Trust Board paper L2

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 2 August 2018

COMMITTEE: Quality and Outcomes Committee

CHAIR: Col (Ret'd) I Crowe, Non-Executive Director

DATE OF COMMITTEE MEETING: 28 June 2018

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

- **Safeguarding Children and Adults Annual Report 2017 (Minute 96/18)**
- **Fire Annual Report 2017-18 (Minute 97/18)**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR CONSIDERATION/ RESOLUTION BY THE TRUST BOARD:

- **discussion on never events (Minute 106/18)**

DATE OF NEXT COMMITTEE MEETING: 26 July 2018

Col (Ret'd) I Crowe
Non-Executive Director and QOC Chair

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
MINUTES OF A MEETING OF THE QUALITY AND OUTCOMES COMMITTEE HELD ON THURSDAY, 28 JUNE 2018 AT 2.10PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Voting Members Present:
Col. (Ret'd) I Crowe – Non-Executive Director (Chair)
Ms V Bailey – Non-Executive Director
Mr A Furlong – Medical Director
Ms E Meldrum – Acting Chief Nurse
Mr B Patel – Non-Executive Director (for Minutes 96/18, 103-110/18 inclusive, and 112/18 -117/18 inclusive)
Mr K Singh – Trust Chairman *(ex officio)*

In Attendance:
Miss M Durbridge – Director of Safety and Risk
Mr D Kerr – Director of Estates and Facilities (for Minutes 97/18 – 104/18 inclusive, and for Minute 111/18)
Ms C Ribbins – Deputy Chief Nurse
Ms H Stokes – Corporate and Committee Services Manager

RECOMMENDED ITEMS **ACTION**

96/18 SAFEGUARDING CHILDREN AND ADULTS ANNUAL REPORT: JANUARY 2017 – DECEMBER 2017

Recommended – that the 2017 safeguarding children and adults annual report be endorsed as per paper H, and recommended for approval at the July 2018 Trust Board (report to be appended to the QOC summary of this meeting). **QOC CHAIR**

97/18 FIRE SAFETY ANNUAL REPORT 2017-18

QOC welcomed this positive report at paper J, particularly noting an 86% increase in the number of fire risk assessment reviews from 2016-17 levels, following the Trust's introduction of a 'positive confirmation' approach. QOC noted ongoing issues, however, with the recording of training compliance figures. Noting Health and Safety Committee comments on the key importance of fire training, the Director of Safety and Risk suggested a need for further discussion at Executive level if the option of on-line training only was to be extended beyond the agreed date of October 2018. The Director of Estates and Facilities advised that face to face training was not a statutory requirement in respect of fire – rather, the Trust was required to carry out a risk assessment to determine who required face to face fire safety training. **DEF**

The Director of Estates and Facilities outlined ongoing work to recruit to fire safety officer vacancies, including potential rebanding of the post, noting the competitive environment for such professionals. He also advised QOC of ongoing work with Leicestershire Fire and Rescue Service to reduce unwanted fire signals and avoid the Trust being charged for unnecessary call-outs. Approximately £1.2m of fire-related capital works were planned by UHL in 2018-19, and the QOC Non-Executive Director Chair noted the need to complete these works in-year.

The QOC Non-Executive Director Chair emphasised his wish for 100% fire warden coverage, and he also considered that there were learning points for staff in terms of fires started by patients with dementia or delirium. It was noted that this issue had also been discussed by the Executive Quality Board. In further discussion on the report, Ms V Bailey Non-Executive Director queried where the outcomes from the Grenfell Tower enquiry panel would be reviewed (once known). As detailed in paper J, Leicestershire Fire and Rescue Service had undertaken appropriate 'high rise premises visits' at relevant UHL buildings following that fire, as part of the national programme. QOC endorsed the annual fire safety report 2017-18, and recommended it for Trust Board approval as attached. **DEF** **QOC CHAIR**

Recommended – that (A) the 2017-18 fire safety report for be endorsed and recommended for approval by the July 2018 Trust Board (via the QOC meeting summary); **QOC CHAIR**

(B) the target date for 100% fire warden coverage be confirmed, and **DEF**

(C) consideration be given to the need for further discussion at Executive level if the option of on-line training only was to be extended beyond October 2018. **DEF**

RESOLVED ITEMS

98/18 APOLOGIES FOR ABSENCE

Apologies were received from Mr J Adler Chief Executive, Professor P Baker Non-Executive Director, Mr M Caple Patient Partner, Mrs S Hotson Director of Clinical Quality, and Ms C West Director of Nursing, Leicester City Clinical Commissioning Group.

99/18 MINUTES

Resolved – that the Minutes of the meeting held on 24 May 2018 be confirmed as a correct record.

100/18 MATTERS ARISING

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of personal data.

101/18 EWS/SEPSIS PERFORMANCE: 2017-18 QUARTER 4 UPDATE

Winter 2017-18 staffing/capacity issues had now largely been addressed, with a corresponding improvement in performance. Progress continued towards a paperless (NerveCentre based) system, and once that was embedded the current (fortnightly) frequency of the sepsis meetings would likely reduce. In response to a query from the QOC Non-Executive Director Chair, the Medical Director considered that the IV antibiotics provision was more clinically important than the 1-hour blood cultures indicator.

Resolved – that the 2017-18 quarter 4 update on EWS and sepsis performance be noted.

102/18 DISCHARGING PATIENTS PRIOR TO TTO MEDICINES BEING AVAILABLE – DRAFT POLICY

The Acting Chief Nurse presented this draft policy for QOC comments, en route to the Medicines Optimisation Committee and then to Policy and Guidelines Committee. Noting the need for appropriate governance of any such practice (which appeared to have occurred owing to winter pressures), the policy therefore set out the steps to be followed when there was an urgent need to discharge a patient prior to the TTO medicines being available. This situation was limited to discharging a patient to a residential home, care home, or community hospital and did not apply to discharge home. In response to a query from Ms V Bailey Non-Executive Director, this exclusion of discharge home was explained in more detail. The Acting Chief Nurse also confirmed that practices at other Midlands Trusts had been reviewed in detail when developing the draft policy, and she reiterated that the policy would be used in a very controlled and tightly-applied way.

In discussion on the draft policy, the QOC Non-Executive Director Chair requested that it make clear that Site Duty Flow and Capacity Managers were responsible for selecting and booking the necessary transport. Ms V Bailey Non-Executive Director also queried whether the policy applied to new medicines only, rather than also to any medication the patient might hold at home (in which case TTOs might not therefore be required), and asked whether any assessment of patient capacity was undertaken. In general terms, QOC also noted the wider need to improve availability of TTO medicines prior to discharge. It was noted that the draft policy related to inpatients only, and the Deputy Chief Nurse advised that packs of more commonly-used medicines were kept in stock in ED for patients.

Resolved – that the draft policy for discharging patients prior to TTOs being available be endorsed for onward review by the Medicines Optimisation Committee and PGC, subject to:- **ACN**

(1) clarifying within the policy that Site Duty Flow and Capacity Managers were responsible for selecting and booking the necessary transport;
(2) clarification on whether the policy applied to new medication only, rather than medicines already held by the patient at home, and
(3) clarification of whether any assessment of patient capacity was undertaken.

103/18 ESTATES AND FACILITIES SERVICES – PROGRESS UPDATE

Paper E set out performance on key estates and facilities indicators for the period January – March 2018, although patient catering continued to perform well, the report showed a general continued 'plateauing' of performance on other indicators, with some cleaning issues in March 2018 linked to overall capacity pressures. The previous slight deterioration in statutory estates compliance had now been addressed.

The Director of Estates and Facilities highlighted some infrastructural estates challenges – drainage issues were a particular issue, and QOC was advised of the very significant wider estates impact of two recent blockages (resulting from the flushing of inappropriate material down Trust toilets by staff). Approximately 70% of reactive maintenance time was being spent on drainage issues, which was not sustainable. Although some capital estates works were planned re: drainage, the Director of Estates and Facilities emphasised that addressing this staff behaviour was an operational issue rather than one for estates, and he advised that he would discuss appropriate staff induction messages on this issue with the Acting Chief Nurse outside the meeting. **DEF** The QOC Non-Executive Director Chair requested that action be taken to clearly publicise the damage done by flushing inappropriate material down Trust toilets. **DEF**

Positive feedback had also been received to the fruit and vegetable stalls now available on each of UHL's sites. In further good news for staff, the Director of Estates and Facilities confirmed that the recent national pay award was also being honoured by UHL for the non-Agenda for Change facilities and estates staff. In response to a query from the QOC Non-Executive Director Chair, the Director of Estates and Facilities outlined the recruitment measures planned re: facilities and estates staff, linking in with UHL's big summer 2018 nursing recruitment event.

Preliminary reading of the most recent PLACE results indicated a very positive result on cleaning (full report to be presented to the August 2018 QOC). **DEF** The Trust's Head of Facilities had recently won a national sector award, which would be appropriately publicised. In response to a query from the Medical Director, the Director of Estates and Facilities advised that improvements in cleaning performance were expected to be driven through the facilities management LLP later in the year and that the new organisation would have cleaning as a key performance metric. QOC would continue to be kept appropriately sighted to this metric. The Acting Chief Nurse also advised that the Infection Prevention team continued to work closely with estates colleagues re: cleaning.

<u>Resolved</u> – that (A) with regard to instances of inappropriate items being flushed down Trust toilets, the Director of Estates and Facilities:- **DEF**

(1) meet with the Acting Chief Nurse outside the meeting to discuss appropriate messages to use at staff induction, and

(2) consider how best to publicise the impact of/damage done by such actions, and

(B) the 2018 PLACE results be presented to the August 2018 QOC. **DEF**

104/18 INFECTION PREVENTION AND CONTROL (IPC) UPDATE

Ahead of a performance review meeting with NHS Improvement, paper F provided high level assurance on UHL's compliance with the Health and Social Care Act 2008: Code of Practice for the Prevention of Infection and Control. The report focused on 5 key areas, and confirmed UHL's compliance with the Hygiene Code. However, UHL's IPC audits were identifying new challenges facing the Trust, including (i) an increased number of Clostridium difficile infection (CDI) in April 2018 – although numbers were now back within trajectory that rise indicated a need to review and change practices eg improve handwashing; (ii) an outbreak of MRSA colonisation in ITU at the LRI – this appeared to now have been addressed; (iii) a particularly virulent strain of Norovirus continuing to affect a medical ward at the LRI, and (iv) limited space (up to June 2018) for decanting to support deep cleaning – this would now be addressed over the summer through the new Emergency Floor phase 2 moves, with plans already in place to support a deep cleaning programme (appropriately targeted, as now outlined by the Acting Chief Nurse).

QOC particularly discussed the estates challenges of infection prevention within UHL, receiving assurance that the Director of Estates and Facilities and the Acting Chief Nurse continued to work closely on these issues. In terms of operational pressures, the QOC Non-Executive

Director Chair commented that winter occupancy rates further hampered the availability of decant facilities. In discussion, the Director of Estates and Facilities clarified that the ITU outbreak had not resulted from the environment nor from the cleaning standards in place. He further commented that cleaning and/or refurbishing ward areas had a significant uplift effect on staff morale – a programme was in place for 2018-19 by the Director of Estates and Facilities emphasised that due to capital constraints this would mean slipping some other parts of the estates capital programme. He was therefore in discussion with the Chief Financial Officer about making those slipped elements pre-commitments on the 2019-20 estates capital plan. He also noted that it was planned to have a rolling decant ward available on the LRI site.

Although welcoming the report, QOC requested that future iterations include further explanation of the 'red' rated areas of the IP scorecard and of the related remedial actions, and also asked for a briefing outside the meeting on those red areas within the current report. The Acting Chief Nurse advised that such information would also be provided in the Infection Prevention Annual Report scheduled for the July 2018 QOC. **ACN**

<u>Resolved</u> – that with regard to the 'red' rated areas of the IP scorecard, the Acting Chief Nurse:- **ACN**

(1) include further explanation of those areas and the planned remedial actions in future iterations of the report, and

(2) brief members outside the meeting on the red areas within the current report.

105/18 SAFEGUARDING ASSURANCE REPORT

Paper G summarised the current position of safeguarding practice within UHL, and outlined any specific safeguarding developments during June 2018. An action plan was in place to address the safeguarding elements from the March 2018 CQC Well-Led report; appropriate specialist advice had been sought on the management of unauthorised DoLs applications, and the Trust was in discussion with CCGs on the development of an appropriate FGM training course for staff. Further work was also underway with the UHL training department re: the recording of safeguarding training undertaken by staff. Noting wider training data issues, QOC suggested that further assurance on HELM data be sought through the People, Process and Performance Committee. **QOC CHAIR**

In introducing the safeguarding assurance report, the Deputy Chief Nurse also noted in particular:-

(a) that this week, UHL would become the first Trust to implement the national Child Protection Information Sharing project (C-PIS) in its ED;

(b) that UHL had exceeded its PREVENT staff training target in April 2018, which was a very positive development, and

(c) the June 2018 introduction of a service level agreement with Leicestershire Partnership Trust, for that Trust to formally provide data on all Mental Health Act detentions on UHL premises. In response to a query from Ms V Bailey Non-Executive Director, it was agreed to confirm whether that agreement also covered the Alliance. In response to a further query, the Deputy Chief Nurse advised that LPT (rather than UHL) hosted the Designated Doctor and Designated Nurse. **ACN**

In further discussion, the Trust Chairman complimented the Trust's (small) safeguarding team on its work, and noted that inter-organisational relationships were often crucial in safeguarding cases.

<u>Resolved</u> – that (A) it be confirmed whether the June 2018 service level agreement with LPT in respect of Mental Health Act detentions on UHL premises also covered the Alliance, and **ACN**

(B) a request be made to the People, Process and Performance Committee for it to review the general level of Trust-wide assurance re: HELM training data. **QOC CHAIR**

106/18 REPORTS FROM THE DIRECTOR OF SAFETY AND RISK

Paper I from the Director of Safety and Risk comprised:-

(i) a revised never event action plan (see discussion below);

(ii) the patient safety report for May 2018 – the rise in never events was a concern, and had also been flagged at the recent Executive Performance Board meeting. This was a key area of focus, hence the inclusion of the revised never event action plan which was also scheduled for discussion at the July 2018 Executive Quality Board. QOC also voiced concern at the number of outstanding RCA reports – in response the Medical Director requested that each CMG's RCA tracker data be shared with that specific CMG at their performance review meetings; **DSR**

(iii) the complaints performance report for May 2018;

(iv) the Freedom to Speak Up 2017-18 quarter 3 update and workplan – the QOC Non-Executive Director Chair voiced his support for the work of UHL's Freedom to Speak Up Guardian. In discussion, Ms V Bailey Non-Executive Director queried how appropriate support and supervision was provided to UHL's Freedom to Speak Up Guardian (as a single handed practitioner); **DSR**

(v) the Environment Agency Warning Notice action plan – this would be shared with the Environment Agency once finalised. Internally, progress against the action plan would be monitored through the UHL Radiation Protection Committee. In response to a query from the Medical Director, the Director of Safety and Risk advised that there was no requirement to have CCTV in the areas specified, and

(vi) the national breast screening incident action plan – the Medical Director particularly noted the good response on this from the UHL team.

Specific detailed discussion also took place on the revised never event action plan, particularly in the context of an increased number of such events. QOC queried whether the current iteration of the action plan was sufficient to deliver improvement. QOC agreed the need to communicate and embed key messages to all staff, to change behaviours, increase local accountability, and reiterate the "never" nature of never events. How best to drive this key issue had also been discussed at the June 2018 Executive Performance Board, potentially involving a 'positive confirmation' approach, although the QOC Non-Executive Director Chair noted the need to avoid a tick-box exercise. QOC further emphasised the need to learn from such events, and suggested exploring the use of short 'personal learning' [video] stories by staff on what had happened and what had been learned (although recognising that some staff might find this challenging) – these could potentially also be shown at staff induction. CMGs should then look at the lessons relevant to their areas and take action to avoid recurrence. It was vital to have a 'learning' rather than a 'blame' culture. **DSR** **DSR**

The Medical Director advised that effort must be taken to 'design out' as much scope for human error as possible, and introduce appropriately robust safety checks – he noted the scope to review UHL's own systems and processes against the recent NHSI letter re: never events in relation to NPSA alerts. He and the Director of Safety and Risk were currently reviewing UHL's responses to the last 3 years' NPSA alerts – the first draft of that work was scheduled for Executive Quality Board discussion in July/August 2018.

QOC asked that never events be a renewed focus in the Chief Executive's staff briefings, and also noted the benefits of learning good practice lessons from other Trusts in reducing never events. In further discussion on this issue, the Acting Chief Nurse also noted the need to review how staff were trained on never events, and she advocated not relying solely on e-learning for delivery of such training. **DSR**

Ms V Bailey Non-Executive Director also suggested that never events be included as a separate item on future QOC agendas (currently contained in the Director of Safety and Risk's report). The Medical Director confirmed that any never events were reported to the Trust Board both through the QOC summary and in the Chief Executive's monthly public report. **QOC CHAIR**

<u>Resolved</u> – that (A) in respect of never events, the Director of Safety and Risk be requested to:- **DSR**

(1) [via the Chief Executive's briefings] renew the focus on never events, reiterating their 'never' nature and embedding that message with staff;

(2) highlight the learning opportunities from never events, and explore the scope for staff involved in such events to develop 'personal learning' stories (eg as learning tools for

other staff);

(3) learn any appropriate lessons from other Trusts, re: learning cultures and reduction of never events;

(4) refresh the existing never event action plan in light of the actions above;

(B) consideration be given to 'never events' being a separate item on QOC agendas; **QOC CHAIR**

(C) each CMG's RCA tracker data be shared with that specific CMG at their performance review meetings, and **DSR**

(D) Ms V Bailey Non-Executive Director be briefed outside the meeting on how appropriate support and supervision was provided to UHL's Freedom to Speak Up Guardian (as a single handed practitioner). **DSR**

107/18 NURSING AND MIDWIFERY QUALITY AND SAFE STAFFING REPORT: APRIL 2018

In introducing the nursing and midwifery quality and safe staffing report for April 2018 (paper K), the Acting Chief Nurse briefed QOC on a change to the reporting of nursing vacancies to improve the quality and accuracy of that reporting. From this report and going forward, the vacancy data presented was therefore based on staff in post in month rather than also including applicants who had been successful at interview but who were waiting to start. Vacancies had increased (to 668.7 WTEs in April 2018), and the Acting Chief Nurse noted an intensive recruitment drive planned over the summer period. Queries raised by Ms V Bailey, Non-Executive Director, re: the establishment/vacancy figure would be discussed further outside the meeting. In discussion, and noting the level of activity in areas such as Surgical Assessment Units, Non-Executive Directors noted the need to identify wards which needed protected staffing during winter pressures, given that different patient cohorts might require different staffing skillsets. Mr B Patel Non-Executive Director also queried whether ward staff felt empowered to voice concerns about caring for different patient cohorts. In response, the Acting Chief Nurse suggested that Non-Executive Directors might wish to consider asking LRI ward 8 staff about their morale levels, on the next safety walkabout on that ward. **ACN/ VBNED** **NEDs**

Ms V Bailey Non-Executive Director, welcomed the report's terminology in identifying wards which 'required additional support and oversight by the Acting Chief Nurse and Corporate Nursing Team'. The report also confirmed that a data error in respect of LGH ward 20 would be corrected in the next iteration of the paper. The Acting Chief Nurse noted that LRI ward 31 would be deep-cleaned during the first week of July 2018.

<u>Resolved</u> – that (A) discussion take place outside the meeting re: queries on measuring against establishment rather than vacancies, and **ACN/ VBNED**

(B) Non-Executive Directors to consider asking LRI Ward 8 staff about their morale levels, on the next safety walkabout on that ward. **NEDs**

108/18 INSULIN SAFETY UPDATE AND DASHBOARD

Noting the CQC background to this issue, paper L updated QOC on the development of an insulin dashboard aiming to report monthly against five key performance indicators. In discussion, QOC queried the usefulness of this dashboard, and noted that further work was in hand to review its format and focus on harms. A further report on this issue was scheduled for the July 2018 EQB. The Medical Director commented that the dashboard needed to provide information on prevalence and incidence – the Acting Chief Nurse agreed with this point but also noted the need for the indicators to be measurable via NerveCentre.

<u>Resolved</u> – that the position be noted.

109/18 NEVER EVENT SUMMARIES

Further to Minute 82/18 of 24 May 2018, papers M and N summarised the learning from two separate never events, re: (i) inadvertent connection onto medical air as opposed to oxygen therapy (STEIS 2018/6082), and (ii) a retained throat swab (STEIS 2018/6098). Processes had changed as a result in both cases, and QOC welcomed the action taken to prevent recurrence and the format of the information presented, noting a need to consider how best to use the **MD**

helpful summaries at papers M and N. The Medical Director advised that no significant patient harm had occurred in either case.

Resolved – that consideration be given as to how best to use papers M and N. **MD**

110/18 CQC UPDATE

A Trust-wide action plan was in development, for discussion at the July 2018 EQB. The CQC update at paper O covered the focused CQC inspection of 29 May 2018 (draft report having now been received for factual accuracy checking), advised members that the section 29A warning notice for insulin safety had now expired, and provided QOC with a copy of the CQC's latest "Insight Report", for information.

Resolved – that the position be noted.

111/18 COMPLIANCE ASSESSMENT AND ANALYSIS SYSTEM (CAAS) – QUARTERLY UPDATE

As outlined in paper P, performance against these input-driven metrics showed a slight downwards trend from the last such report, although the Director of Estates and Facilities did not consider any of the issues raised to be of significant concern. The CAAS was a useful tool, and would assist UHL in evidencing its Premises Assurance Model position. The Director of Estates and Facilities also confirmed that since the time of writing the report, the annual Independent Authorising Engineer Reports for high and low voltage electricity, lifts and ventilation had now been received.

Resolved – that the position be noted.

112/18 QOC ANNUAL WORK PLAN 2018-19

Resolved – that paper Q be noted.

113/18 ITEMS FOR INFORMATION

113/18/1 New Interventional Procedures Authorising Group (NIPAG) Annual Report 2017-18

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

113/18/2 Claims and Inquests 2017-18 Quarter 4 Update and Annual Report

In response to a query, the Medical Director noted plans to include the GIRFT information (by CMG) in the pack for each individual CMG's performance review meeting.

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

114/18 MINUTES FOR INFORMATION

Resolved – that the following be received for information:-
(1) action notes and actions from the 1 May 2018 and 5 June 2018 Executive Quality Board respectively (papers T1 and T2), and
(2) action notes from the 22 May 2018 Executive Performance Board (paper U).

115/18 ANY OTHER BUSINESS

There were no items of any other business.

116/18 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 5 July 2018 Trust Board, and **QOC CHAIR**

(B) the following items be referred to the July 2018 Trust Board for approval:- **QOC**
(1) safeguarding children and adults annual report January 2017 – December 2017 (Minute 96/18 above), and **CHAIR**

(2) the 2017-18 fire safety annual report (Minute 97/18 above).

117/18 DATE OF NEXT MEETING AND MEETING DATES 2019

Resolved – that (A) the next meeting of the Quality and Outcomes Committee be held on Thursday 26 July 2018 from 1.15pm until 4.15pm in the Board Room, Victoria Building, Leicester Royal Infirmary, and

(B) 2019 QOC meeting dates be approved as per paper V:-

DATE	TIME	VENUE
Thursday 31 January 2019	1.15pm-4.15pm	Board Room, LRI
Thursday 28 February 2019	1.15pm-4.15pm	Board Room, LRI
Thursday 28 March 2019	1.15pm-4.15pm	Board Room, LRI
Thursday 25 April 2019	1.15pm-4.15pm	Board Room, LRI
Thursday 30 May 2019	1.15pm-4.15pm	Board Room, LRI
Thursday 27 June 2019	1.15pm-4.15pm	Board Room, LRI
Thursday 25 July 2019	1.15pm-4.15pm	Board Room, LRI
Thursday 29 August 2019	1.15pm-4.15pm	Board Room, LRI
Thursday 26 Sept 2019	1.15pm-4.15pm	Board Room, LRI
Thursday 24 October 2019	1.15pm-4.15pm	Board Room, LRI
Thursday 28 November 2019	1.15pm-4.15pm	Board Room, LRI
Thursday 20 December 2019	1.15pm-4.15pm	Board Room, LRI

The meeting closed at 4.30pm Helen Stokes - **Corporate and Committee Services Manager**

Cumulative Record of Members' Attendance (2018-19 to date):

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
J Adler	3	1	33	E Meldrum	3	3	100
V Bailey	3	3	100	*B Patel*	3	3	100
P Baker	3	1	33	*K Singh (Ex-officio)*	3	1	33
I Crowe (Chair)	3	3	100	*C West – LC CCG*	3	0	0
A Furlong	3	3	100				

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
M Caple	3	2	67	*S Hotson*	3	2	67
M Durbridge	3	3	100	*C Ribbins*	3	2	67