Trust Board Paper T

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: 7 January 2016

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Dr S Dauncey, QAC Chair

DATE OF COMMITTEE MEETING: 26 November 2015

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

- **None**

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

(i) Update on Health and Safety Executive (HSE) Improvement Notice re. Sharps (Minute 120/15/5 refers), and
(ii) Discussions under the quarterly update on cancer performance and the decision to develop a quality dashboard (Minute 120/15/8 refers).

DATE OF NEXT COMMITTEE MEETING: 17 December 2015

Dr S Dauncey
QAC Chairman
30 December 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY, 26 NOVEMBER 2015 AT 1:00PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Dr S Dauncey – Non-Executive Director (Chair)
Mr J Adler – Chief Executive
Mr M Caple – Patient Adviser (non-voting member)
Colonel Ret'd I Crowe – Non-Executive Director
Dr A Doshani – Associate Medical Director (on behalf of Acting Medical Director)
Ms D Leese – Director of Quality, Leicester City CCG (non-voting member)
Ms C Ribbins – Deputy Chief Nurse (on behalf of Chief Nurse)
Ms J Wilson – Non-Executive Director

In Attendance:
Mr S Barton – Director of CIP and Future Operating Model (for Minute 120/15/7)
Miss M Durbridge – Director of Safety and Risk
Ms S Hotson – Director of Clinical Quality
Mr A Johnson – Non-Executive Director
Mrs H Majeed – Trust Administrator
Mr R Moore – Non-Executive Director
Ms C Ribbins – Deputy Chief Nurse
Mr K Singh – Trust Chairman (until Minute 120/15/3)
Mr M Traynor – Non-Executive Director (from Minute 121/15/1)
Ms M Wain – Lead Nurse/Manager, Cancer Centre (for Minute 120/15/8)

RESOLVED ITEMS

117/15 APOLOGIES AND WELCOME

Apologies for absence were received from Mr A Furlong, Acting Medical Director and Ms J Smith, Chief Nurse. The Committee Chair welcomed Mr A Johnson, Non-Executive Director to his first QAC meeting.

118/15 MINUTES

Ms D Leese, Director of Quality, Leicester City CCG highlighted that she had raised a query under Minute 109/15/2 (ambulance handover times) regarding ' how do QAC gain assurance that the Trust had robust arrangements in place to monitor quality and safety of patient care within the emergency pathway. This was particularly at times of pressure within UHL and when 4 hour performance and ambulance handover time was challenged'. In response, the Chief Executive advised that there were a number of processes for monitoring the situation and minimising risk. This information was also captured on the Quality Dashboard. The Committee Chair undertook to feedback the query from the Director of Quality, Leicester City CCG to the Chief Nurse who would follow-up this action.

Committee Chair/ Chief Nurse

Resolved – that the Minutes of the meeting held on 29 October 2015 (papers A and A1 refer) be confirmed as a correct record subject to the inclusion of the above comment.

119/15 MATTERS ARISING REPORT

Members received and noted the contents of paper B, noting that those actions now reported as complete (level 5) would be removed from future iterations of this report. Members specifically reported on progress in respect of the following actions:-

(i) Minute 93/15a – the Trust Chairman had emailed Dame J Mellor, PHSO extending an invitation to attend a QAC meeting to discuss 'Dying without Dignity' and wider issues. A meeting would be arranged according to Dame Mellor's availability, and

(ii) Minute 94/15/11 – the Trust Chairman advised that although a report on 'Out of hospital SHMI' had been circulated for the LLR Chairs meeting on 12 November 2015, it could not be discussed due to a number of reasons. This would now be discussed at the next LLR Chairs meeting. This item therefore be removed from the log. **TA**

Resolved – that the matters arising report (paper B refers) be confirmed as a correct record and the actions outlined above be noted and undertaken by those staff members identified.

120/15 SAFETY

120/15/1 Update on Electronic Blood Project Update

The Associate Medical Director presented paper C, an update on the current position of the electronic blood tracking project. The implementation of the BloodTrack system had been delayed significantly due to a combination of technical and IT issues. The roll-out of ward based checking and electronic documentation of transfusions was expected to commence in the second week of January 2016. Any further delays in the implementation of the new Blood Transfusion Laboratory Computer system (Winpath) and the ability to release clinical staff for training were the current risks associated with this project. It was noted that the latter issue including resource requirements for training 4000 staff on the BloodTrack system would need to take place at the Executive Quality Board. Responding to a query from the Director of Clinical Quality, it was noted that the MHRA had been informed of progress with this project and the reasons for the delays. **CE**

Mr I Crowe, Non-Executive Director queried if there were any other statutory requirements that were not currently being fulfilled by the Trust. In response, the Chief Executive highlighted that all of the CQC requirements were statutory, however, the Trust was not compliant with all of those. In discussion, it was noted that some of these requirements were being monitored, however, there would be other statutory requirements that were not being appropriately tracked. Therefore, the Chief Executive requested the Director of Safety and Risk to consider all areas where the Trust should be statutorily complaint and whether/not the Trust was achieving this compliance. The Director of Safety and Risk undertook to take forward this work with assistance from the Director of Clinical Quality and provide an update to QAC in February 2016. Further to this report being presented to QAC, if it was identified that the Trust was non-compliant in a significant number of areas, then a report would need to be submitted to the Audit Committee. **DSR/ DCQ**

Resolved – that (A) the contents of paper C be received and noted;

(B) the resource requirements for training 4000 staff on the BloodTrack system and the ability to release clinical staff for training be discussed at EQB, and **CE**

(C) the Director of Safety and Risk with assistance from the Director of Clinical Quality be requested to consider all area that the Trust should be statutorily compliant and whether/not the Trust was achieving this compliance and provide an update to QAC in February 2016. **DSR/ DCQ**

120/15/2 Patient Safety Report

The Director of Safety and Risk presented paper D, patient safety data report for October 2015. The graph on page 1 of the report showed the rate of reported patient safety incidents per 100 attendances. There had been a reduction in reported incidents in September and October 2015. The Director of Safety and Risk reported the top five

themes of all incidents by 'stage of care' in October 2015. QAC members were advised that the stages of care had been separated onto Statistical Process Control (SPC) charts to display data and this was reported on a weekly basis – members welcomed the new style reporting through SPC charts. In the safety plan within the Quality Commitment for 2015-16, the Trust had committed to reduce harm events (moderate and above) by 5% and progress was on-track to achieve this.

There were three patient safety serious incidents escalated in October 2015 which were in relation to:-

- wrong site radiotherapy treatment (this was also an Ionising Radiation (Medical Exposure) Regulations (IRMER) incident;
- failure to act on an incidental finding, and
- removal of unnecessary lymph nodes due to misreading of fine needle biopsy.

A brief update on these incidents was provided.

The Trust had achieved 100% compliance with CAS performance. There had been one breach in respect of the 60 day RCA performance.

Responding to a query on the areas that would need to be monitored to provide internal and external assurance that quality of care was not being compromised over the winter period, the Director of Safety and Risk listed 7 indicators that would be monitored and reported within the patient safety report to EQB and QAC. **DSR**

The Patient Adviser noted that the number of patient safety incidents in some CMGs was significantly higher than other CMGs and queried the reason for this – in response, the Director of Safety and Risk advised it would be expected that some CMGs (i.e. Clinical Services and Imaging (CSI)) would have a higher number of patient safety incidents because all drug related errors would be picked up by this CMG, however, work was taking place to address the incident trends in Emergency and Specialist Medicine (ESM) and Musculo Skeletal and Specialist Surgery (MSS) CMGs.

Responding to a comment from the Trust Chairman, the Director of Safety and Risk advised that a thematic review of serious incidents was undertaken to identify trends/clusters.

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

(B) the Director of Safety and Risk be requested to include an update within the patient safety report to EQB and QAC on indicators that would be monitored to ensure that safety and quality of care was not being compromised over the winter period. **DSR**

120/15/3 NHSLA Scorecard

The Director of Safety and Risk presented paper E and highlighted that the NHSLA scorecard provided an analysis of the Trust's clinical claims together with the specialty, type and cost of these claims. The recurrent themes in respect of the Trust's inquests and claims was 'failure to recognise, monitor, escalate, respond and treat the deteriorating patient' and this was cross cutting across wards, Specialties and Clinical Management Groups (CMG). From the total of 161 claims reviewed, 38 claims were related to one or more of the Trust's Quality Commitment priorities. The score card broken down my Specialty had been sent to CMG colleagues for review. It was noted that the high cost claims were usually in relation to maternity and the hot spot area was orthopaedics.

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

120/15/4 Radiology Discrepancies Review

The Director of Safety and Risk presented paper F and reported that further to an identified possible trend of missed cancers on X-rays, a review had been undertaken to explore causative factors and additional actions that could be implemented outwith those already defined in the action plans for those incidents. The review had identified a number of findings including environmental factors, such as the quantity of light, having a negative effect on the radiologist's performance. Distractions and interruptions were also significant contributory factors and a multifaceted approach was being taken to resolve this issue.

The Director of Quality, Leicester City CCG noted the need for pace in addressing the issues and also highlighting the need for assurance that monitoring was continued and the action plan was leading to the correct outcome. It was agreed that the Clinical Director, CSI should be invited to attend QAC in February 2016 to present a RAG rated action plan. **CD,CSI**

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

(B) the Clinical Director, CSI be invited to attend QAC in February 2016 to present a RAG rated action plan further to the review of the identified possible trend of missed cancers on X-rays. **CD, CSI/TA**

120/15/5 Update on Health and Safety Executive (HSE) Improvement Notice re. Sharps

The Director of Safety and Risk reported verbally that the EU Council Directive 2010/32/EU1 published in May 2010 had been designed to prevent injuries and the transmission of blood borne infections to hospital and healthcare workers from sharp instruments such as needles, scalpels, etc. In May 2013, the UK Health and Safety (Sharps instruments in Healthcare) Regulations were introduced, transposing the directive into UK law.

Members were advised that the HSE inspection in relation to 'sharps' safety compliance at UHL on 21 September 2015, had identified contraventions to Health & Safety law and the Trust had consequently been served with an 'improvement notice'. There were four areas where UHL had failed to comply. The following actions were required in order to comply with the notice:-

a. implement the use of safer sharps across UHL where it was reasonably practical to do so;
b. avoid unnecessary use of sharps;
c. prevent resheathing of needles, and
d. ensure that needlestick incidents were adequately investigated and actions had been taken to prevent them at a local level.

The Director of Safety and Risk highlighted that there would be a significant cost associated with providing 'safer sharps' across UHL and it was recognised that the timescale (March 2016) for implementation was short and would have significant challenges. The Chief Executive suggested that a discussion be held outwith the meeting in respect of the realistic deadline by which compliance could be achieved and that an extension be requested from the HSE before end of December 2015. **DSR**

Resolved – that (A) the verbal update be received and noted, and

(B) the Director of Safety and Risk be requested to have a discussion with appropriate colleagues outwith the meeting in respect of the realistic deadline by which compliance could be achieved in respect of the sharps improvement notice and an extension be requested from the HSE before the end of December 2015. **DSR**

120/15/6 Freedom to Speak Up Update Report

The Director of Safety and Risk presented paper G and advised that the recommendations made by Sir Robert Francis and the DoH had been reviewed and further to a gap analysis, actions had been identified for the Trust re: the Government's response to the Francis "Freedom to Speak Up" report. The Trust had embraced the principles within the report and was actively pursuing a culture of openness, listening and learning. Appendix 1 provided a poster which detailed ways in which UHL actively promoted staff to raise concerns. A pulse check would be undertaken in January/February 2016, to test staff confidence in using the various routes for raising a concern.

Responding to a query from the Director of Quality, Leicester City CCG, it was confirmed that 'freedom to speak up' work was appropriately aligned to existing whistleblowing arrangements within UHL. It was agreed that a further update should be provided to QAC once the appointment of the national Freedom to Speak Up Guardian was made. **DSR**

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

(B) an update on 'Freedom to Speak Up' be provided to QAC once the appointment of the national Freedom to Speak Up Guardian was made. **DSR**

120/15/7 Quality Sign-Off and Assurance Process – Cost Improvement Programme (CIP) 2015-16

Mr S Barton, Director of CIP and Future Operating Model attended the meeting to present paper H, an update on the new quality sign-off and assurance process for the Cost Improvement Programme. He advised that the new CIP quality assurance process approved by QAC had been launched retrospectively against indicators at the end of quarter 2 of 2015-16. There were 2 themed indicators that required a more in-depth investigation. The impact increased theatre productivity was having on 'on the day cancelled operations' had been off-set by the significant operational pressures which were currently being experienced. The impact of bed reductions on emergency pressures was being monitored closely, but evidence suggested that currently it was not a single root cause.

The implementation of the process had identified some critical learning points which would be implemented in new project initiation documents. One of the learning points was for the Medical Director and Chief Nurse sign-off process to be supported by the Director of Clinical Quality and Director of Safety and Risk, along with the Director of CIP and Future Operating Model to enable a group sign-off of high risk schemes with a confirm and challenge process for CMGs.

In response to a query from the Patient Adviser, it was noted that discussions were on-going with a Patient Partner in respect of patient and public involvement in the CIP assurance process. The IFPIC Chair requested that the CIP cross cutting theme reports to IFPIC included an update on key risks related to performance, safety and quality.

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

120/15/8 Quarterly Update on Cancer Performance

Ms M Wain, Lead Nurse/Manager, Cancer Centre attended the meeting to provide an update on current cancer performance at the Trust. The following was highlighted in particular:-

(a) 2 week wait for an urgent GP referral for suspected cancer to date first seen (target 93%) – the Trust achieved 90% in October and November 2015 and was

forecasted to achieve the two week wait standard in December 2015. All referrals were processed within 24 hours of receipt. A leaflet highlighting the importance of attending the appointments had been developed in discussion with a Cancer User Group and GP colleagues;

(b) 31 day (diagnosis to treatment) wait for first treatment (all cancers) (target 96%) – the Trust currently achieved 92%. The most significant reason for failure of this target was elective capacity in Urology. Any patients who were waiting more than 100 days from referral to treatment were reviewed on a fortnightly basis to identify any harms, and

(c) 62 day wait from referral to first treatment – the 62 day backlog remained high. The themes around reasons for breaches include complex diagnostic pathways, late tertiary referrals and patient-initiated delays. Additionally, there had been cases where patients were either unfit for treatment, particularly in the case of surgery, or had co-morbidities which meant they required high risk assessment.

In response to a query in respect of whether there had been a reduction in patients cancelling their appointments, the Lead Nurse/Manager, Cancer Centre advised that an initial audit had been undertaken and a further audit would be undertaken when the leaflet (as mentioned in point (a) above) was more embedded. She re-iterated that when patients rang to cancel an appointment, a discussion was held regarding the reason for cancelling the appointment.

Responding to comments from Ms J Wilson, Non-Executive Director and the Director of Quality, Leicester City CCG regarding the quality and safety indicators that should be measured in respect of cancer performance, the Lead Nurse/Manager, Cancer Centre undertook to develop a quality dashboard for measuring cancer performance and present this at the next quarterly update to QAC in February 2016. **LN/M. CC**

<u>Resolved</u> – that (A) the verbal update be noted, and

(B) the Lead Nurse, Cancer Centre be requested to develop a quality dashboard for measuring cancer performance and present it at the next quarterly update to QAC in February 2016. **LN/M. CC**

121/15 QUALITY

121/15/1 <u>Quality Commitment Quarter 2 (2015-16) Performance Report</u>

The Director of Clinical Quality presented paper I, the quality commitment quarter 2 (2015-16) performance report and advised that performance had been met for the overall Key Performance Indicators for reducing preventable mortality, reducing the risk of error and adverse events and improving patients and their carer's experience of care. There were some areas where performance had not been met against specific actions and these included some aspects of Sepsis and FFT scores in outpatients and maternity.

It was noted that the change in metrics in respect of Sepsis might have contributed to the apparent deterioration in performance. The Chief Executive highlighted that an update on Sepsis performance had been included in the November Chief Executive's briefing and it would be considered prior to the formulation of the Quality Commitment priorities for 2016-17.In discussion, it was noted that the ED Sepsis pathway in place differed slightly to that used by the rest of the Trust and there was a need to resolve the existence of 2 separate pathways and discussions on this subject were to be taken forward through the Sepsis Group. Responding to a query regarding whether the retrieval of case notes (of all emergency admissions to see if they met the criteria for sepsis screening) was the barrier in improving Sepsis performance, the Director of Clinical Quality undertook to check the position. **DCQ**

<u>Resolved</u> – that (A) the contents of paper I be received and noted, and

(B) the Director of Clinical Quality be requested to check the position regarding whether the retrieval of case notes (of all emergency admissions to see if they met the criteria for sepsis screening) was the barrier in improving Sepsis performance. **DCQ**

121/15/2 Month 7 – Quality and Performance Update

Paper J provided an overview of the October 2015 Quality and Performance (Q&P) report. The following points were noted in particular:-

- many of the quality indicators were on target for improving including diagnostics, MRSA and CDifficile rates, pressure ulcers, appraisals and FFT in inpatients;
- Fractured Neck of Femur performance had been disappointing;
- Food – in response to a query from the Patient Adviser, it was noted that the first meeting of the Nutrition and Hydration Committee had taken place with representation from Interserve and appropriate actions would be taken to oversee all Trust activity relating to nutrition and hydration;
- Waiting Times in Outpatient Clinics – Responding to a further query from the Patient Adviser, the Chief Executive advised that this information was not routinely collected and therefore it had not been included in the Q&P Report. This data would need to be manually collected and a pilot project to improve waiting times in Ophthalmology was being taken forward;
- FFT Score – members stressed the need for improving outpatient coverage. The Deputy Chief Nurse advised that the Patient Experience Team had been supporting Outpatient Teams in improving the uptake;
- RIDDOR underperformance – there had been a sudden increase in RIDDOR incidents reported in October 2015 and there was no specific trend identified;
- Emergency Readmission within 30 days – in response to a comment from the Director of Quality, Leicester City CCG, the Chief Executive advised that the Acting Medical Director had undertaken a deep dive of the reasons for the increase in UHL's readmission rate in 2015-16 and noted that a report was expected to be presented to CQRG. The Director of Clinical Quality undertook to check whether this report had been submitted to CQRG. **DCQ**

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

(B) the Director of Clinical Quality be requested to check whether the report detailing a deep dive of the reasons for the increase in UHL's readmission rate in 2015-16 had been presented to CQRG. **DCQ**

121/15/3 Nursing and Midwifery Safe Staffing Report

The Deputy Chief Nurse presented paper K, a report providing the current nursing and midwifery staffing position within UHL for September 2015. An update on staffing in Childrens' department would also be included in future iterations of the report. The change to weekly pay for bank staff had improved the bank nurse fill rate. A number of different recruitment activities was being undertaken to address the nursing vacancies.

Responding to a query from the Committee Chair, the Deputy Chief Nurse advised that significant work was underway to review and refresh the process for assessing and reviewing patients requiring 1 to 1 nursing support. Responding to a further query on the effectiveness of E-rostering, it was noted that the project was going well and the E-Rostering Board was chaired by the Chief Financial Officer and was getting appropriate focus.

In discussion on the need for a similar report on the medical staffing position, it was agreed that the Acting Medical Director should liaise with Dr C Free, Associate Medical **AMD**

Director in respect of collating medical staffing data from CMGs and producing a meaningful report for submission to QAC on a regular basis (i.e. at least two times a year – April and August).

The Director of Quality, Leicester City CCG highlighted that the nursing and midwifery report provided a one-dimensional view and it needed to include an update on other staffing groups (i.e. Allied Health Professionals) in order to know the real situation. She also noted the need for the report to capture any issues in relation to the recent 'agency caps' and what it meant for patients and how the impact of that was being monitored. In response, the Deputy Chief Nurse advised that the position in relation to 'agency caps' was being monitored and discussions were on-going with the Director of Workforce and Organisational Development. There would be issues and risks attached to implementing the caps in the required timescale and therefore discussions were on-going with the Executive Team to make detailed plans for migration to the new rates which balanced the need to comply with the policy with the need to maintain safe staffing. It was noted that the NTDA had been informed of this position. **CN/DCN**

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

(B) the Acting Medical Director be requested to liaise with Dr C Free, Associate Medical Director in respect of collating medical staffing data from CMGs and producing a meaningful medical staffing report for submission to QAC on a regular basis (i.e. at least two times a year – April and August), and **AMD**

(C) the Nursing and Midwifery report to include an update on other staffing groups (i.e. Allied Health Professionals) in order to know the real situation because it currently provided a one-dimensional view. **CN/DCN**

121/15/4 Friends and Family Test Scores – September 2015

Paper L detailed the friends and family test scores for September 2015. The Deputy Chief Nurse highlighted that Maternity Services had achieved 49.9% and postnatal wards had achieved a coverage of 56.9% which was outstanding. The Alliance had achieved a coverage of 20% further to focussed work by clinical staff. Eye Casualty, who contributed to the Emergency Department score, had also achieved the expected coverage of 20% after some focused work to improve coverage. Adult inpatients, had not achieved the required 30% coverage but had achieved 29% and improvement plans were in place to achieve the target in October 2015.

A peer analysis for August 2015 Friends and Family Test for ED indicated that UHL had scored first and QAC members commended this noting that despite the significant emergency pressures, the Emergency Department team had achieved an exceptional FFT score. UHL scored sixth in the peer analysis for 2015 FFT score in Inpatients.

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

121/15/5 2015-16 CQUIN and Quality Scheduled – Quarter 2 Performance Update

The Director of Clinical Quality presented paper M and highlighted that the National 'Sepsis Screening' CQUIN Scheme had been rated 'red' due to deterioration in percentage of eligible patients screened. Amber RAGs were anticipated for end of year performance for 2 of the National CQUIN schemes (Acute Kidney Injury (AKI) and Sepsis) due to the high thresholds set (90%) plus the Local CHC Assessment CQUIN (95%). QAC supported the actions being taken to mitigate anticipated Amber or Red RAGs in Quarter 2 and to improve performance to achieve end of year thresholds.

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

122/15 ANNUAL REPORTS FROM EQB SUB COMMITTEES

122/15/1 2014-15 Resuscitation Committee Annual Report

Paper N detailed the 2014-15 annual report of the Resuscitation Committee. Members were advised that the Resuscitation Committee had been reconstituted, had a clear work programme and now met on a monthly basis. It was noted that there had been significant progress since April 2014 in resuscitation procedures, policies, training, equipment, audit, benchmarking, and monitoring relating to cardiac arrests. Cardiac arrest outcomes were within the expected range when benchmarked nationally in the National Cardiac Arrest Audit.

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

122/15/2 Point of Care Testing Committee Annual Report 2014-15

Paper O provided the 201-15 annual report from the Point of Care Testing Committee. It was noted that progress was required particularly with policy and training around DNA CPR. The End of Life and Palliative Care Committee now had patient representation from Healthwatch, Leicester.

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

123/15 ITEMS FOR INFORMATION

123/15/1 Haematology Peer Review Visit

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

123/15/2 Internal Communication re. winter plan

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

124/15 ITEMS FOR THE ATTENTION OF QAC FROM EXECUTIVE QUALITY BOARD (EQB)

124/15/1 EQB Meeting of 6 October 2015 – Items for the attention of QAC

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

124/15/2 EQB Meeting of 3 November 2015 – Items for the attention of QAC

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

125/15 MINUTES FOR INFORMATION

125/15/1 Executive Performance Board

Resolved – that the action notes of the 27 October 2015 Executive Performance Board meeting (paper T refers) be received and noted.

125/15/2 QAC Calendar of Business

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

126/15 ANY OTHER BUSINESS

126/15/1 Industrial Action

The Deputy Chief Nurse advised that the government had agreed to meet ACAS and the BMA in an effort to resolve the junior doctors' dispute. However, the strikes had not

yet been called off by the BMA. Plans were in place to maintain a safe level of patient services in the event of industrial action.

Resolved – that the position be noted.

126/15/2 CQC EMAS Inspection

The Chief Executive advised that the CQC had recently inspected EMAS and attended UHL's ED and had identified ambulance handover delays. There was a possibility that the CQC might be following-up this with an inspection of a part of ED.

Resolved – that the position be noted.

127/15 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that the following be brought to the attention of the Trust Board:-

(i) update on Health and Safety Executive (HSE) Improvement Notice re. Sharps (Minute 120/15/5 refers), and
(ii) discussions under the quarterly update on cancer performance and the decision to develop a quality dashboard (Minute 120/15/8 refers).

128/15 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality Assurance Committee be held on Thursday, 17 December 2015 from 1.00pm until 4.00pm in the Board Room, Victoria Building, LRI.

The meeting closed at 3:54pm.

Cumulative Record of Members' Attendance (2015-16 to date):

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	8	5	62.5	*C Ribbins (Acting Chief Nurse capacity)*	4	1	25
I Crowe	8	8	100	*J Smith*	4	3	75
S Dauncey (Chair)	8	6	75	*J Wilson*	8	8	100
A Furlong	8	5	62.5				

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
M Caple	8	6	75	*K Singh*	8	8	100
C O'Brien – East Leicestershire/Rutland CCG	6	3	50	*M Traynor*	8	7	87.5
D Leese – Leicester City CCG	2	2	100	*R Moore*	8	8	100

Hina Majeed, Trust **Administrator**