Present: Helen Taylor, Non-Executive Director (*Chair*)
Elaine Noske, Associate Non-executive Director
Lisa Nobes, Director of Nursing
Denver Greenhalgh, Director of Governance
Crawford Jamieson, Medical Director
Paul Fenton, Director of Estates
Simon Hallion, Director of Operations
Alison Smith, Community Services Director

In attendance: Rebecca Pulford, Associate Director of Nursing & Clinical Services, Division 1
Sara Impeciati, Interim Associate Director of Nursing, Division 2
Alison Littler, Matron, Division 3
Karen Kemp, Head of Patient Safety
Kevin Purser, Chief Pharmacist
Fiona Whitfield, Head of Nursing and Professional Practice, East Suffolk Community Healthcare
Michelle Appleby, Governance Manager, Division 4
Clare Harper, Executive Assistant to Director of Governance (*minutes*)
Nadine Darlow, Clinical Lead Emergency Department (*Item 2.4*)
Holly Gissing, Antimicrobial Pharmacist (*Item 3.2*)

Apologies: Nick Hulme, Chief Executive
Neill Moloney, Managing Director
Clare Edmondson, Director of Human Resources
Laurence Collins, Non-executive Director
Nicole Day, Matron, Division 3
Claire Thompson, Associate Director of Nursing Division 4
Sarah Higson, Patient Experience Lead
Sharon Hnatiw, Quality Governance Coordinator
Mark Bowditch, Clinical Director, Surgery & Gastro
Debo Ademokun, Clinical Director, Cancer, Pathology, Women & Children
Rob Mallinson, Clinical Director, Medicine, Therapies & Community Services
Neill Abbott, Auditor, TIAA

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<th>Item</th>
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<tr>
<td>111/17</td>
<td>Apologies/Introductions</td>
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<td>1.</td>
<td>The Chair welcomed Fiona Whitfield, Matron at Community Hospitals to her first attendance at the Quality Committee meeting and Nadine Darlow, Clinical Lead for the Emergency Department.</td>
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<td>2.</td>
<td>Apologies were noted as above.</td>
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<td>112/17</td>
<td>Minutes of the Last Meeting</td>
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<td>3.</td>
<td>The minutes of the meeting held on 18 August 2017 were</td>
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<td><strong>113/17</strong></td>
<td><strong>Action Log</strong></td>
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<td>4.</td>
<td>The Committee reviewed and noted progress of actions on the Action Log, in particular:</td>
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<td>• <em>Action 58/16</em> – IA Nutrition &amp; Hydration. Director of Nursing advised the Committee that during the Deputy Director of Nursing’s vacancy, the Associate Director of Nursing in Division 1 had stepped in to lead the Patient Nutrition Group to significantly revamp the action plan and drive this action forward. The Committee noted that Claire Thompson had commenced as the new Deputy Director of Nursing, and the action would be reassigned to her to push this forward. It was noted that there were nutritional outcome issues and a further audit on nutrition was required. The Committee sought assurance that any issues picked up by the Patient Nutrition Group were escalated through to the Quality Committee via the Patient and Carer Experience Group. <strong>Action:</strong> Meeting to be arranged offline to agree reporting and inclusion in highlight report through patient experience going forward.</td>
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<td>• <em>Action 17/17</em> – Compliance of Sepsis Training. The Medical Director advised the Committee that he had met with the Director of Medical Education regarding improvements to junior doctor compliance rates for Sepsis training. This training had been included in the Junior Doctor Induction programme and sessions on key training issues held periodically.</td>
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<td>• <em>Action 70/16</em> – Aligning divisional quality improvement reports with Quality Improvement Strategy. The Committee noted that the Director of Nursing, Director of Governance and Medial Director had met last week to discuss and a paper will be brought for the Committee to consider <strong>Action:</strong> Paper to be submitted to this Committee for discussion in due course.</td>
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<td>• <em>Action 84/17</em> – Governance issues following GMC survey. The Medical Director confirmed that issues raised from the GMC survey, including Hospital at Night, had been discussed at the Medical Staffing Committee and an action plan was now in place which would be brought to a future Quality Committee meeting.</td>
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<td>• <em>Action 52/17</em> - Mortality reporting. The Medical Director advised that Mortality Reporting was currently being submitted to the Clinical Audit &amp; Effectiveness Committee for oversight and it was agreed that the reports would be brought to the Quality Committee on a quarterly basis for noting going forward.</td>
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<td><strong>114/17</strong></td>
<td><strong>Matters Arising</strong></td>
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<td><strong>C-Section Audit (Risk 34)</strong></td>
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<td>5.</td>
<td>The Associate Director of Midwifery advised the Committee that a clinical audit was commissioned on the number of C-sections (elective/emergency) and whether meeting the national</td>
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recommendation. It was noted that for Category 1 C-sections: lower segment caesarean section (LSCS), there was a 100% compliance with a decision to delivery time of under 30 minutes.

6. It was noted that a repeat audit was undertaken for emergency Category 1 LSCS (immediate threat to life) from April – June 2017 of which 11 cases (81.8%) were compliant with a 30 minute decision to delivery time. In the 2 cases (18.2%) which exceeded 30 minutes (32 mins and 35 mins), both were subsequently downgraded in theatre to a category 2 LSCS. The overall compliance with a 30 minute decision to delivery time for category 1 LSCS over the two audit periods was 92.9% and there had been no adverse incidents or safety issues related to a decision to delivery time exceeding 30 minutes.

7. The Director of Governance commented that the risk relating to the length of journey time to theatre was originally placed on the Risk Register as critical and subsequently regraded as the Division was able to evidence it was managing risk to safety well for Category 1 patients. However it was noted that further evidence relating to the scenario of setting up to deliver by C-Section in one of the maternity labour rooms was required. **Action:** Next audit to include how we look at those scenarios.

**Nursing KPIs for IPR**

8. The Director of Nursing advised that the roll out of new format for the Integrated Performance Report (IPR) had been delayed and she would be discussing this matter at the Trust Executive Meeting on Monday. If the new format was not forthcoming she would revise the KPIs in the current format to ensure they were captured with appropriate timeframes to deliver these accordingly. Other patient safety metrics and those of Community Services would be linked to ensure they were also captured.

**Interim Solution to Diagnostic Results Acknowledgment Mechanism**

9. The Associate Director of Nursing - Division 2 advised the Committee that a new form had been trialled on Debenham Ward and following feedback from doctors the form had been adapted and was being re-trialed. If it is deemed to be fit for purpose, this would be rolled out across the Trust.

10. The Director of Nursing commented that an audit carried out in 2015 of the functionality of Lorenzo had prompted concerns about its functionality. This would be looked at again by clinicians to determine if it was now working sufficiently and could include blood test results. She added that Colchester Hospital was currently using a system called ICE and a clinical project group had been set up to review this system for consideration at this Trust enabling alignment of the quality and safety engagement work.

11. The Committee noted that feedback on the interim solution was still required and requested any incidents relating to the new form to be tracked and brought back to this committee. **Action:** SI

**Quality Dashboard KLOE, Mortality and Community Services**
### Report

12. The Committee received the Quality Dashboard (as a subset of the Integrated Performance Report) for September 2017 data, noting:

- Concerns that Saxmundham, Somersham and Kesgrave Wards were consistently under scoring on heatmaps. This had been discussed at Division meetings and with the ambition to close Waveney Ward plans were in place to move some substantive staff from Waveney Ward to Kesgrave Ward together with a revision of the action plan to ensure it would impact more positively on the heatmap score. The secondment of a Sister onto Somersham Ward was also making robust improvements.
- The threshold for Induction rates on the maternity dashboard required further work and the current KPIs would need to remain until there was a better understanding of our baseline data to provide sufficient assurance. It was noted the patients were safe despite not scoring Green. **Action:** Undertake an audit of all women inducted to ascertain how many inductions were appropriate; consider assurance process; and which committee would provide oversight.
- Complaints - 25 extensions and 8 overdue. Director of Nursing suggested a thorough review of complaints data and trends was required by each division however she was unclear at this stage what or how the data should be used to measure against and would give this further consideration for discussion in 6 months’ time.

### Mortality Report

13. The Medical Director gave an overview of the SHMI data for Q1 which indicated that a comparison of mortality rates during weekdays and weekends showed an increasing trend of deaths at weekends against national figures. The Committee noted the urgency to roll out the Hospital at Night programme and address issues regarding 7 day working standards. **Action:** Report on Hospital at Night and 7 day working standards to be included in meeting planner.

### Community Services Quality Dashboard

14. The Matron of Community Services advised that KPI metrics were of high standard, there had been a low level of complaints and plans were in place to amalgamate Trust and Community infection control statistics going forward. **Action:** Summary of Community Quality dashboard to be provided each month.

15. The Chair commented that there were increasing numbers of EOLC patients dying in hospital and asked whether there was a good understanding of triggers for this. The Director of Nursing advised that the End of Life Care Group was co-chaired by the Chair of St Elizabeth Hospice and there had been much discussion on triggers. A workshop was also planned in January with lead partnering decision makers such as the Suffolk County Council to look at how to pull together the integrated care team for...
16. It was suggested that a further links with mortality data needed to be establish perhaps via the Chairs of EOL Group and the Mortality Group attending both meetings. DG added the need for the Trust quality improvement plan to be further linked with the community and how this translates across. The Chair requested a timeline of when the alignment of the Community Services and the Trust’s Quality Improvement Plan would happen.

### Delayed Transfers of Care

17. The Committee received a summary of interim findings of a review of admissions to the acute setting from community hospital beds following a deep dive into the number of delayed transfers of care in community hospitals and a clinical review of readmissions, which included:
   - Length of time between transfer to a community hospital and readmission back to IHT;
   - Length of time from step up bed in community hospital to admission into IHT bed;
   - For admissions into IHT from community hospital step up beds, to review care plan to determine whether patient could have been managed differently.

18. The following key findings were noted:
   - Readmissions from community hospitals to the acute trust had increased over the last three years. Approximately 22% of discharges in 2016/17 had a discharge destination ‘returned to the acute trust’ compared to 19% for the same period in 2015/16.
   - Once transferred back to the acute sector 12% were returned to the community beds (60% within 48 hours) indicating that the reason for transfer was for diagnostics or short intervention.
   - 21 patient records were reviewed over two sessions by a review team consisting of an Interface Geriatrician, CCG Executive, Senior Matron and Operations Manager from Community Hospitals. Specific questions were used to guide the review and it was found that patients were being readmitted appropriately to the acute and suggests that community hospital staff were good at escalating concerns to the medical team and seeking support from GP and interface geriatrician appropriately.

19. Areas of learning were identified as:
   - Improvements in Patient Medical Management Plans - little evidence of these were found in the notes reviewed;
   - Appropriate consideration given to the concerns raised by community hospital staff when the patient is being reviewed in the acute hospital – avoiding multiple readmissions for some patients;
   - Patients are increasingly frail upon readmission; and
20. The Chair commented that there was adequate assurance within the report and noted the Director of Community Services would continue discussions with partners regarding patient pathway blockages and community bed availability given the plans to close Waveney Ward.

116/17 Cancer Breach Panel Update
21. The Associate Director of Midwifery provided a summary of breaches of the 31 day and 62 day cancer standards for September.
22. It was noted that there were 24 breaches ranging from 63 days to 149 days from referral to the treatment date.

Questions/Comments:
23. The Head of Patient Safety advised the Committee that the CCG had queried how the Trust was measuring psychological harm to patients. The Director of Operations advised that the Cancer Network Group was having this debate at present and feedback would be brought back to this Committee in due course.
24. The Director of Nursing commented that further work was required on patient experience and how the Trust was taking actions from feedback received. It was noted that the Consultant Oncologist was currently working on a feedback action plan relating to the level of communication and wait times given and the impact this has on patients. The action plan would be shared through MDTs.
25. The Director of Operations noted the report required further work to include the number of patients over 62 and 104 days, more detail of the reason for delay and where each one is sitting within the breach timeframe.
26. EN queried what was being done to prevent or address the matter of future breaches. The Director of Operations advised that cancer metrics were delivering 85% on target on 62 days and an improvement in cancer pathway had been recorded.
27. The Associate Director of Nursing – Division 1 commented that Division 1 was currently mapping every point of pathway moved to green for lung cancer patients to provide assurance on impact to the patient.
28. The Committee received the report noting that more detail would be provided going forward.

117/17 Internal Audit Reports:

Review of Health and Safety 2017/18
29. The Committee received the Internal Audit report of Health Safety review undertaken to provide assurance that health and safety processes are being complied with at a divisional level with specific focus on governance arrangements to ensure that health & safety procedures and accountability arrangements were robust and that they link to the corporate Trust-wide health & safety
30. The Committee noted that Reasonable Assurance had been provided with an overall conclusion that:

- The Trust’s policy on health and safety had been approved and is within its review date;
- Whilst the Trust Safety Group provided oversight of the governance requirements within the policy and met regularly, issues were been raised regarding attendance and reporting to Trust Board;
- Monitoring by the Estate Compliance team could be improved to ensure that each division’s health & safety assessments were fully completed in line with their plans and requirements;
- Links to the Trust’s risk management systems were being maintained through the environmental audits and health & safety assessment processes; and
- As at the end of May 2017, 91% of staff members had completed the NLMS E-Assessment mandatory training.

Medical Equipment
31. The Committee received the Internal Audit report following the review of Patient Safety – Medical Equipment, noting:

- it is a requirement that all NHS trusts have in place an organisation wide policy on the deployment, monitoring and control of medical devices, as set out in the Medical Devices Regulations 2002.
- the review covered areas as required by NHS Regulations with particular focus on asset management, maintenance, escalation and training, governance and organisational structure.

32. The Committee noted that Reasonable Assurance had been provided with an overall conclusion that:

- Policies were up-to-date and overseen by the Medical Equipment Management Group (MEMG).
- The e-Quip Electronics and Medical Engineering (EME) database was introduced in October 2016. Passive Radio Frequency Identification (RFID) tags were being rolled out, with a proposal to introduce active tags. This would assist in controlling mobile equipment.
- Several items of equipment listed on e-Quip could not be found during audit testing, and some devices found had passed planned maintenance dates. Data cleansing is taking place to improve accuracy, assisted by the appointment of key staff and other initiatives.
- It had not been possible to test training dates on e-Quip, as work involving Estates and Nursing was ongoing as to how training would be recorded.

118/17 ED Action Plan – focus on outcomes
33. The Committee received and noted the ED Action Plan.

34. In addition to the Action Plan, Nadine Darlow, Clinical Lead Emergency Department gave a presentation on the current work
undertaken in ED to ensure Patient Safety, noting:

- the implementation of the Safety Toolkit to provide:
  - Safety Measures: System failures and leading indicators;
  - Safety Culture;
  - Simulation training for safety;
  - Complaint management;
  - Maintaining the risk register;
  - Incident reporting and analysis;
  - Measurement of good science; and
  - Routine auditing

- Current board assurance provided via the RCEM Quality Indicator 2011 (Median time to be seen by clinical decision maker will consistently be less than 60 minutes) and the Manchester Triage System (Yellow Category Patients seen within 60 minutes).

- The Red to Green week in September achieved median time for patients to be seen below 60mins for 4 out of the 5 days. Further w

- Crowding measures indicating that 10% of admitted patients had a time from decision to admit to finally leaving the department of over 120 minutes, and 10% of the cubicles were occupied by patients who had a decision to admit (also known as temperature measures leading to diverse incident);
- Safe staffing levels;
- Daily breach analysis (proportion of patients discharged between 220 and 240 minutes)

35. The Committee noted the next steps to be taken:

- changes to the Professional Standards Dashboard (median time to be seen by Clinical Decision Maker - all and Ambulance arrivals; and measure of proportion of patients discharged between 220 and 240 minutes);
- Review of how best to capture measures of crowding;
- Work towards NICE staffing levels within constraints of budget;
- Introduce regular audit of frequency of observations and appropriate actions;
- Monitor deaths within 24 hours of admission through ED (review these in addition to deaths in ED in the mortality and morbidity meetings);
- Move to a system that can capture live data

Questions/Comments:

36. The Chair thanked ND for a comprehensive presentation.

37. The Director of Nursing asked whether the mortality review group would be picking up deaths within 24hrs in ED and how were patients who die post discharge captured. The Medical Director confirmed this was not currently included but could be worked into the data.

38. The Director of Nursing commented that the department was very
reliant on clinicians advising if it was a safe environment. ND advised that due to the complexity of the triage system, it would not be appropriate to label patients red or green as Red patients are seen immediately, orange are triaged within 10 minutes and therefore have already been seen hence a simpler labelling system of yellow or major was used.

The Committee noted the presentation.

119/17 Updates on External Quality Assurance visits

39. The Committee received for information the External Quality Assurance Visits and Plan noting that within the plan there were currently 7 overdue milestones, the status of which are awaiting updates during October and November 2017.

40. It was also noted that following the recent CQC inspection all activities had been completed, with the exception of 6 information requests which should be completed this week. Initial feedback from the inspection had been received and the final report was awaited.

41. The Committee received and noted the report.

120/17 PLACE Inspection Report

42. The Director of Estates presented an update report on the annual Patient-Led Assessments of the Care Environment (PLACE) self-assessment which was undertaken in May 2017.

43. The Committee noted the purpose of the assessment was to see how the organisation was performing against a range of non-clinical activities which impact on the patient experience of care against criteria that represent aspects of care which patients and the public have identified as important, and good practice as identified by professional organisations whose members are responsible for the delivery of these services, including but not limited to the Health Estates and Facilities Management Association, the Association of Healthcare Cleaning Professionals and the Hospital Caterers Association.

44. The Committee was informed that the assessment falls into six categories:
- Cleanliness;
- Food and hydration
- Privacy, dignity and wellbeing (how the environment supports delivery of this);
- Condition, appearance and maintenance of premises, and;
- Disability Access
- Dementia friendly environment

45. It was noted that whilst the overall assessment showed an improvement in 5 of the 6 areas and 1 deterioration compared to
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<td>the previous year, the Trust still remained below national average. A detailed action plan was due to be shared with each ward and department that was audited and where appropriate those operational actions listed will be the responsibility of that ward or department to deliver. This high level action plan must be published on the Trusts internet site.</td>
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<td>46. The Committee noted that where actions require building or decoration works, capital investment or a requirement for ISS or Berendens to action, these will be managed by the Estates and Facilities team under the responsibility of the Director of Estates &amp; Facilities.</td>
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<td>Questions/Comments:</td>
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| 47. EN commented that she was unable to open the action plan embedded within the report and requested that was sent separately to members. | PF
PF/CH |
<p>| 48. The Chair requested that the integrated Trust and Community action plan be brought back next month under matters arising. | |
| 121/17 | Highlight Reports: |
| 49. The Committee received the following highlight reports: | |
| Patient &amp; Carer Experience Committee - Noted | |
| Medicines Safety Committee – Noting The Chief Pharmacist advised that there continued to be a shortage in commonly used medicines. Action: KP to provide advance notice of shortages to Community staff to ensure they can implement appropriate training for community nurses where necessary. | KP |
| Patient Safety Committee – Noting Following the move from MEWS to NEWS the Group was considering whether to revise current policy or completely rewrite it. Director of Nursing was looking at hardware base for inclusion of this module and potential for a H@N module. | |
| Trust Safety – Noting Due to low or no attendance issues the Group had failed to meet to 2 occasions. Noted that a full action plan had been implemented and a steering group set up to feedback any issues to the Trust on Safe sharps assessment in the Community. | |
| Safeguarding - Noted | |
| Clinical Audit Effectiveness Committee - Noting In April the decision was made to split the Patient Safety and Clinical Effectiveness Group into a Patient Safety Committee and a Clinical | |</p>
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<td>Audit Effectiveness Committee. The latter met for the first time on Wednesday. Only 19% clinical audits from the annual plan had been completed in Q1&amp;Q2 therefore prioritisation of audits going forward would need to be agreed. Noted that a number of clinical audits had been completed which were not on the audit plan therefore discussions being had with clinicians not to deviate from the agreed plan. Of the completed audits 4 did not meet the standards and subsequently risk assessments were undertaken.</td>
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<td>122/17</td>
<td>Patient &amp; Carer Experience Q1 Summary</td>
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<td>50. The committee received the Patient &amp; Carer Experience Q1 Summary report noting that all KPI metrics were now aligned with the Quality Improvement Strategy metrics.</td>
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<td>123/17</td>
<td>Safeguarding Committee Q1 Report</td>
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<td>51. The Committee received the Safeguarding Committee Q1 Report noting that it was difficult to determine whether Trust was performing well against other Trust as this information was not currently being benchmarked. There were issues relating to DOLS in that assessments were not being received. New legislation had been released and feedback would be provided to this Committee next month.</td>
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<td>124/17</td>
<td>Antibiotic Prescribing</td>
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<td>52. Holly Gissing, Antimicrobial Pharmacist gave a presentation to the Committee on Antibiotic Prescribing, noting that a 4 week audit of approximately 5 prescriptions per ward per day was undertaken with the following findings:</td>
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<td>• Underachievement of review of antibiotic prescriptions within 72 hours of initiation;</td>
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<td>• The Trust was above the national target with regards to antibiotic consumption and a 2% reduction required this year.</td>
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<td>• Approximately 23 antibiotics were stopped following the audit. Point prevalence would be undertaken shortly.</td>
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<td>53. The Committee noted the following actions to be undertaken:</td>
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<td>• Review of antibiotic prescriptions to be included in daily ward rounds.</td>
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<td>• Routine cultures taken on all IV antibiotic initiations where appropriate and assurance that FY1 doctors and ED/EAU teams are adhering to this.</td>
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<td>• Assurance that appropriate actions are taken on –ve cultures.</td>
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<td>54. LN suggested that feedback from Microbiologists that more scrutiny was required with regard to prescribing antibiotics and welcomed trajectories and hard figures on what the Trust needs to achieve.</td>
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<td>55. KK commented that further assurance was required around what interventions were in place, what the drivers were and how these would be measured. She added that she would raise this item at the next community meeting however a new lead would need to be sourced following her departure in December.</td>
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<td>56. CJ commented that the Trust should not be complacent on the antibiotic figures and offered to be or source a clinical champion to assist.</td>
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**125/17 SIRI Briefing**

57. The Committee received and noted the SIRI Briefing report.

**126/17 Consent to Examination or Treatment Policy v6.1**

58. The Committee received for ratification the Consent to Examination or Treatment Policy v6.1, noting:
- the litigation risk;
- consent audits had been completed and were planned annually going forward; and
- assurance that the policy would be disseminated throughout divisions upon ratification.
59. The policy was ratified by the Committee.

**127/17 Medication Policy for Healthcare Professionals v12.0**

60. The Committee received for ratification the Medication Policy for Healthcare Professionals v12.0.
61. FW sought assurance around the process of dissemination to all medical and nursing staff, adding that Community staff were requested to sign a read and receipt form. It was noted that there may be an opportunity to add a module on the ESR system.
62. The policy was ratified by the Committee.

**128/17 Complaints and PALs Annual Report**

63. The Committee received the Complaints and PALs Annual Report.
64. EN asked whether there was an action plan to reduce the number of complaints received. LN proposed that a trends analysis should be undertaken over a period of 6-12 months before an action plan is produced.
65. EN agreed to look into using some of the Innovation funding for a researcher to perform some analysis and proposed

**EN**
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<td>129/17</td>
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<td>Pain Management Unit</td>
<td>LN/SH</td>
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<td>66. EN raised concerns with regard to current wait lists for the Pain Management Unit which was thought to be due to one of the psychologist’s long term sickness absence leaving a gap in clinical team.</td>
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<td>67. The Committee noted that there were 30 patients on the wait list, all of which had now been reviewed and prioritised to be seen by the psychologist or referred to the community.</td>
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<td>68. It was noted that there is no professional standard which states when a patient should be seen and the Committee considered whether a local standard should be set. The Committee also raised concerns regarding the current location of the Pain Management Unit. <strong>Action:</strong> LN to pick up with SH.</td>
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<td>Mental Health Patients</td>
<td>RP</td>
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<td>69. LN raised concerns with regard to the treatment of mental health patients in the acute setting. It was noted that 136 Sections can only be issued if a patient is in the public domain and this did not include when a patient is being transported from home to hospital, thus raising concerns around a suitable place of safety for such patients.</td>
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<td>70. The Committee noted the concerns and requested a presentation at a future committee meeting to include ‘place of safety’. <strong>Action:</strong> RP</td>
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<td>Date of Next Meeting</td>
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<td>22 November 2017, 12:30pm-3:30pm, DSR</td>
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