Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

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

Held on 17th November 2015 at 2.00pm in the Conference Room, Jenner House, Chippenham SN15 1GG

These Minutes are presented for **Approval**

Members Present

Susan Thompson (ST) – Non-Executive Director (Chair)	Hayley Richards (HR) – Medical Director
Ruth Brunt (RB) – Non-Executive Director	Mathew Page (MP) – Acting Director of Operations
Barry Dennington (BD) – Non-Executive Director	Tony Gallagher (TG) – Chairman

Staff In Attendance

Tim Williams (TW) – Clinical Director, Specialised Services	Paul Townsend (PT) – Managing Director, Specialised Services
Sarah Fairham (SF) – Occupational Therapist, Specialised Services	Ann Tweedale (AT) – Head of Quality and Information Systems
Robin Kendall (RK) – Occupational Therapist, Specialised Services	Simon Joseph (SJ) – Clinical Audit Manager
Penny Stanbury (PS) – Involvement Coordinator	John Owen (JO) – Clinical Director, South Gloucestershire
Helen Cottee (HC) – Head of Quality, Specialised Services	Mark Dean (MD) – Head of Safeguarding

Members of the public in attendance

Olly – Service User	Gina – Carer
Kyle – Service User	

QS/15/075 Presentation by Specialised Services

1. TW led a presentation/discussion by Specialised Services.
2. Olly presented his personal experiences within Specialised Services where he had learned to develop tools and strategies that enabled him to deal with his condition. He also provided a very positive overview of the work he was now doing with others suffering from Personality Disorder.
3. ST asked Olly what the trigger point had been for the turnaround in his recovery. He advised that during his journey he had been fortunate to have the right people around to talk with at the right times and this had enabled him to make small and gradual changes that built up his confidence.
4. TW advised clinicians were often uncomfortable with the diagnosis of Personality Disorder and it was noted that more training would be helpful to enable confidence in the diagnosis and to provide the relevant treatments.
5. Gina introduced herself as a nurse leading on family work for psychosis for the Trust. She advised that this had helped her during the journey she had been on with her son who had drug addiction issues. She told the story of her journey with her son. Her son had come to AWP after accessing voluntary drug services. In her role as a carer she began to investigate what was on offer to help him. Her son had stayed at Acer Unit (in-patient detox unit) and this had really changed her views

about drug services and helped her to realise that sometimes an in-patient stay was necessary. She summarised that Drug Services had been hard to navigate and had found there to be service gaps which had led her son to become hopeless at times. However, following rehabilitation counselling, he had begun volunteering with AWP as a chef. He had now found supported accommodation and had been offered a regular chef job. He had been drug free for 15 months now.

6. SF introduced herself as an occupational therapist working in the Bristol Autistic Spectrum Service. Kyle introduced himself as a peer mentor in the BASS Team who was helping people with Autism and Asperger's to undertake more social activities. Kyle advised that he had accessed the service himself and had been diagnosed with Asperger's. Within a year he had felt that he had improved enough to want to give something back to BASS and had looked into volunteering options. Kyle had been attending the Advice Service and when the peer mentor left, he volunteered to take over this role. His role was to help those with Autism and Asperger's feel welcome and safe and to provide them with a familiar face.
7. Sarah advised that Kyle was filling an important role in showing that it was possible to build up tolerance and practice social skills that could enable people diagnosed with Autism and Asperger's to function well in society.
8. ST asked why the Advice Service had been set up. SF advised that the Service had been set up to tackle social isolation. The Service facilitated service users to meet others and to develop interests.
9. BD asked if the Group Work undertaken as part of the service assisted people to find work and to go through interview processes. SF advised that in terms of the peer mentors, working within the Groups could enable them to realise their own positive skills and qualities and could lead to other work opportunities.
10. TG thanked those who had presented and made the observation that signposting was an issue. He noted that if an AWP employee had found the system difficult to navigate, then people new to the services would find it even harder.
11. RB noted also that the stigma from other parts of the health care service was something that patients often raised and suggested there was still a big job to do in terms of educating other sectors of the health and social care community to understand how they could be more actively helpful. Gina noted that she had found that pharmacies had often been unhelpful in relation to dispensation of methadone prescriptions for her son.
12. ST noted the value of peer workers and lived experience in supporting people within the Service. She advised that as an organisation there was a commitment to develop this further. She noted how struck she had been by the strength and the positive nature of the peer mentors and suggested that the AWP needed to consider how they could develop and increase their roles. It was noted that Gina had assisted with some training. It was also noted that RK and Olly had set up a service user group in collaboration with MIND. Olly sits in on team meetings.
13. HC presented the data and charts that the Specialised Services Management Team reviewed on a monthly basis.
14. HC provided an overview of the data challenges of Specialised Services that were a result of the different team structures that were in place. She explained that LD Services were seconded to other organisations and therefore not all data was available to the Management Team.
15. It was noted that data was sometimes difficult to capture because of IT issues in the Prison system. To counter this, incidents were reported on a form by Specialised Services staff, fed

through to the Commissioners and were discussed during Prison Governance meetings. The incidents were tracked so that the trajectory could be identified. Quality was impacted because some group work programs that the Service was commissioned to deliver could not be provided.

16. Incident Management was monitored carefully and managers were reminded when cases were open for over 21 days.

17. It was noted that data was collected from outside the sphere of the Specialised Services area of responsibility. The narrative behind the numbers was noted as being very important in providing an explanation of some of the negative results that had been recorded. RB asked if the team was confident that the anomalies in data collection could explain the reasons for the poor results. TW advised that the team could quickly identify which cases fall directly under Specialised Services and notified the responsible care coordinating team where breaches are identified outside their sphere of responsibility. It was acknowledged that it would be sensible to separate out the cases that fell to Specialised Services and those that fell within the remit of a secondary care team. RB noted that it was important the Quality and Standards Committee understood this because when the data was presented at Trust level, it looked as though there was a permanent problem for Specialised Services.

18. It was noted that RiO was not used as the primary record keeping mechanism in many of the Specialised Services teams. The varied size and workflow of teams was noted as contributing toward the data entry timeliness issues that had been identified in the presentation.

19. The Friends and Family response charts were explained with HC explaining that the number of responses was currently quite high, although the IQ response data was showing declining response rates.

20. TW highlighted the achievements of Specialised Services noting the positive feedback from CQC relating to HMI Prisons, Mental Health visits in Clifton Ward and the Mother and Baby unit, and South Gloucester Safeguarding. The Team had received national recognition for their NPS training work. There were new innovations in the shape of the Nexus PD Unit in HMP Eastwood Park and Daisy. Praise had been received for the complaints handling process within Specialised Services. TW advised that the team had also received several Staff Awards during the year.

21. ST suggested that the complaints handling process should be shared throughout the Trust as other areas were struggling to handle complaints effectively. HC advised that the low service user rate made the complaints process easier to manage. She advised that the process was thorough and that she dealt with the complainants personally. It was acknowledged that feedback from within the Trust had identified that the personal touch from a high level made a real difference to the way that people perceived the response to complaints from the Trust.

22. PT identified the Quality and Safety Risks noting that they centered on Effectiveness, Economy and Efficiency.

23. Effectiveness referred to Specialised Services delivering their goals, maintaining good outcomes for patients and measuring these outcomes in a meaningful way. Staff should be well trained and competent in delivering evidence based approaches. Practice needed to change as new guidance was released. The audit program was a key aspect of effectiveness and talked to the issues in a meaningful way, assisting the team to identify the weaknesses, giving them information about the functionality of services and enhancing their credibility in the market place. Efficiency was about return on investment in an environment where funding and resources were being cut. Economy was about delivering services on time and within budget.

24. The Committee discussed what level of deterioration in quality would be acceptable in the Drug and Alcohol Service given the financial constraints. TW advised that work was being done on

looking at the Service specifications, the guidance from the NTA and Public Health about what the essentials were to deliver the service. TW noted that there could be room to implement a waiting list which would expose patients to a large amount of risk but noted that this level of risk was accepted in other parts of the country. He noted that discussions with Commissioners would need to be held.

25. ST thanked the Specialised Services team for their presentation and thanked those attendees who had shared their stories with the Committee.

QS/15/076 Questions from the Public Attendees

1. There were no members of the public in attendance.

QS/15/077 Close of Public Session

2. This section of the meeting was closed.

QS/15/078 Apologies

3. No apologies had been received.

QS/15/079 Declaration of Members' Interests

1. In accordance with AWP Standing Orders (s8.1), all members present are required to declare any conflicts of interest with items on this agenda.
2. None were declared.

QS/15/080 Minutes of the Meeting on 15th September 2015

1. The minutes of the meeting were reviewed for accuracy page by page.
2. HR noted that the action raised against her name on Page 1, item 6 was not reflected in the action list. ST recalled having raised the issue in the context of the positive work being done in North Somerset around employment of adults of working age. She had asked whether there were figures available to identify how many AWP service users were in contact with vocational services. HR undertook to address the action recorded in the action tracker during the meeting.
3. RB referred to Page 3, item 19 and advised that she has been impressed in the amount ''of time'' invested in making links with organisations. She asked that the wording be amended accordingly.
4. The Committee **approved** the minutes subject to the amendments recorded above.

QS/15/081 Matters Arising from the Previous Meeting

1. It was noted that Items one, two, three, five and seven had been dealt with in the Clinical Executive Report. The items were marked as **complete**.
2. On item three, HR clarified that all service users between the ages of 16 and 69 had been classified as working age adults for the data reported on service users in employment. This item was marked as **complete**.
3. On item five, HR advised that an [Enterprise Board] could be the place where QIA could be tested and aligned with other Trust-wide initiatives relating to Quality and change. This item was marked as **complete**.
4. It was noted that action item four would come back to the Quality and Standards Committee in January. This item was recorded as **ongoing**.
5. On item six, HR reported that the timeliness of complaints had been reduced and there were

capacity issues. She sought leave to await a report from [1:14:23.0 CIOG] and provide a response to this item in January. This extension was granted. This item was recorded as **ongoing**.

6. On item seven, HR advised that the Trust was working on a new format for the PALS and Complaints report that would enable them to benchmark themes. ST noted the importance of being able to demonstrate how the themes from PALS and Complaints were being incorporated into the Quality Priorities. RB indicated that the organisation needed to be able to show how it had learned from complaints, to show what changes had been implemented, and to demonstrate how these actions had made a difference. HR undertook to come back to the Committee with a revised approach in January. This item was recorded as **ongoing**.
7. The remaining action items were recorded as **complete**.

Horizontal Reporting

8. On action item one, it was acknowledged that there had been improvements in the Financial Reports which now showed indicator trajectories. RB recalled the suggestion that had been made to Executive about showing indicators that were on the right trajectory as being green although they had not necessarily met the targets as yet.
9. AD advised that in the new quality tracker the theme would be shown along with the plans. The rating would be given to whether the plans were achieving what they were supposed to do. The theme could be identified as red, but the indicator would show green if the plans were on trajectory to deliver within required timeframes.
10. Item two was deferred until January.

QS/15/082 Week in Focus Reports

1. JO tabled the South Gloucestershire Week in Focus report and took it as read.
2. He noted that there had been a lot of positive feedback and that a number of issues that had been raised were already been dealt with by the locality. He advised that there was a locality Quality and Standards meeting coming up shortly.
3. ST advised that the Committee was looking forward to visiting South Gloucestershire in January.
4. The Committee **noted** the South Gloucestershire Week in Focus report.

QS/15/083 Quality and Performance Report M7

1. MP advised that the report had been updated to suit both the Quality and Standards Committee and the Financial Planning Committee and invited feedback from those in attendance.
2. MP tabled the report and took it as read. He highlighted the areas of concern.
3. In regard to Gatekeeping of Admissions by Crisis Team, he noted particular issues around gatekeeping in Wiltshire. He noted that although some of the issues had been resolved by improvements and measures that had been put in place, there remained a deteriorating position. He advised that weekly reporting from the triumvirates to MP detailing breaches was now being implemented. He noted that there would be additional scrutiny from the triumvirate and the senior leadership team that would ensure the processes were followed rigorously. MP confirmed that the figure of 17 identified for Wiltshire was a three-month figure.
4. ST sought clarification about what the Gatekeeping indicator actually showed. MP advised that the target was about ensuring that Crisis Teams managed admissions into hospital. The indicator showed that the majority of people identified had had a mental health assessment, but the Crisis Team may not have interacted appropriately with that process by providing a timely assessment.

Common breaches are around the Mental Health Act Assessment and service user attendance at emergency departments outside of Wiltshire locality (meaning that the Wiltshire locality relied on the Crisis Team for the area in which the ED was located).

5. BD sought information on the reasons for not complying with the Mental Health Act Assessment requirements and asked about the consequences of not doing so. MP advised that the quality of the assessment was not in question, but rather the fact that the Crisis Team was not as involved in this process as may be expected. This lack of involvement raised questions of quality. The people who carried out the MHA were healthcare professionals and therefore any decision to admit was a sound one. BD asked if individuals would be at risk as a result of this gap. AD advised that individuals would not be at risk as they would still be assessed and provided with a hospital bed if it was required. However, there may be people who were admitted who could have been assisted by the Crisis Team. This was the area of concern.
6. RB suggested that the statement about the measures showing a sustained or improved position were actually misleading given the sustained position was, in some cases, being sustained at a suboptimal level which was not acceptable. She noted that Referral to Assessment had actually got worse having started at green and progressing through amber to red. She noted that Memory Services had not improved at all during the course of the year. RB noted particular issues in relation to responsiveness and suggested that it would be the lack of responsiveness that service users would notice most. MP acknowledged these comments and undertook to consider how to best represent the overall trends. RB noted that the Committee should be able to assure the Board that actions were being taken to make a difference in the areas of consistent low performance. TG suggested the reports should present the problems, the actions and a date by which the issues should be resolved.
7. ST acknowledged that this was beginning to happen in some areas citing the Referral to Assessment on Memory Services and associated interventions in Somerset, following which positive results had been reported. She acknowledged that it was important to have a clear picture on whether things were improving overall, and whether improvement had been sustained.
8. ST asked how confident Swindon was that Memory Services would be where they wanted them to be by the year end. A report was provided monthly to the CCG and Swindon was currently ahead of the required trajectory.
9. MP acknowledged the issues with responsiveness and timeliness, noting that they were predominantly found in Bristol. He noted that these were being addressed in the Bristol Service Improvement Plan.
10. MP advised that he had discussed the comments made at the previous meeting about the bed usage graphs with TR but no suitable alternatives had been identified at this point.
11. MP flagged the issue of unallocated cases in Central Recovery noting that information had come to light following the Bristol Grievance that had raised significant concerns for the Board. MP advised that the team was looking at a structural way to ensure that full visibility was available on this problem. He noted that Rio was not a flow management system and did not tell them about where cases were sitting and who was awaiting allocation. There had been consideration of other metrics (e.g. Referral to Treatment) that may provide better information for reporting.
12. MP advised that the team had begun work on the Risk Analysis and would develop this further to ensure that it was integrated into the overall report. ST noted that she had had questions about how the Risk Analysis reconciled with the report, but undertook to take them offline. She noted that she was particularly concerned about the triggers for escalation and de-escalation. **ACTION**

ST/MP.

13. BD referred to Appendix D and asked about the Unallocated Case numbers in the Recovery Navigator and Care Coordinating line items. MP advised that the reasons for the higher numbers in these lines were related to the lack of professionally registered people working in the teams.
14. TG noted that the Appendix D chart was good, but asked that it be trended. **ACTION MP**.
15. TG suggested that the triumvirates be asked to validate their Unallocated Caseload information given the recent events in Bristol. MP advised that he had written to the triumvirates to inform them of the problem that had been identified and asked them to check whether they had similar issues. Bath had advised that they had a similar issue (which was small compared to the scale found in Bristol) and this was subsequently resolved. It was anticipated that the system that was being designed would provide more visibility in the future. TG noted that it would take external validation to give him assurance that the issues had been resolved. AD advised that some spot checks would be carried out on the caseload as part of the Ward Compliance checking for CQC.
16. TG asked about the accommodation breach. MP undertook to seek the rationale/decision making process around the breach. **ACTION MP**.
17. [HR] asked whether the bed in Laurel had re-opened. MP advised that the first bed had been re-opened and the second one was yet to re-open.
18. The Committee **noted** the Secure Services Exception report. It was acknowledged that Exception Reports were only required when the LDU had something specific to report although it was noted that exceptions could be reported in the Quality and Performance Report.
19. The Committee **noted** the Quality and Performance Report.

QS/15/084 Clinical Executive Report

1. AD tabled the Clinical Executive Report and took it as read. He highlighted particular areas as follows.
2. AD reported that the detail on Safer Staffing had been included in the appendices. He reported that no wards were below 80% staffing overall in September. Six wards were below 80% on certain shifts but there had been no indication of an escalation process. 23 wards were over 120% due to reported increased clinical need. There were times that people had been brought in to meet the Safer Staffing requirements. It was noted that anomalies were being resolved with the implementation of the new safer staffing figures. No unsafe wards had been flagged at this point.
3. In regards to the PMVA, ST asked if the lack of budget to support training in terms of delivery had been resolved. AD advised that it was not necessarily a lack of budget that was the issue, but more that the training was not quite correct. He noted that there were questions about the content of the five day course. AD advised that he was investigating this and advised that the resource required could be smaller if all relevant training was provided as part of the five day course.
4. AD reported that water testing had been planned across all sites. HR advised that some issues had been raised by Estates and Facilities around the cost of doing this testing. AD advised that he would be taking over the Water Management Group and would be addressing the issue of testing. Reporting would be provided in the Clinical Executive Report going forward. **ACTION AD.**
5. AD advised that weekly audits were being carried out on prescription and administration records.
6. Rapid Tranquilisation PRN reporting had not yet commenced. ST noted that it was important to

continue to report to a national audit on this given the Trust had been given an action to reduce the high levels of PRN and Polypharmacy prescriptions.

7. AD reported that a monthly Mental Health Assessment Act audit would be commissioned and the results would go to the Integrated Governance Group. The results of the first audit had been disappointing. The Quality Directors would be taking forward their plans to address this. ST noted that the Mental Health Dashboard had picked up some of the issues raised in the audit. HR suggested they could make the Dashboard represent the categories. It was noted that not all of the issues reflected within the CQC inspections were able to be pulled through directly from Rio and further work would be required to make improvements to Rio to assist with data capture/retrieval. She noted that Rio was the subject of the next Quality Forum.
8. HR undertook to write to all of the Section 12 Approved doctors in the Trust and their trainees about their responsibilities around data capture. **ACTION HR.**
9. In regards to CQC compliance, AD advised that in June 2014 there had been 72 actions and 4 warning notices. In April the warning notices had been removed and in July the report had been reissued and showed 57 actions. ST noted that one of the challenges to the organisation was that they were slow to respond and were not moving fast enough in terms of improvement. AD advised that in the past they may have been slow to the respond but this had not been the case more recently. He acknowledged that they were not moving as efficiently as they should be and noted his concern about information streams. A library of information was therefore being set up.
10. BD asked if the areas showing as compliant in the report would remain so. AD advised that re-checks were regularly made. HR added that the indicators would be changed accordingly. She noted that regular meetings were being held with CQC about responsiveness and advised that they had shared their approach to the inspection, the task list and the clients.
11. Regarding the Key Issues outlined in Section 4.4 of the report, AD advised that he would present a paper on the Acute Care Pathway and Bed Management to the next Committee meeting. PICU would be included in this paper. **ACTION AD**.
12. AT presented the section on Quality Account Improvement Priorities Q2 highlighting the red light against service user and carer experience. She advised that this related to the outcomes from the Friends and Family Survey which indicated that the Trust was not achieving the Community Response rate. The indicator, which identified whether Service users had been asked if they had a carer, was not showing the required improvement. It was suggested that this may be related to data quality and poor local record keeping. ST noted that the Quality and Performance Report had shown that no improvement had been made in this regard and the Committee asked for an update from Operations on this. The Director of Operations undertook to provide a report on the figures and trajectory in relation to Carer Recording (i.e. whether the carer was recorded on Rio). **ACTION MP**.
13. AT reported that the Trust was likely to lose some income in relation to not achieving part of the Cardio Metabolic In-Patients scheme.
14. TG noted that the chart in CQUINs was misleading because the green and ambers added up to a red light. AT advised that the red highlighted the at-risk position. TG suggested that the Cardio Metabolic Assessments should perhaps be red given there was a 50% deviation from where the Trust expected to be. ST asked for the reasons behind this noting that physical health had been a focus in terms of Quality and Improvement. AT advised the Trust was recording the Cardio Metabolic risk factors fairly well, but where there was an indication that something needed to be put in the care plan, recording what actions were being taken in response to this.

15. TG asked if a timeline could be provided to enable the Committee to see when the 57 [CQC issues 2:31:45.4] would be reduced to zero. AD undertook to consider this. **ACTION AD**.
16. ST noted that it would also be useful to see the CQC Heat Map. AD advised that there was not a Heat Map but there was a task list. He undertook to make this available to any Committee member who wished to view it. It was noted that it was available on Ourspace. Any exception reports would also be provided through the Clinical Executive Report.
17. The Quality and Standards Committee **noted** the Clinical Executive Report.

QS/15/085 Safeguarding Annual Report

1. MD presented the 2014-15 Report. He provided the headline information.
2. The Trust's Safeguarding Work Plan was substantially completed as were the process specific work plans which sat underneath. There had been significant increases in requirements, activity and demand over the year. There had also been increases in activity and complexity. The Trust had recognised the increases.
3. The issues and risks had been identified for 2015-16.
4. The conclusion of the report had been that the Trust had maintained ongoing compliance with legal, mandatory and contractual standards throughout the period. Sixty nine documents had been referenced to support this conclusion.
5. The high level actions had been set out at the back of the appendices and there was a detailed action plan against those actions.
6. Emerging issues were identified as being the impact of the Care Act 2014 in the way that it had increased the number of cases being reported as being ''of concern'' through threshold reduction. Some local authorities had also been passing workload onto provider organisations. The Trust was working with CCGs to ensure they ended up with a sensible workload. The changing financial situation was impacting on partner agencies which were attempting to offload capacity onto the Trust.
7. RB suggested that it would be useful to have a clearer picture of action resolution expectations. MD acknowledged the feedback and considered that receipt of the action plan earlier in the year would also be helpful. He noted that most of the projects outlined in the action plan were on a trajectory to be completed by the end of the year. He noted that the plan around data systems and Rio may require more time for full completion, but would be underway by the end of the year.
8. ST requested that the performance of the work plan be presented against the objectives for 2015-2016 (high level view) for the December meeting. **ACTION MD**
9. It was noted that the work plan inputs included Section 11 audits which were normally complete by the end of April. It was agreed therefore that a 2016-17 work plan would be produced in Q1. **ACTION MD**
10. It was noted that there would be more central support to support the localities in Safeguarding as per their request.
11. The Quality and Standards Committee noted the Safeguarding Annual Report.

QS/15/086 Annual Community Mental Health Survey

1. HR presented the Community Mental Health Survey Report.

2. HR advised that three Trusts nationally had eight or more scores of ''better than expected''. In benchmarking the AWP Trust against similar Trusts, they had fared quite well.
3. The qualitative feedback had shown a balance of positive and negative comments. It was proposed that the verbal feedback should be fed into the more detailed plans that would be drawn up to address the issues arising from the Report. It was proposed that the actions would be mapped into the Trust objectives and mapped forward into the Quality Approval work of the Trust both locally and Trust-wide.
4. ST asked if it was possible to take one item from the report and identify the journey of how this item was mapped across local delivery or Trust-wide quality improvement plans. She suggested that Crisis Care may be a relevant item given that it had been identified as an area for focus. She noted that in undertaking this exercise, the Committee would have assurance that they could evidence the integration of report outcomes into the setting of the quality improvement areas. **ACTION HR**.
5. ST acknowledged that the Report had been much more positive than the report given in the previous year.

QS/15/087 Harm Free Care Report Q2

1. HR provided an overview of the highlights of the report.
2. HR advised that all wards were moving toward using the classic safety thermometer for reporting. The Harm Free team would be formulating and benchmarking the data.
3. The Survey showed a change in the burden of harm across the organisation. Previously there had been lower/moderate harm falls and Category 2 pressure ulcers. In this report DVT had also been identified. A multi-disciplinary working group had been convened to identify and review why this had occurred. It was noted that it may be due to the way the Trust was recording.
4. It was noted that progress had been made on fall reduction. There had been a 10 point reduction per 1000 bed days. The Falls Reduction Work Plan was presented with the Report.
5. Further investigation would be carried out on the VTE issue and this would continue to be reviewed at the Trust Infection Control Group and the VTE Working Group.
6. TG asked if an analysis had been carried out of falls by locality. HR advised that Laurel had been an outlier and some specific work had been targeted there. She indicated that there were no longer any outliers. ST advised that the Trust appeared to be an outlier because they had only reported on older persons' wards.
7. ST asked if the Falls Reduction Plan formed part of the each locality's governance review. It was advised that the team had ensured there were mechanisms to ensure that localities were monitoring progress against the Plan.
8. ST asked about the role of medication in falls noting that the Falls Conference had identified this. She asked where this would come into the Falls Reduction Plan. It was noted that the annual audit of the Care Packages would include review of medication. It was also noted that the wards were benchmarking against the Fall Safe standards and this included considering falls when conducting a medication review.
9. ST noted that the report had provided a useful update.
10. The Quality and Standards Committee **noted** the Harm Free Care Report.

QS/15/088 Reducing Restrictive Practices Q2

1. [HR] provided a high level update to the Committee.
2. Improvement had been noted in the PMVA training figures. North Somerset had fallen below target and the bank remained of concern.
3. There had not been any significant change in the use of restraint between Q1 and Q2 overall although differences had been identified in the type of restraint used. This showed the Trust to be using less restrictive practices. It was also noted that compared with the same period of time the previous year, there had been a 10.7% reduction in all in-patient restraints. RB asked how confident the team was about hitting the 20% reduction target by April 2016. [HR] advised that a reduction had been identified in the use of seclusion by 13% over Q1 and Q2. It was noted that there would be an 85% confidence level that the overall target would be met.
4. RB asked what the consequences would be of not hitting the Restrictive Practices targets. There was a discussion about the 0% prone restraint target with it being identified that the target was in fact a 0% prone restraint outside of the Mental Health Code of Practice. Documentation of the reason for restraint would be necessary. It was advised that on average there were 20-30 episodes of prone restraint across the Trust per month. Each was analysed and reported to the Violence Reduction Group where they would be checked against cogent reasons. It was noted that the consequences of not meeting the target would be mainly reputational.
5. ST noted that it had been good to see the reduction in seclusion. She asked whether there was any cause for concern around the number of times that an individual had been secluded or the length of seclusion. It was noted that the team had monitored seclusion over eight hours and could report this data back to the Committee. The new Code of Practice had identified new review processes in instances where seclusion went on for more than eight hours. The team did not identify any causes of concern about individual cases of seclusion.
6. The Quality and Standards Committee **noted** the Reducing Restrictive Practices Report.

QS/15/089 P073 Clinical Audit Policy

1. The Committee reviewed the Clinical Audit Policy. It was noted that the policy was significantly shorter and had taken a lot of the bureaucracy out of getting audits done.
2. The Quality and Standards Committee **approved** the Clinical Audit Policy.

QS/15/090 P056 NICE Guidance Implementation Policy

1. The Committee reviewed the updated NICE Guidance Implementation Policy. [Simon] advised that NICE had assisted with the writing of the policy. It was noted that IGG had agreed to take the role of the centralised group that oversees new NICE guidelines. This was now a standard agenda item for IGG. It was noted that the policy was shorter. Simon advised that it had been approved by NICE which had indicated that they would like to use it as an example for other Trusts.
2. ST asked how the changes to the policy would be disseminated through the organisation. It was noted that a Policy Update Notification would be sent out. ST noted that NICE Guidance is one of the areas on which CQC is focussing and suggested that more action could be taken to ensure that staff were aware of the new policy. It was acknowledged that the information could also be disseminated through Trust publications. It was also noted that consideration was always given to who needed to be informed about any given policy updates and the relevant communications were made.
3. The Quality and Standards Committee **approved** the P056 NICE Guidance Implementation Policy.

QS/15/091 Any Other Business

1. [3:25:35.5 HR] reported that it appeared that the Trust was taking more under-18 service users into the Section 136 Suites. Although there were protocols in place for this to happen, she indicated that she would like to understand the reason for the increase in frequency. She identified that she was not satisfied with the response from CAHMS providers that should provide nursing care, assessment and a bed. More work needed to be done to understand how the Trust's relationship with CAHMS providers was working. **ACTION HR**
2. No Horizontal Reporting or escalation to the Board was recorded.

Committee Evaluation

1. RB noted that the agenda continued to be long and the meeting was taking a lot of time to get through. She noted that it had been positive to hear from the service users in Specialised Services. RB scored the meeting 3.5.
2. Simon noted that this meeting had felt more focussed than previous meetings he had attended. He considered that the focus on trajectory was positive. He noted his feeling that there was a lack of understanding about how the Committee implements actions in a progressive way. Simon scored the meeting 4.
3. HR scored the meeting a 3. She noted that the reporting was improving over time, but noted there was some way to go to have the means to shorten the agenda. She noted that if the Committee was receiving better and clearer assurance it would become quicker.
4. TG advised that in comparison to prior meetings the policies were short and to the point. The Clinical Executive Report was welcome. He scored the meeting a 4. He noted that there was not much that could be cut out of the agenda without sacrificing the level of scrutiny.
5. BD scored the meeting a 3. He noted he had enjoyed Part 1 and indicated it had been well presented. In Part 2, the Quality and Performance and Clinical Executive Report had been useful. He found it took a long time to get through the reading material.
6. AT noted that the first section had been good. She suggested that the reports could be clearer in identifying the must-know issues. She scored the meeting a 3.
7. ST scored the meeting a 3.5. She noted that the Clinical Executive Report had been the best they had seen to date. She noted that it had been helpful to have the analysis around the Specialised Services although she would have preferred to have the data pack in front of her. She noted that the Harm Free Report and the Restrictive Practices Report were well delivered and focussed on what the Committee needed to know. She suggested that the annual reports should be noted as having gone through the right processes and scrutinised by the right people. She suggested there should be an Executive Sponsor outlining the Executive response to the report, identifying how the Trust had met its obligations, identifying the risks for the organisation, confirming the work plans and raising any alerts for the Committee.
8. ST thanked the meeting participants and closed the meeting.