Trust Board Paper N

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 3 November 2016

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Colonel (Retired) I Crowe

DATE OF COMMITTEE MEETING: 29 September 2016

RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE TRUST BOARD:

- **Minute 92/16 – Aseptic Medications – Update on Chief Pharmacist responsibilities – delegated product approval and existing capacity plan.**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR THE INFORMATION OF THE TRUST BOARD:

- **Minute 92/16 – Aseptic Medications – Update on Chief Pharmacist responsibilities;**
- **Minute 95/16/5 – The Committee supported a proposal by the Chief Pharmacist to allow Pharmacists without prescribing qualifications, to generate the TTO section of the discharge letter, and**
- **Minute 96/16/1 – Patient Led Assessment of the Care Environment (PLACE) 2016 Results.**

DATE OF NEXT COMMITTEE MEETING: 27 October 2016

Colonel (Retired) I Crowe
Non-Executive Director and QAC Chairman
27 October 2016

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY 29 SEPTEMBER 2016 AT 1PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Colonel (Retired) I Crowe – Non-Executive Director (Chair)
Mr J Adler – Chief Executive
Mr M Caple – Patient Partner (non-voting member)
Mr A Furlong – Medical Director
Mr A Johnson – Non-Executive Director
Mr R Moore – Non-Executive Director
Mr B Patel – Non-Executive Director
Mr K Singh – Trust Chairman
Mr M Traynor – Non-Executive Director
Ms C West – Director of Nursing and Quality, Leicester City CCG

In Attendance:
Ms J Dixon – Senior Site Manager (for Minute 95/16/2)
Miss M Durbridge – Director of Safety and Risk
Ms C Ellwood – Chief Pharmacist (for Minute 92/16 and Minute 95/16/4-95/16/5)
Mrs S Hotson – Director of Clinical Quality
Mr D Kerr – Director of Estates and Facilities (for Minute 96/16/1-96/16/2)
Ms S Leak – Director of Emergency Care (for Minute 95/16/2)
Mrs H Majeed – Trust Administrator
Mr M Metcalfe – Deputy Medical Director (for Minute 95/16/1-95/16/2)
Ms C Ribbins – Deputy Chief Nurse
Dr A Rickett – Clinical Director, CSI (for Minute 95/16/3)
Ms L Tebbutt – Head of Performance and Quality Assurance (for Minute 96/16/1-96/16/2)

RECOMMENDED ITEM

92/16 Aseptic Medications – Update on Chief Pharmacist responsibilities (action note 8.8 of EQB on 6 September 2016)

The Chief Pharmacist presented paper H and provided a brief background on the recent update to the standards laid out in the Quality Assurance of Aseptic Preparation Services (QAAPS) Guide whereby some additions had been made to the responsibilities of Chief Pharmacists.

There was a new requirement to formally document in an organisational policy (such as the injectable medicines policy) that the Chief Pharmacist held ultimate responsibility for the adequate resourcing of the aseptic preparation service to ensure it met QAAPS standards. The Chief Pharmacist was also required to ensure that a policy on aseptic preparation was in place, detailing all products that were prepared aseptically within the organisation. Both of these requirements would be addressed by an addition to the IV policy (currently under review) and development of an aseptic preparation policy. There were new requirements for Board level approval of the existing capacity plan and delegated product approval. The Committee recommended the delegated product approval and existing capacity plan to the Trust Board for formal approval. There were deficits in relation to storage facilities for aseptic consumables that had not been resolved and were currently on the risk register. An update on this subject was requested for the QAC meeting in January 2017.

Chair

CP

Recommended – that (A) the Committee to recommend the delegated product approval and existing capacity plan to the Trust Board for formal approval, and **Chair**

(B) the Chief Pharmacist be requested to provide an update to QAC in January 2017 on deficits in relation to policies, personnel and storage facilities. **CP**

RESOLVED ITEMS

93/16 WELCOME AND APOLOGIES

The Committee Chair welcomed Ms C West, Director of Nursing and Quality, Leicester City CCG to her first meeting of the Quality Assurance Committee.

Apologies for absence were received from Dr A Doshani, Associate Medical Director, Ms J Smith, Chief Nurse and Ms L Tibbert, Director of Workforce and Organisational Development.

94/16 MINUTES

Resolved – that the Minutes of the meeting held on 25 August 2016 (paper A refers) be confirmed as a correct record.

95/16 MATTERS ARISING

Paper B detailed both the actions from the most recent meeting, and also any which remained outstanding from previous QAC meetings.

Resolved – that the matters arising report (paper B refers) be confirmed as a correct record.

95/16/1 Reducing Readmissions Subgroup Update (Minute 64/16/4 of 30 June 2016)

Mr M Metcalfe, Deputy Medical Director attended the meeting to present paper C, an update on actions being taken to deliver a reduction in readmissions.

The Trust had been a national outlier for high readmission rates within 30 days with a rate of 8.9% for 2015-16. The 2016-17 Quality Commitment included a target for the reduction in readmissions to below 8.5%. This commitment was now being taken forward through the Reducing Readmissions Steering Group (RRSG) meeting which was being held on a weekly basis. The work programme for the RRSG was based primarily upon a continuation of the Preventing Avoidable Readmissions Project (PARP), which took place between January and April 2016. From continuing refinement of the processes identified in PARP, the Trust had shown a reduction in readmissions, achieving the target of 8.5% in June 2016.

The Deputy Medical Director advised that the Reducing Readmissions Steering Group had developed a multidisciplinary approach across the LLR health and social care community to integrate safe discharge processes to reduce readmissions. An update was provided on the work streams being developed to achieve a stretch target of 8.4% and thereby deliver the Quality Commitment for the full year. The Committee supported the resources required to coordinate the implementation of the RRSG work plan.

Resolved – that the contents of paper C be received and noted.

95/16/2 Update on Discharge Workstreams across the Trust including Delayed Discharges (Minute

74/16/1 of 28 July 2016)

Ms S Leak, Director of Emergency Care and Ms J Dixon, Senior Site Manager attended the meeting to present paper D, an overview of both Trust and LLR wide discharge work streams.

The Director of Emergency Care acknowledged that discharge processes across the Trust needed to be improved. Therefore, a parallel approach was being taken, whereby the Trust's discharge workstreams was being aligned with LLR workstreams to support the Emergency Care programme externally, whilst supporting ward processes internally.

The Senior Site Manager provided a comprehensive update on the various new discharge pathways that were being put in place. Whilst several of these were relatively new, the support of the clinical team provided confidence that it would improve patient quality and impact on the length of stay. Mr B Patel, Non-Executive Director suggested that consideration be given to engaging patients and carers in respect of the new discharge pathways and the available options be explained to them.

Responding to a query from the Committee Chair, the Senior Site Manager supported the proposal for Pharmacists to generate the medicine section of the discharge letter highlighting that the delay in availability of TTOs had always prevented early discharges.

The Trust was managing delayed discharges via the A&E Recovery Board and RAP which identified all the key areas for change and improvement.

Resolved – that the contents of paper D be received and noted.

95/16/3 Radiology Discrepancy Management – update on the three actions that had been delayed (Minute 27/16/2 of 24 March 2016)

Dr A Rickett, Clinical Director, CSI attended the meeting to present paper E, an update on progress being made against identified improvement actions with regard to Radiology Discrepancy Management.

The Clinical Director, CSI advised that a number of environmental factors thought to increase discrepancy rates had been addressed. There was a plan to increase access to workstations dependent on plans for reconfiguration. Improvements in electronic notification of results were reliant on the introduction of Peervue through GE PACS provided through EMRAD as the electronic notification system of choice. The GE PACS provision was expected to become 'live' in mid- September 2016 and there would be a three month period of set-up and preparation before this component of the system would 'go live'.

Responding to a query from the Director of Safety and Risk, the Clinical Director, CSI advised that there was no clarity on whether other Trusts report each discrepancy as a serious incident, however, in respect of UHL, each discrepancy was discussed at the Discrepancy meeting and a collective view was taken on whether an abnormality had been missed.

`Medical Director commented that a letter had been received from the CQC requesting if there were any delays owing to the implementation of EMRAD. Despite the Trust having responded to this letter, a further letter from the CQC had been received on 28 September 2016 on the same matter. A conference call had been arranged with the CQC to discuss this matter in detail on 29 September 2016.

Resolved – that the contents of paper E be received and noted.

95/16/4 Homecare Update (action note 7.6.1 of EQB on 7 June 2016)

The Chief Pharmacist presented paper F and advised that although there were some risks still associated with supply of medicines through Homecare, these had reduced since the previous report to the Committee in February 2016 (Minute 15/16/2 of 25 February 2016 refers). Homecare remained on the risk register, but the risk score had reduced from 16 to 12. These risks included issues with external homecare companies, risks owing to insufficient capacity in the Pharmacy Homecare team and risks associated with internal processes.

Capacity issues within pharmacy had been partly addressed through secondment of a Pharmacist to Homecare and prioritisation of new Homecare schemes based on risk and financial/operational benefit. Where existing schemes had been identified as 'high risk', as a result of external factors, these schemes had been reviewed and switched to alternative provision where feasible. Work was underway with relevant clinical specialties to resolve risks arising from internal processes (e.g. generation of prescriptions and requesting and monitoring of blood results). A business case had been submitted to NHS England and CCGs requesting additional funding for the Homecare team.

Resolved – that the contents of paper F be received and noted.

95/16/5 TTO Accuracy Update and Proposal for Pharmacists to write TTOs (Minute 15/16/3 of 25 February 2016)

The Chief Pharmacist also presented paper G1, an update on TTO accuracy and actions in place to address TTO prescribing errors. She highlighted that TTO accuracy had been re-audited in July 2016 and the error rates were similar to previous audits. The current actions to improve TTO accuracy were targeted predominantly at improving inpatient prescription accuracy, as this had been shown to influence TTO accuracy. There was a need for further actions to improve TTO accuracy and it was recommended that this included greater involvement of Pharmacists in generation of the medicine section of the TTO.

A further report (paper G2) was presented which detailed a proposal to enable Pharmacists, who were not prescribers, to write the medication section of the discharge letter (TTO). This proposal would be progressed via a quality improvement project to develop a solution that was multidisciplinary, robust and flexible which could adapt to different services and patient needs. In order to deliver this routinely across UHL would require additional investment in pharmacists' time which would need to be quantified during the project and a business case developed for investment. In order to allow the project to proceed, it was essential that formal agreement was given for Pharmacists without prescribing qualifications to generate the medicine section of the TTO letter. The Committee supported this proposal. The Director of Nursing and Quality, Leicester City CCG noted the need for appropriate documentation be put in place to confirm the accountable prescriber and also need for appropriate Trust-wide communication regarding this proposal. **CP**

Resolved – that (A) the contents of papers G1 and G2 be received and noted, and

(B) the Chief Pharmacist to ensure that appropriate documentation was put in place to confirm the accountable prescriber and also need for appropriate Trust-wide communication regarding the proposal for Pharmacists without prescribing qualifications to generate the medicine section of the discharge letter. **CP**

95/16/6 Management of Fractured Neck of Femur Patients (Minute 72/16/3 of 28 July 2016)

The Medical Director provided a verbal update advising that the #NOF Steering Group had met on two occasions and had agreed terms of reference and ensured suitable cross-CMG and Corporate representation for the #NOF Operational Group that would be chaired by Dr A Currie, Clinical Director, MSS CMG. The Operational Group had been tasked to undertake a full review of the action plan developed in June 2016 following the contract performance notice and an updated action plan would be presented at the next Steering Group meeting on 18 October 2016. The outputs of this meeting would form the basis of an update on progress to October 2016 QAC and November 2016 EQB and CQRG meetings. The Medical Director reiterated that theatre capacity and the impact that Spinal Service had on the Services were the main issues that needed to be resolved.

Resolved – that the verbal update be noted.

95/16/7 Update on External Review of Clinical Quality Assurance Process (Minute 69/16/1 of Audit Committee on 1 September 2016)

The Medical Director advised verbally that further to discussion at the Audit Committee meeting on 1 September 2016, the scope of the external review of the Trust's quality governance and assurance processes had been reviewed and the terms of reference had been drafted. The review would run over a 6-8 week period and was expected to be completed by mid-November 2016.

Resolved – that the verbal update be noted.

95/16/8 Statutory Compliance Report (Minute 52/16/1 of 26 May 2016)

Resolved – that the report (paper I) was not available and therefore deferred to the QAC meeting in October 2016. **DSR/ DEF**

96/16 REPORTS FROM THE DIRECTOR OF ESTATES AND FACILITIES

96/16/1 Patient Led Assessment of the Care Environment (PLACE) 2016 Results

The Director of Estates and Facilities attended the meeting to present paper J, an update on the results of the PLACE assessment programme for 2016.

Members were advised that the PLACE audits took place in March 2016, when Interserve were the private provider of soft FM services. Members noted that the results had been disappointing. The Director of Estates and Facilities discussed the results and noted the need to be mindful that the results were a Trust-wide issue. Action plans had been developed and distributed across a number of areas particularly to address cleanliness and maintenance issues. The Committee Chair suggested that consideration be given to applying for charitable funds if any schemes that were being put in place to address the cleanliness and maintenance issues also inferred patient benefit.

A desktop exercise/ snapshot audit aligned to the PLACE requirements would be undertaken in November 2016 to confirm and inform improvement requirements in advance of next year's PLACE audit. An update on this matter would be provided to QAC in January 2017.

A brief discussion took place regarding the PLACE process and criteria and it was noted that a direct comparison to previous year's results could not be made owing to differing

criteria each year. Members were advised that the Nutrition Steering Group had been established and metrics had been revised as part of the Nursing Safe Staffing report.

Resolved – that (A) the contents of paper J be received and noted, and

(B) an update on the desktop exercise/snapshot audit aligned to the PLACE requirements which was scheduled to be undertaken in November 2016 be provided to QAC in January 2017. **DEF**

96/16/2 Environmental Health Officer Inspection

The Director of Estates and Facilities presented paper K, an update on the Environmental Health Officer (EHO) Inspection held on 23 August 2016. The results of the inspection were disappointing, a rating of 2 for both retail and patient catering at Glenfield and a 3 at the LRI. The main issues raised were in relation to training, environmental cleanliness and estates maintenance.

A number of actions had been put in place to resolve the issues identified and these would ensure that the ratings would improve. The Director of Estates and Facilities highlighted that the Trust was now aware of those matters of concern that would require investment and it was crucial that these were dealt with appropriately and investment was available to address these issues as a matter of urgency.

The EHO would be re-inspecting on 6 October 2016 to assure that matters had been dealt with and that plans were in place to address environmental reconfiguration and purchase of equipment. A further update on this matter would be provided to the QAC in October/ November 2016. **DEF**

Resolved – that (A) the contents of paper K be received and noted, and

(B) an update following the EHO re-inspection on 6 October 2016 be provided to QAC in October/November 2016. **DEF**

97/16 PATIENT EXPERIENCE

97/16/1 Friends and Family Test Scores – July 2016

The Deputy Chief Nurse presented paper L, an overview of FFT scores for July 2016. The 52.4% coverage in Maternity was impressive. The clinical team in the Emergency Department (ED) were continuing to work towards achieving the nationally expected coverage of 20% in all areas of the department, however, coverage had been low particularly in the Urgent Care Centre and Majors. There was a 5.4% increase in the response rate in Eye Casualty submission levels in July 2016 and EDU had again exceeded the minimal 20% target with a submission level of 24%.

The SMS texting trial for outpatients took place during August 2016 and included 119 clinic codes. The early results of the trial showed excellent response rates from patients. Specific issues identified from the trial were now being addressed and EE (telephone provider) required 6 weeks to establish structures to ensure patients text responses were charged to the Trust. The trial also illustrated that once the service was established it could become expensive and therefore needed to be established with mechanisms to control expenditure.

Discussion took place regarding alternative ways of sourcing patient feedback, including the use of digital applications. The Medical Director highlighted that an application (i.e.

app) software had been developed with IBM to source patient feedback – in discussion on this matter, the Chief Executive undertook to follow-up with the Chief Information Officer and the Director of Performance and Information regarding when this app would be put in place. **CE**

The peer analysis for the national Inpatient FFT data in June 2016 had ranked UHL in third position for score and fifth position for submission level. The Trust's ED had been ranked third highest in score and twelfth for submission level.

Resolved – that (A) the contents of paper L be received and noted, and

(B) the Chief Executive to follow-up with the Chief Information Officer and the Director of Performance and Information regarding when the application software (i.e. app that had been developed with IBM to source patient feedback) would be put in place. **CE**

98/16 QUALITY

98/16/1 CIP Quality and Safety Impact Assessments

The Medical Director on behalf of the Director of CIP and Operating Model presented paper M and advised that there was a robust process to link quality and safety assurance process in the Trust and identify any CIP schemes that might be adversely affecting outcomes. The CIP programme quality matrix was now in place and was being used within the Quality & Safety Performance meetings led by the Chief Nurse and Medical Director. The Committee were assured by this process.

Resolved – that the contents of paper M be received and noted.

98/16/2 Nursing and Midwifery Quality and Safer Staffing Report – July 2016

The Deputy Chief Nurse presented paper N, a report providing the current nursing and midwifery staffing position within UHL for June 2016.

There continued to be a high number of wards within each of the CMGs that were triggering a level 1 concern predominantly caused by non-achievement of nursing metrics, which was an expected outcome of the changes made to the metrics. There were also an increased number of level 2 concern wards, again mainly caused by nursing metrics and 1 ward was triggering a level 3 concern. The Deputy Chief Nurse provided a brief update on wards particularly triggering a level 2 and level 3 concerns. The Chief Executive requested that an action plan was appended to future iterations of the safe staffing report for any wards triggering a level 3 concern. It was noted that a meeting was to be convened with senior CMG colleagues and the Deputy Chief Nurse to particularly discuss the support that could be offered to wards at the LGH and an update on this matter would be provided to the Executive Performance Board in October 2016. **DCN**

Resolved – that (A) the contents of paper N be received and noted, and

(B) the Deputy Chief Nurse to ensure that an action plan was appended to future iterations of the safe staffing report for any wards triggering a level 3 concern. **DCN**

98/16/3 Month 5 – Quality and Performance Update

The Committee received a briefing on quality and performance for August 2016 (paper O refers) from the Deputy Chief Nurse and Medical Director. The following points were highlighted in particular:-

(a) **Mortality** – the latest published SHMI (covering the period January 2015 to December 2015) was 98 – below the Trust's Quality Commitment of 99;
(b) **Readmission rates** – at 8.3% were within the UHL's threshold of 8.5%, the lowest rate for over 18 months;
(c) **#NOF** - target not achieved for the second time this year due to the volume and complexity of the spinal surgery activity undertaken in August 2016;
(d) **Infection Prevention** – performance had been in-line with trajectory;
(e) **Sepsis –** the new sepsis indicators would be included in future iterations of the Q&P report;
(c) **Grade 2 pressure ulcers** – there had been a national spike particularly due to the hot weather, and
(d) **Cancer Standards 62 day treatment –** performance had been disappointing particularly due to cancellations caused by lack of ITU/HDU capacity and emergency pressures.

Resolved – that the contents of paper O be received and noted.

99/16 COMPLIANCE

99/16/1 Report on Compliance with CQC Enforcement Notice and CQC Comprehensive Inspection Update

The Medical Director presented paper P, a report on the Trust's compliance with the CQC Enforcement Notice in respect of ED and paper Q, a report detailing the CQC comprehensive inspection.

The Committee was advised that weekly updates were being provided to the CQC in respect of Emergency Department (ED) time to assessment (15 minute standard), ED staffing and sepsis care bundle (screening and antibiotics) for patients presenting to the ED.

As per the existing conditions on the licence, performance was being monitored on a daily basis against the identification of ED patients with red flag sepsis, using the screening tool and sepsis 6 interventions, with a specific focus on ensuring patients with red flag sepsis received IV antibiotics within one hour. The use of the sepsis screening tool and time to IV antibiotics on Assessment Units (Medical, Surgical, Children's, Oncology, Gynaecology & CDU) and Adult wards was being monitored in a similar way to that being done in ED. Most of this currently relied on paper based audits and was a time-consuming process.

The Chief Executive complimented the pace of progress in this area specifically highlighting that it was Trust-wide. Electronic Observations (eOBs), with clinical escalation triggers for both the deteriorating patient and patients with red-flag sepsis, using Nerve Centre would be in place in all clinical areas by October 2016. eOBs was now clinically 'live' on 42 out of 89 wards. Discussions were on-going with NUH NHS Trust in respect of collaborative working to use the different aspects of the Nerve Centre system to generate reports etc. It was noted that the draft report following the CQC inspection in June 2016 was expected in late October/early November 2016.

Resolved – that the contents of papers P and Q be received and noted.

100/16 SAFETY

100/16/1 Report from the Director of Safety and Risk (Paper R):-

- Patient Safety Report – August 2016
- Complaints Performance Report – August 2016

- Duty of Candour Update, and
- Safety Improvement Presentation.

Paper R appendix 1 detailed patient safety data for UHL for August 2016. The number of incidents being reported and the number of prevented patient safety incidents reported (near misses) had increased which reflected a good safety culture. There had been 3 Serious Incidents escalated in August 2016, 2 of which were related to anticoagulation therapy. The CCGs and UHL safety teams had agreed to undertake a joint safety improvement project on improving anticoagulation safety across primary and secondary care. CMG leads had been requested to note the safety theme related to anticoagulation therapy and assure themselves that this was considered consistently within ward rounds, post-operative care and discharge planning. The Director of Safety and Risk also highlighted the following:- incident theme relating to failure to follow policy, the need for safety and governance processes around third party clinical teams and the requirement for a robust escalation process for missing patients.

Paper R appendix 2 summarised complaints activity and performance for August 2016. Complaints performance for 25 day complaints remained consistent and there had been a significant improvement in performance for 10 day complaints.

Paper R appendix 3 provided the duty of candour update. The Committee was informed of changes to the UHL Being Open/ Duty of Candour Policy, as follows:-

(a) DoC letters would be uploaded to Datix rather than adding copy into case notes, and
(b) that the UHL Being Open/ Duty of Candour Policy to be revised to advise that when moderate or severe harm occurred as a result of a recognised complication, a DoC conversation with the patient and/or relatives should still take place and be documented clearly in the notes, but it was not necessary to follow up with a letter if the patient was consented. It was important that the consent process was robust and the patient was fully aware of the risks of a suggested treatment.

Members were advised that the GMC visit on 25 October 2016 would have a particular focus on the requirements for Duty of Candour.

Owing to time constraints, it had not been possible to view the safety improvement presentation. As the Director of Safety and Risk was not available for the QAC meeting in October 2016, it was agreed that Trust Chairman and Director of Safety and Risk would have a discussion with the Director of Corporate and Legal Affairs regarding whether it would be appropriate to schedule this presentation as a part/end of the next or a future Trust Board Thinking Day session.

Trust Chair/ DSR

Resolved – that (A) the contents of paper R be received and noted, and

(B) the Trust Chairman and Director of Safety and Risk be requested to have a discussion with the Director of Corporate and Legal Affairs regarding whether it would be appropriate to schedule the Safety improvement presentation as a part/end of the next or a future Trust Board Thinking Day session.

Trust Chair/ DSR

100/16/2 Freedom to Speak Up (F2SU) Update

The Director of Safety and Risk presented paper S, an update on the Government's response to the Francis 'Freedom to Speak Up Report' and an action plan in line with NHS Improvement (NHSI) requirements to appoint a local Freedom to Speak Up Guardian.

The Director of Safety and Risk advised that a F2SU focus group had taken place at each of the 3 sites and there had been good attendance at these events. An on-line survey had been developed, and gone 'live' to gain further input and opinion. All feedback would be reviewed at the Task and Finish Group meeting on 4 October 2016 with a view to shaping the future of the F2SU guardian appointment and to progress to advert in early October 2016.

Resolved – that the contents of paper S be received and noted.

100/16/3 Report from the Deputy Chief Nurse

Paper T was initially scheduled on the agenda for the QAC meeting on 29 September 2016, however, further to the Committee Chair's agreement, this report was withdrawn from the agenda and deferred to the QAC meeting in October 2016.

Resolved – the position in respect of paper T be noted.

101/16 MINUTES FOR INFORMATION

Resolved – that the following Minutes/items be received for information:-
(A) Executive Quality Board – 6 September 2016 (paper U refers);
(B) Executive Performance Board – 23 August 2016 (paper V refers), and
(C) QAC calendar of business (paper W refers).

102/16 ANY OTHER BUSINESS

102/16/1 Mr P Cleaver, Risk and Assurance Manager

The Director of Safety and Risk made members' aware that Mr P Cleaver, Risk and Assurance Manager would be retiring from the Trust on 30 September 2016. Members wished Mr Cleaver the best for the future.

Resolved – that the verbal update be received and noted.

102/16/2 Wakerley Lodge

Responding to a query from the Committee Chair, it was noted that there was still uncertainty in respect of funding for Wakerley Lodge refurbishment. Discussions had been on-going with colleagues in the Diabetes service in respect of funding availability and the outcome of this was awaited. If it was not possible to secure funding, then the scheme would be put on hold until the start of the new financial year (i.e. April 2017).

Resolved – that the position be noted.

103/16 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that (A) a summary of the business considered at this meeting be presented to the Trust Board meeting on 6 October 2016, and

(B) the following items be particularly highlighted for the Trust Board's attention:-

- **Minute 92/16 –** Aseptic Medications – Update on Chief Pharmacist responsibilities**;**
- **Minute 95/16/5 –** The Committee supported a proposal by the Chief Pharmacist to allow Pharmacists without prescribing qualifications, to generate the medicine section

of the discharge letter, and

- **Minute 96/16/1** – Patient Led Assessment of the Care Environment (PLACE) 2016 Results.

104/16 DATE OF NEXT MEETING

<u>Resolved</u> – that the next meeting of the Quality Assurance Committee be held on Thursday 27 October 2016 from 1pm until 4pm in the Board Room, Victoria Building, LRI.

<u>The meeting closed at 4.00pm.</u>

Hina Majeed – **Trust Administrator**

Cumulative Record of Members' Attendance (2016-17 to date):

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	6	5	80	*K Kingsley – Leicester City CCG*	2	0	0
P Baker	3	0	0	*R Moore*	6	6	100
I Crowe	6	5	80	*K Singh*	6	6	100
S Dauncey (Chair)	3	3	100	*J Smith*	6	3	60
A Furlong	6	4	60	*M Traynor*	6	6	100
A Goodall	2	0	0	*C West – Leicester City CCG*	1	1	100
A Johnson	6	6	100				

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
M Caple	6	5	80	*D Leese – Leicester City CCG*	2	0	0
M Durbridge	6	6	100	*C Ribbins*	6	6	100
S Hotson	6	5	80	*L Tibbert*	5	1	25