RB commented that it would be useful, in assessing QIPs, with a RAG rating. All Localities need to understand the criteria and trajectory along with what represents scoring and have that shared understanding against each improvement priority.

The Chair reiterated that this would be a helpful format due to Quality Plans needing consistency and welcomed the Trust's input over this. EA advised that the Integrated Quality Plans have already been distributed Trustwide to reflect upon.

2. Bristol – James Eldred:

Main actions identified were presented as follows due to the changing nature of Bristol defined by commissioners as a modernised health system:

- Increased carer and user representation at every level and evidencing their influence throughout service delivery.
- Safe transition for staff as not all will be retained
- Re-provision of inpatient services.
- LIFT integration
- Liaison service in North Bristol.
- Safe Management of S136 for Bristol, BANEs and North Somerset impacting on large number of stakeholders.
- Local structures/ management structure change – will retain the triumvirate model with other providers integrating which is under negotiation at present.

Questions:

Emma Adams observed that *'The plan seems to be different in what is Quality Improvement as this is mainly for the management, what is the actual quality issue? Not given enough support over service development as this is one of the three areas the Garvey Report identifies making it difficult for the Quality Academy to support and the Quality Account to report on'.*

3. North Somerset – Eva Dietrich:

The main priorities were identified and presented as follows:

- Improvements around the Physical Healthcare process
- Healthcare Clinic alongside Depot Clinic for patients difficult to engage. The promotion of healthcare involves CQUINS with Western General Hospital.
- Development of the Hospital Liaison Service for later life within the Locality; This is due to lack of funding but the Management Team is building a business plan to address.
- Streamlining Community Teams review / assessment and creating interventions alongside the Inpatient Ward as necessary.

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Questions:

The chair enquired over the situation at Liaison Services. ED responded that Older Adults Service is not commissioned but if it was could impact on harm free days; no psychiatric liaison services are offered into the General Hospital but could also reduce bed delays. The team are working with WGH and Commissioners. Section 75 work is part of the integration service around GP services and Social Service working across the pathways.

4. South Glos – John Owen:

The main priorities were identified and presented as follows:

- Issues surrounding Whittucks Road,
- Improving pathways between inpatients managed by Bristol LDU and South Glos community services
- Achieving HTAS accreditation for South Glos intensive team, which is partly achieved at present.
- LIFT service integration
- Locating a replacement for Bybrook Lodge.
- Service User Involvement,
- Liaison Work with Travelling Community

Questions: None

5. Norman Atkinson – Wiltshire:

The main priorities were discussed and presented as follows:

- Teams addressing the level of details under each/ patient safety and action plan and identifying themes
- Investigating incidents and implementing meaningful changes
- Increasing Service User & Carer Involvement, currently the Involvement Worker is building them up to be being more meaningfully involved.
- Safeguarding processes to continue working safely and ensuring people are adequately trained with the documented process.
- Caseload profiling tool to continue being monitored through supervision to establish team risk register/ safeguarding/ locality risk plan.
- Meds Optimisation – Group within the Locality has been put together to oversee medication and formulatory issues from MOP plan.
- Recovery team has been profiling community services to make an ageless service in Wilts addressing unique challenges due to geography/ making use of estates/ mobile working.
- Quality issues around to address capacity and caseload issues to be actioned with care pathways training and record keeping. Adult teams are very stretched with amount of referrals received and stepping people down (common theme identified with other community teams in Localities)
- Not all GPs will take people on depot meds. The Team will continue with dialogues/ reassurance with GPs and outcomes. ED & NA to meet outside of meeting to share strategies with GPs.

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Questions:

RB enquired *'What would a Service User perceive as different at end of this year'* NA advised they would expected to see an improvement in accessing the service, a planned step down and reassurance about being supported and clearer about the service they are receiving along with the intended outcome.

6. Specialist – Tim Williams:

The main priorities were identified and presented as follows:

- CQC and identified specific issues continue to be a priority with intended measured outcomes.
- The Friends and Family test is not always appropriate, the Team are looking to develop measures to quantify this collected data.
- CQC and records audit is continuing to be helpful to help staff to focus on quality outcomes.

Questions:

KD commented that '*client evaluation is highly valuable to focus interventions to client's needs (taken from 'Innovation in the NHS' publication) which can be taken at intake and after 12 weeks; Is held to be a very valuable tool which can be used not just for Secure Service'.*

7. Secure Services – Pete Wood

The main priorities were identified and presented as follows:

- Staffing: Further training for bands 6-7, leads established for talent spotting/, succession and recruitment. The locality is currently going through a Redesign.
- Behaviour of staff/ minimum standards of dress and behaviour have been established and coaching to be introduced. Supervision and appraisal is on IQ but the Team will enhance the quality of this.
- Full implementation of Triangle of Care, recruitment panels etc.
- Recurring themes from Service Users Feedback will be addressed through redesign (Feedback of boredom, lack of activity and food. Full occupation of their time will enhance their experience.
- The outcome of improvements one year from now is the intention of having skilled, trained and professional staff.

Questions:

'How this will impact on the Service Users?' PW responded that it will impact positively on relationships, risk, careful handling of people who are fragile, emulating good behaviour and being utterly professional at all times with the client group.

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8. Swindon – Newlands Anning:

The main priorities were identified and presented as follows following on from the Francis Report:

- Triangle of Care
- Effectiveness,
- Bed Management,
- Safety – RCA recommendations and 'Lessons Learnt'
- Service User and Carer engagement.
- Evidence Based Design work on Applewood Ward
- Ongoing recruitment of peer mentors and volunteers.
- Triumvirate now has open sessions at local ASDA stores with Service Users, Staff, Carers providing assistance. SUNS relationship is now re-energised and all are working towards rebuilding AWP's reputation which is strengthening again over historic issues.

Questions:

NA confirmed that the three changes identified by the Triumvirate would be the Teams taking ownership, the importance of CQC inspections and actioning these appropriately.

9. The committee **RESOLVED** to **NOTE** the quality reports given by the Triumvirates.

QS/14/006 – Draft Quality Account 2013/14

1. The Committee received a report on the process and progress for producing the Annual Quality Account 2013/14 to the required timescales and to the specifications as set out by legislation, Department of Health good practice guidance and Monitor guidance. The committee was asked to note that the sections in red were statutory wording.
2. The content of the report was discussed by the committee. RB questioned the difficulty of how challenging these quality improvements are going to be and whether a reasonable target or not? Assurance was given in that the report contained collated evidence from the Professional council, i.e. records management indicators/ looking and agreeing as an organisation what is reasonable/ trajectory to be achieved. It was questioned if the report has been considered by the A&R committee and if sighted on recommendations outside to the role of the Q&S committee. Concerns were expressed that this committee is not being sighted for audits.
3. The Chair expressed her unease over quality plans being formulated outside of the Quality Account. EA explained issues with planning cycles occurring at the same time and offered to work with governance team to oversee when items are to be produced alongside KD who is currently working with the Governance Manager over timings.

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4. Assurance was given to the Committee that the draft will be delivered to TWEG but a possible gap when producing statutory documents has been identified when ensuring involvement from Service Users and Carers. The Chair commented that the Quality Account shares the same paramount importance as the Trust's Quality Improvement Plan and the identified items such as inpatient and community improvement, safeguarding, and lessons learnt regarded as the Top 3 identified today from presentations are not identified in the Quality Account.

4. **The Committee resolved to agree the Quality Account as a draft but reserved the right to include additional items to go to consultation. ST/ HR/ AM/ RB to discuss post Strategy Summit on 16.4.2014 and amend if any additional items are to be added and AT to submit accordingly.**

QS/14/007 – Quality Impact Assessments

1. The Medical Director verbally reported to the Committee over the process for Cost improvement. This process is now in place for leads to undertake assessments which will be allocated across the year, any with the requirement for clinical scrutiny to be submitted the committee.
2. No assessments are available today. Next tranche will come to the committee next month as an ongoing agenda item.
3. The Committee **resolved** to **NOTE** this report.

QS/14/008 – Quality Dashboard Report

1. The Committee received the monthly Quality Dashboard Report from the Director of Operations which sets out performance against the three indicators delegated to the Committee by the Trust Board to provide assurance as a subset of the seven 'Early Warning' quality indicators reported via the IQ system. The report was discussed and the three areas of Friends & Family, CQC and Records Management were reviewed.
2. Lime Ward has experienced two serious incidents in a space of three weeks. Both are being investigated and 72 hour reports have been completed.
3. The committee were informed that the outcome of the Redesign Consultation for Secure Service is published.

3 Exception Reports from Localities – **NONE RECEIVED**

4. The Committee **resolved** to **NOTE** the report.

QS/14/009 – Review of Social Care Implications connected to the Published Inquiry reports into Homicides linked to AWP

1. The Committee received a report from the Head of Social Work/Social Care Pathways Lead updating them on the eleven actions identified and the subsequent progress/ completion of work undertaken.

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2. The Committee resolved to **NOTE** the report with the agreed actions monitored and managed through the Mental Health Legislation Group on an operation level who will report back exceptions.
3. The committee **noted** that this was **CLOSED as an action for this committee.**

QS/14/010 – QGAF Action Plan Update

1. The Committee received a update on the action plan to improve compliance against the Quality Governance framework that supports the Trust's Foundation Status application. This has now complete and supported by collated evidence which will be reviewed by the Trust's consultant, KPMG.
2. Once this self-assessment is validated by KPMG the Board will discuss the portfolio of detail at a Board Seminar before submission. Aspirant Foundation Trusts must have a risk score of 3 or less to enter the FT assessment process; the Trust was previously assessed at a level of 4.5 with several recommendations made to improve its position based on the criteria set out in the Monitor Quality Governance Framework guidance.
3. The Committee **resolved** to **NOTE** the report and **AGREED** the following action:
    - **Self-assessment by Board to be completed prior to submission to KPMG at a scheduled Board Seminar by ER.**

QS/14/011 – Ligature Point Assurance Report

1. The Committee received a Ligature Point Assurance Report from the Acting Director of Nursing summarising the following:
    - There is a robust risk assessment process in place across the Trust. Risks are considered by the anti-ligature group. A programme of works is developed annually. The programme is assessed and prioritised based on the allocated resource.
    - Solutions to reducing the risk of harm from ligature points may have un-intentional consequences and increase other risks
    - Clinical assessment of local risks does not always concur with national statistical evidence and national priorities.
    - There is a gap between what is needed and what has been currently allocated. The work plan for 2014-2015 addresses a number of priorities and also identifies areas of risk where required works are not funded.
    - A strategic review of the assessment and management and financing of risk from ligatures ligature points is being undertaken.
2. Further to the report, the Acting Director of Nursing reported 2 further incidents of ligature suspended suicide on Lime Ward and recently on the Sycamore Unit; assurance was given that both are being currently investigated.
3. In line with the recent sad deaths, door sensors are being reviewed along with specialised windows . P5 of the report details issues around funding and the Anti-Ligature Group is to make a decision over unfunded programme of high risk

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and if anti ligature windows are to be upgraded. A Ligature point review is scheduled for June and then report to SMT and Q&S in July 2014 which will encompass all Inpatient areas.

4. The Trust will identify a Consultant Nurse to review reducing harm from ligature points, risk management processes and approaches regarding intervention and investments in this nationally and internationally.
5. The Acting Director of Nursing assured the committee that Risk Assessment Processes are in place.
6. The Medical Director gave the Committee a verbal exception report around these very recent deaths; Taking this report into account over compliance the Trust is deeply shocked and upset over another Inpatient death and gave assurance that immediate risk and investigation steps have been undertaken. Ward staff are receiving and accepting significant support and debrief, and the usual 72 hour reporting is being reviewed through CIOG.
7. The 2 deaths that occurred in a space of 3 weeks were of a similar nature therefore, the Trust's Chief Executive and Medical Director are working with RUH in regards to Crash Teams and protocols. There is to be an external review of coherence with H&S policies and the way in which these are relevant to staff behaviour for clarity. Work has already been undertaken to prioritise investment to cost this up.
8. A '360 Degree' service appraisal will be used as a methodology for a review; this 'risk summit' will involve different stakeholders with the intention to understand how the clinical care pathways/ services work or don't work together and develop a pathway in keeping with terms of service redesign to enable staff therapeutic understanding of self-harm and commit suicide, rather than negate behaviours i.e. changing 10 min observations to a constant and empathetic engagement process.
9. The Chair expressed surprise at ligature points, in context of trust active management of risk management historically. KD explained that the constant change in equipment available to reduce ligature points is continually evolving and investments in windows once deemed ligature proof are no longer, along with old buildings not fit for purpose. Addressing equipment for anti-ligature changes can't financially be done all at once which reflects in the acuity across Trusts nowadays. There can be a balance to be struck for dignity/ respect but the Medical Director reiterated the need to understand the Trust's philosophical response/ environment vs. the patient centered service.
10. The Chair offered sympathies to all at Sycamore Ward and reiterated the need to be sighted on actions taken for this review separately from CIOG in regards to output including funding. RB commented that the Committee requires the Board position regarding care of the individual and risk appetite which must be an agreed view informed by the clinical recommendations. It was recognised that Sycamore Ward is not conducive to good quality care in its physical environment which has resulted in the prioritised repositioning also on the

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Trustwide Risk Register.

11. The committee **resolved** to **NOTE** the report and agreed the following actions:

- **Item to be escalated in the Q&S Chair's report to the Board**

QS/14/012 – Q&S Draft Work Plan 2014/15

1. The Committee noted the rolling programme of presentations to come to Committee. There will be no presentation in May as Quality Impact Assessments will be reviewed and the programme will commence in June with SDAS.
2. It was agreed that the public part will last for 45 minutes with a focus on Service User and Carers leading the sessions with their stories and the Clinical Director reporting on top 3 Quality improvement measures within the 45 minutes but still have the 'deep dive' quality part in the second part of the meeting.
3. The Committee **agreed** the **draft work plan** with the above **amendments**; to be redistributed to the group with venues/ dates. **ADP**

QS/14/013 – CQC Reviews/ Action Plans

1. Callington Road: report received by the Committee which will be monitored through the CQC Inspection Preparation Group for compliance with actions prior to the Inspection in June.
2. Community Review 2014; report received by the Committee which will be monitored through the CQC Inspection Preparation Group for compliance with actions prior to the Inspection in June.
3. KD assured the committee that the contents of the community review were already known and that an action plan is in place accommodating a 4 week review. Callington Road is receiving peer assessments and measures are in place which are being reviewed by Operations SMT as an overview for actions and reactions.

QS/14/014 – Any Other Business

None was reported.

QS/14/015 – Items to escalate to Board or Horizontal reporting to other Committees

The following items were identified for escalation as follows:

- Board – as per the Chair's report.
- F&P & ESEC Committee - Safer Staffing; chairs to meet and discuss quality strands and non-duplication of data and financial implications.
- A&R Committee to review QIA process and when audit comes out to agree whether internal or external audit will review.

Action

QS/14/016 – Next Meeting

1330-1630, 20th May 2014

Jenner House – Maple Room.