Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

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

Held on Tuesday 20th May 2014

Venue: Maple Room, Jenner House, Chippenham

These Minutes are presented for **Approval**

Members present:

Susan Thompson (Chair) – Non-Executive Director

Ruth Brunt – Non-Executive Director

Alan Metherall – Acting Director of Nursing

Staff In attendance

Kristin Dominy – Director of Operations

John Owen – Clinical Director – South Gloucestershire

Pete Wood – Consultant Forensic Psychiatrist & Clinical Director, Secure Services

Emma Adams – Head of Academy

Alison Devereux-Pearce - Governance Support Officer (Minutes)

Antony Harrison – Consultant Nurse (in part)

Patrick McKee – Associate Director of Practice and Quality Improvement (in part)

Linda Hutchings – Head of Patient Safety Systems

Dr Claire Williamson – HoPP, BANES (in part)

Norman Atkinson – HoPP, Wiltshire

Bina Mistry – Chief Pharmacist

Anita Hutson – HoPP, North Somerset

Julie Hankin – Clinical Director, Wilts (in part)

Tony Gallagher – Non Executive Director & Trust Chair

Sarah Jones – Lead Nurse (in part)

Action

QS/14/029 - Apologies

1. Apologies were received from the following:

Emma Roberts – Director of Corporate Affairs
Liz Bessant - Interim Deputy Director of Nursing & Head Of Infection, Prevention & Control.
Ann Tweedale - Head of Quality Information and Systems
Dr Hayley Richards – Medical Director

QS/14/0028 – Declaration of Interests

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

None were declared.

QS/14/030 – Minutes/summary from previous meeting on 15.4.2014

1. p4 – 3rd line; Reworded as *'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 if so, could also reduce bed delays'.*
2. P9 – Item 4: action against this to be noted on the Matters Arising as *'identify consultant nurse'*
3. P9 – Item 8: Reworded as *'The Chair expressed surprise at ligature points, in context of trust active management of risk management historically'.*
4. P9 – Item 9: Reworded as *'It is recognised that Sycamore Ward is not conducive to good quality care in its physical environment'.*
5. P10 – Horizontal reporting to Audit & Risk committee to be noted.
6. With the above amendments, the Committee **resolved** to **APPROVE** the previous minutes.

QS/14/030.1 – Minutes from the Extraordinary Policy Meeting on 7th May 2014

1. The Committee **resolved** to **APPROVE** these minutes.

QS/14/031 – Matters Arising from previous meeting on 15.4.2014

1. The Committee considered the Matters Arising and resolved to note progress and remove items completed.
2. **Falls Update:** Liz Bessant and Claire Leonard are undertaking a review of the management of falls and the minutes of the Falls Management Group are to come to the Committee next month for information. Feedback from Safety Thermometer and 'Harm Free Days' was discussed with additional feedback on incident reporting. An issue over data collection has been identified and is being addressed.

   The Chair enquired whether there is an accepted level of falls within a care environment; AM discussed the difficulty in comparing rates with acute departments. We are intending to join a patient safety falls collaborative.

   RCA's mention patient frailty as the biggest accepted rationale yet RB expressed her concern that falls sustaining fractures and increased mortality can only be assessed retrospectively. The Committee discussed a 'zero tolerance' approach but acknowledged the difficulty to agree 'acceptable levels' for falls for those suffering hip fractures.

   The impact of medication prescribing practice was discussed, with the Committee to receive annual or bi-annual reporting to enable it to ultimately assure the Board regarding practice in this area. It was requested that AM contribute by presentation in the future.

3. The Committee **resolved** to **NOTE** the update.

QS/14/005 – Quality Impact Assessments for Cost Improvement Programmes 2014-15

1. The Committee received a report presenting the Trust's Cost Improvement Programme (CIP) Quality Impact Assessment (QIA) position.
2. Across the Trust there are a total of 35 QIAs required to support the CIPs. To date 28 plans have been scrutinised as per the delivery schedule with a total of 5 remaining amber and under review pending second round review. These QIAs have been amended but have not had the opportunity for further review by the Medical Director and Deputy Director of Nursing so will be reviewed outside of the meeting for expediency, and submitted for scrutiny of the Committee in June 2014. There are no further QIAs due in June but the remaining 7 QIAs will be scheduled for the scrutiny of the Committee in July and August 2014.
3. The Chair expressed her satisfaction in the detail in terms of cost referencing and CIPs along with form content directly linked to localities to assist quick redesign. Assurance was given by the Acting Director of Nursing that there are no identified concerns over safety to service users and no negative impact for further CIPs planned. KD summarised that the process encourages change through making better use of resources available despite decreased finances.
6. TG explored the scoring rationale and asked how the QIAs were considered to be acceptable or not. He also asked for clarity over the RAG rating used as the QIAs are being assessed halfway through the year. He reminded the Committee that the Trust has been set a task by the Board to complete all the QIAs in adequate time. KD gave assurance that there will be a phased approach taken by the Project Manager within the process. The scoring balance or threshold is a locality decision but the Committee would receive narrative over this via the QIA, and the Board will receive a summarised version of the evaluation accordingly.
8. The Chair requested a report mid-way through the process, to include locality monitoring of CIPs in additional to the PMO monthly report to Finance. **ACTION:** KD is to explore reporting of CIP impacts in the future and report back to the Committee.
9. The Committee **resolved** to **NOTE** the report.

QS/14/033 – Quality Dashboard Report

1. The Committee received the monthly Quality Dashboard Report from the Director of Operations, setting out performance against the three indicators delegated to the Committee by the Trust Board; Friends & Family, CQC Compliance and Records Management.
2. The following points were discussed:

   2.1 Quality Management: Issues have been identified and will be addressed by the localities.

   2.2 IQ review: The self-assessment review method is preferred by staff. This doesn't provide assurance but understanding peer to peer evaluation has been helpful. A combination of the two should exist according to EA.

2.3 Inputting into IQ system: The Quality Academy is reviewing responses on IQ. Both negative and positive reviews will enable a further review of Friends and Family data. PW commented that this element in Secure Services is difficult to answer but depends on how and when the question is asked. Those leaving the service will have a change in attitude of how quality of the service is perceived. He noted that the Prison Mental Health Service is exempt for this indicator.

2.4 Records management: Levels are static, however triangulated evidence across localities confirms that for crisis relapse and contingency and risk planning are scoring uniformly low across localities. Teams need to investigate the root cause of why this is challenging. Teams identified need to look at this area of assessment and method of entering in IQ as per a 'Deep Dive' records audit by the Quality Academy. Contracting and scheduling of Bristol SDAS and OT in Bournemouth Service remains challenging.

2.5 Sycamore Ward: Issues were raised recently at Board. Assurance was given that the team will continue to work through actions/ recommendations.

2.6 Lack of commissioning in Wiltshire: This situation has created Delayed Transfers of Care (DTOC) due to different CCGs funding residential and nursing homes outside of Wiltshire. This is currently on the Delivery Executive risk Register. JH will raise the issue at the Health & Wellbeing Board meeting.

3. RB questioned if locality levels differ to that of Trustwide expectations. The Committee was assured it's locality led but cumulatively Trust agreed. KD is discussing this tomorrow in the Operations SMT Meeting and will formulate a process reconciliation for both. Recommendations and review of IQ will come to this Committee once complete. Mock inspection procedures and responsiveness for inspections will all feed into review to go to this Committee
4. The Committee **resolved** to **NOTE** the report.

QS/14/033.1 – Exception Reports from Localities

1. Wiltshire – Inpatient wards are being investigated for DTOC before the next meeting of the Committee, as per above update.
2. South Gloucestershire – Supervision and appraisal levels are being investigated by the Team Manager. Staff results will be reviewed, in addition, by ESEC.
3. Specialised Services – New appraisal system has resulted in a slight decrease in compliance. Team are addressing this.
4. North Somerset – Maternity leave has had an impact upon Juniper Ward for leave for Service Users. Junior Doctor rota and sustainability was discussed. Out of locality placements are also including 11 out of 25 beds mainly from out of hours admissions. Lack of Occupational Therapists also reported.
5. The Committee **resolved** to **NOTE** the reports.

QS/14/0034 – Integrated Quality & Safety Plan Q4 Report

1. The Committee **resolved** to **DEFER** the report until the next meeting.

QS/14/035 – Annual Learning From Experience Report

1. The Committee received a report providing an overarching record of the Trust's organisational memory in respect of learning in 2013/14. There are no key issues to report, but themes were identified in the different learning opportunities and responses. In addition, it was explained that the introduction of the Patient Safety Development Plan has been instrumental in strengthening Trust's processes in this area.
2. The Committee received assurance that the Trust has robust systems and processes in place to capture learning and share and disseminate that learning with staff, although there is always room to further embed these processes. The report captures highlights of learning activity in the last year, and a more detailed breakdown and analysis is available from the Head of Patient Safety Systems.
3. Recommendations are classified by Trust, locality and team accordingly for immediate action. The Acting Director of Nursing described proposed changes to the review process which will ensure the review process is extended to ensure implementation of lessons learnt.
4. The Chair expressed her thanks on behalf of the Committee and praised the report but questioned how the localities are using information effectively for governance processes and learning, and how quickly information on lessons learnt is communicated. Assurance was given that localities receive information on a monthly basis. The issue goes to the Critical Incident Overview Group (CIOG) initially with a robust clinical discussion, then an alert is sent. On average the process takes 2-3 months but assurance was given that if urgent the information will be shared immediately.
5. The Acting Director of Nursing commented that staff have reported not getting feedback after completing incident forms; This will be addressed along with improving the overall experience with staff.
6. The Committee **resolved** to **NOTE** the report.

QS/14/036 – Trustwide Engagement Group Minutes

1. The Committee **resolved** to **NOTE** the minutes.

QS/14/037 – ECT Annual Assurance Report

1. The Committee **resolved** to **DEFER** the report until the next meeting.

QS/14/038 – Assurance Report on Restrictive Practice

1. The Committee received a report which summarised the recently published Department of Health guidance Positive and Proactive Care: reducing the need for restrictive interventions(2014). The report outlines the key actions for the programme, existing information relating to use of restrictive practices in the Trust, actions already taken in response to Positive and Proactive Care and other reports; and actions still required.

2. The key actions contained in the report relate to both the reporting of incidents of restrictive practices, types of practices used and how incidents can be reduced.

3. SJ discussed key areas of action and provided a baseline summary in responding to positive and proactive care publication by DoH including Restraint, seclusion and rapid tranquilisation. Face down restraint can only be quantified once the national definition has been received and a reporting system established to commissioners. The Trust currently reports on last position utilised in restraint.

4. Safer Wards interventions are to be worked towards by the Trust over the next 6 months. The report contains current figures and a baseline established from the system at this point in time but the Team can track changes.

5. The workplan for the Violence Reduction Group has been drawn up which recognises Trustwide training levels at 67% and is low at present for PMVA.

6. It was acknowledged that there's a large number of restraint used at Elizabeth Casson House; this is to be reviewed by the Lead Nurse and discussed with Ward Manager.

7. RB commented that preventing 'face down' restraint is a national imperative, and asked what oversight this Committee will have. The Acting Director of Nursing advised that this is discussed with commissioners in the quarterly safeguarding report but requires Board oversight within the Trust. EA confirmed that this will be in the update on the Quality Account which will come to the Committee on quarterly basis from the Head of Quality and Information Systems.

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

QS/14/039 – Suicide Prevention Strategy 2014/17

1. The Suicide Prevention Strategy 2014-17 was presented to the Committee for scrutiny and approval. It has been developed by the Suicide Prevention Group and is consistent with the requirements of the national Suicide Prevention Strategy.

2. Minor changes to P10 and P11 were noted due to merging of the Anti-Ligature Group and amendments to the training element in the workplan.

3. The revised national strategy for the UK means the removal of targets in suicide reduction and this identifies key areas for health and wellbeing to the Trust Board and its partners to prioritise suicide prevention. A report will be received on a 3 yearly basis for findings/ baseline. The Trust is slightly below the benchmark rate currently but will improve once the evidence is explained as we

report more than required by NCI. It was also acknowledged that a thematic review will separate out the data further.

2. The Committee **resolved** to **approve** the **strategy** and **NOTED** the report with the **agreed ACTION** that Anthony Harrison to action the training amendment element in the workplan.

QS/14/040 – Crisis Care Concordant

1. The Committee **resolved** to **DEFER** the report to the next meeting.

QS/14/041 – Policies

1. **Self-Administration Policy:** This is a newly established, overarching and enabling policy which provides different levels of assessment. It was reiterated that this is not suitable for all but enables Service Users in various stages of recovery and different patient settings by also holding procedures beneath it.

   The chair questioned if medication is taken away when patients are admitted to wards? BM affirmed that this wasn't the case and there is a risk associated not with self-administering on ward but other patients accessing along with correct accessible storage. Policy is not applicable to all patients in the Trust but is dependent on the point of care pathway, insight into illness and adherence to medication. The policy was discussed and upheld by the Committee as a position to move toward MOP Group recommendations and medical good practice.

2. **Complaints Policy:** This policy has been revised in line with the findings of the Clwyd Report and is in accordance with statutes. The policy has previously been received and approved by TWEG where a lack of Service User (SU) representation was recognised, but it is going to SU groups now for review but is unlikely to be changed substantially from the Service User and Carer Groups. The Committee **resolved** to **APPROVE** the policy.

3. **Missing Persons and AWOL Procedure:** This update on the previous procedure for missing persons and AWOL has been ratified by local police colleagues and the protocol updated in consultation with Wilts and BANES leads for Police and Mental Health. In accordance with the code of practice, a change in greater focus on prevention and implementation of protocols for missing patients has been made.

   The procedure includes AWOL contingency planning, info sharing with police, key risks and escalation for risk ranking by Police which differs to that of the Trust but agreed arrangements mean that missing persons remain our responsibility.

   It was acknowledged that previous resistance over using photos by SU and staff was expressed as an invasion of privacy at that time. A discussion by the Committee reiterated the Trustwide position in that usage of identifiable images CCTV or photos can be used with AM as the self- appointed lead for this. RB reiterated the explicit need to link to patient safety and the risk will determine sharing. A revised policy on sharing information is being prepared by the Head of Safeguarding. The Committee **resolved** to **APPROVE** the policy.

QS/14/042 – CQC Quality & Risk Profile

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

QS/14/043 – CQC Reviews/ Action Plans

1. The committee **resolved** to **NOTE** the report.

QS/14/044 – CQC Compliance Reports

1. **Sycamore:** The ward is partially compliant for points 14, 17 and 20 under the mock inspection. No ward manager is currently in place but the position has been successfully appointed to. Assurance was given over no risks to the Committee. The management team continues to oversee work to improve the quality of the environment and record keeping standards. It is recognised that strong leadership is crucial. The re-provision of Sycamore has begun through an Executive Team visit by KD/ IT and HR. A feasibility project by Capita and IPG group is progressing but no update has been received as yet.
2. **Swindon Victoria Centre:** Has been re-inspected and is now compliant.
3. The Committee **resolved** to **NOTE** the reports.

QS/14/045 – Any Other Business

1. None were identified.

QS/13/046 – Agree any items to escalate to Board or horizontal reporting to other Committees

1. Suicide Strategy to be discussed in Chair's monthly report to Board.
2. QIA Process Update to be summarised to Board in Chair's monthly report.

Next Meeting:

1300-1600 Tuesday 17th June 2014

(Conference Room, Fromeside – Locality Presentation from Specialised Services)