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: 25 April 2013

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Mr D Tracy

DATE OF COMMITTEE MEETING: 19 March 2013

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

- None

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

- None

DATE OF NEXT COMMITTEE MEETING: 16 April 2013

Mr D Tracy
8 April 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON TUESDAY 19 MARCH 2013 AT 9:30AM IN THE LARGE COMMITTEE ROOM, MAIN BUILDING, LEICESTER GENERAL HOSPITAL

Present:
Ms J Wilson – Non-Executive Director (Chair)
Mr J Adler – Chief Executive
Mr M Caple – Patient Adviser (non-voting member)
Dr K Harris – Medical Director
Mrs S Hinchliffe – Chief Nurse/Deputy Chief Executive
Dr R Palin – General Practitioner (non-voting member)
Mr D Tracy – Non-Executive Director
Professor D Wynford-Thomas – UHL Non-Executive Director and Dean of University of Leicester Medical School

In Attendance:
Dr B Collett – Assistant Medical Director
Miss M Durbridge – Director of Safety and Risk
Mr A Jones – Discharge Project Lead (for Minute 25/13/2)
Mrs H Majeed – Trust Administrator
Mr S Mitchell – Programme Director, Theatres (for Minute 25/13/1)
Mr A Powell – Head of Performance and Assurance, LLR FMC (from Minute 28/13/4 to 28/13/6)
Mr I Reid – Non-Executive Director
Mrs C Ribbins – Director of Nursing

RESOLVED ITEMS **ACTION**

23/13 APOLOGIES

Apologies for absence were received from Mrs S Hotson, Director of Clinical Quality, Mr P Panchal, Non-Executive Director, Ms C Trevithick, Chief Nurse and Quality Lead, West Leicestershire CCG, Mr M Wightman, Director of Communications and External Relations and Mr S Ward, Director of Corporate and Legal Affairs.

24/13 MINUTES

Resolved – that the Minutes of the meeting held 19 February 2013 (papers A and A1 refer) be confirmed as a correct record.

25/13 MATTERS ARISING REPORT

Resolved – that the matters arising report (paper B) be noted.

25/13/1 Theatres Transformation Programme

Mr S Mitchell, Theatres Programme Director attended to present paper C to brief the Committee on the proposed outline for a Theatre Transformation Programme and its current progress. He highlighted that in respect of internal resources/transformation support, it had been agreed to match the external support as part of an intentional move to build internal capability and transition to the internally led programme beyond the 6 months.

In discussion on this item members:

(i) noted that the outline business case for the theatre transformation programme would be developed by April/May 2013, further to this a 3-5 year business case would be progressed;
(ii) made particular note that over recent years a number of initiatives had been

developed to address the issues within theatres, however this had not been sustained and therefore there was a need to define achievable goals in the business case;

(iii) were advised that patient and public involvement would be encouraged and incorporated into the planned activities relating to the changes to service provision and configuration (i.e potential redesign);

(iv) queried whether this project which was a UHL led project needed to be linked with the Better Care Together workstream – this was agreed;

(v) suggested that consideration be given to the reporting arrangements of this programme; **CE/ Chairs , QAC/ F&P**

(vi) noted the need for quality and safety aspects to be included, and

(vii) suggested that liaison be made with IM&T (noting that many aspects were IT related (i.e electronic prescribing)).

Resolved – that (A) the contents of this report be received and noted, and

(B) the Chief Executive and the Committee Chairs of the Quality Assurance Committee and the Finance and Performance Committee to discuss and confirm the reporting arrangements of the theatre transformation programme. **CE/ Chairs, QAC/ F&P**

25/13/2 Update on Discharge Performance

Further to Minute 119/12/4 of 26 November 2012, Mr A Jones, Discharge Project Lead attended to present paper D, which detailed an update on discharge performance within the Trust and he particularly highlighted that there had been significant and progressive improvement in discharges before 1pm. Within the patient centred care element of the UHL Quality Strategy, discharge experience was a key work stream. One of the phases of the patient flow project was focused upon discharge, work on this phase had recently commenced and would enhance and support the embedding of best practice models and processes. He noted the need to ensure co-ordination between the Quality Strategy 'Next Steps' and 'Right Place, Right Time' project from a discharge perspective.

In discussion on this item, members advised that the key for the 'RAG' rating in Appendix 2 be included in future reports. In respect of discharges before 11am, the Chief Nurse/Deputy Chief Executive requested that issues relating to patients waiting in the 'discharge lounge' would need to be addressed. In response, it was noted that this was particularly in relation to TTO and Ambuline issues. **DPL**

The Director of Safety and Risk reported that complaints relating to discharge remained high and noted that Divisions were tasked to respond to such complaints, however she requested that it would be helpful if there was input from the discharge team.

The Chief Executive commented that the rate of improvement was relatively slow despite the best efforts of the team and suggested that appropriate linkage be made with the Right Place Consulting workstream. In response, the Discharge Project Lead advised that discussions on integrating ward rounds with the discharge process were being made.

The Committee Chair requested that next report in June 2013 included the key milestones for the project and the associated trajectory of performance. The Chief Nurse/Deputy Chief Executive requested that it would be helpful to have a summary sheet detailing each workstream of the discharge project including the deliverables. **DPL** **DPL**

Responding to a query, it was noted that confirmation of transformation funding to continue the competency based discharge training had not been received. However, the Director of Nursing advised that training would be taken forward as part of the Quality and Safety Commitment work.

Resolved – that (A) the contents of this report be received and noted, and **DPL**

(B) the Discharge Project Lead to present a report to the Quality Assurance Committee in June 2013 in respect of the discharge project including:-

- **the key milestones and associated trajectory of performance;**
- **a summary sheet detailing each workstream and the deliverables, and**
- **key for the 'RAG' rating in Appendix 2.**

26/13 GOVERNANCE

26/13/1 QAC Terms of Reference and Draft 2013-14 Annual Work Programme

Papers E and E1 outlined the draft terms of reference of the existing and new Quality Assurance Committee (QAC) respectively.

Paper E2 detailed the annual programme of work for the QAC. It was suggested that a working assumption be made that quarterly 'Updates on Francis Inquiry' would be provided to the QAC and Trust Board.

In response to a query on whether monthly update in respect of the Net Promoter Score should be provided to the QAC, it was noted that an update on this was included within the Quality and Performance reports to the Trust Board. An update on the Quality and Safety commitment was scheduled to be provided to the Trust Board in April 2013 and QAC in July 2013. Professor D Wynford-Thomas, Non-Executive Director suggested that the headings in the work plan be reviewed to ensure that items featured under appropriate headings. 'Monitoring ED performance with regards to quality, safety and performance aspects' to be included in the work plan with the first such update to be provided to QAC in April 2013. **CN/DCE** **CN/DCE**

In response to the Francis Inquiry, Mr M Caple, Patient Advisor highlighted that the following issues were raised by the Patient Advisors Group:-

(a) *proficiency in English of Doctors* – in response, the Medical Director advised that currently English Proficiency Tests were undertaken only for non-EU candidates, however it was anticipated that the legislation would change. There was a need to ensure that the Trust had a structured interview process to ensure that such tests were made, and

(b) *need for re-structure in relation to engaging with patients and public* – the Chief Nurse/Deputy Chief Executive advised that the Director of Nursing and the Director of Communications/External Relations were the leads for this workstream and a framework/overview would be provided to the QAC meeting in April 2013, further to which it would be shared with Divisions. **DN/ DCER**

The Medical Director noted the need for reviewing Trust-wide documentation to ensure that the reference to Governance and Risk Management Committee 'GRMC' was changed to 'QAC'. The Director of Corporate and Legal Affairs was tasked to provide verbal confirmation at the next QAC meeting that this has been actioned. **DCLA**

Resolved – that (A) the new terms of reference of the QAC meeting be approved;

(B) the annual work programme be updated to reflect the comments above; **CN/DCE**

(C) an update on monitoring ED performance with regards to quality, safety and performance aspects be provided to the QAC meeting in April 2013; **CN/DCE**

(D) the Director of Nursing/Director of Communications and External Relations to present an overview to the QAC meeting in April 2013 in respect of the Trust's **DN/**

engagement with patients and public, and **DCER**

(E) the Director of Corporate and Legal Affairs to provide confirmation at the QAC meeting in April 2013 that work was in progress to ensure that documentation referring to GRMC would be replaced with QAC. **DCLA**

27/13 SAFETY AND RISK

27/13/1 The Francis Inquiry: Key Themes

The Director of Safety and Risk gave a detailed presentation on the key themes arising from the Francis Inquiry (paper M refers). The presentation covered:- key issues, warning signs, increasing vigilance and monitoring, developing culture of honesty, SUIs, candour, inquests, effective complaints handling and learning from complaints.

In discussion on this item, the following points were made:-

- the first draft of the gap analysis for UHL relating to the Francis Report was scheduled to be discussed by the Executive Team on 19 March 2013. Further to this discussion, a decision would be made on whether a standalone workstream would need to be developed to address the recommendations from the Francis Inquiry (or) whether this would be embedded within other existing workstreams; **CN/DCE**
- need for rigour and clarity on how the changes would be made, and
- timescales to be agreed on when the next update would be provided to the QAC and Trust Board. **CN/DCE**

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

(B) the Chief Nurse/Deputy Chief Executive to confirm:- **CN/DCE**

- **whether a standalone workstream would need to be developed to address the recommendations from the Francis Inquiry (or) whether this would be embedded within other existing workstreams, and**
- **when an update would be provided to the QAC and Trust Board.**

27/13/2 Patient Safety Report

The Director of Safety and Risk presented the patient safety report (paper F refers). The following points were noted in particular:-

(a) key themes from the Francis Inquiry report which were provided separately as paper M;
(b) narrative of six randomly selected care complaints;
(c) an update on the 5 critical safety actions programme;
(d) SUIs reported within the Trust in February 2013, and
(e) CAS and RCA performance information and an update on the never events thematic review action plan.

The Director of Safety and Risk stressed the importance of giving consideration of how the Board could receive the narrative/stories of complaints as well as the numbers. She also noted the need for consideration to be given as to whether complaints should be signed off at Executive Director level noting that current UHL procedure requires Divisional heads to sign complaint responses on behalf of the Chief Executive. The Director of Nursing provided assurance that nursing care complaint responses were reviewed by the Chief Nurse/Deputy Chief Executive and Director of Nursing. Shared learning across Divisions was taken forward through the Nursing Executive.

In relation to the complaints outlined in appendix 1 of the report, concern was expressed whether the issues highlighted had been tackled at the bottom level. The Chief Nurse/Deputy Chief Executive advised that ward managers had jurisdiction of the wards

that they governed and were expected to ensure that issues were dealt with at source so that complaints were not made. Queries were also raised on whether corrective action had been undertaken in each one of the cases listed in the report. In response to this, it was suggested that 3 complaints be selected and the end to end complaints process be reviewed by the QAC in April 2013. **DSR**

Members were advised that a national review of the complaints process was being undertaken. However, the Chief Executive requested that an interim Trust-wide review of the complaints process be undertaken to cover the following :-

(a) appropriate level of responding to complaints;
(b) what the Trust does about following-up care if failings have happened, and
(c) decision tree approach (as used for incidents).

Proposals on the above to be submitted to the QAC in April 2013. **CN/DCE**

The Committee Chair noted that all actions arising from the thematic review of never events had been completed. However, she queried whether an on-going tracker of actions arising from never events/SUIs should be developed and agreed to discuss the options with the Director of Safety and Risk outside the meeting. **Chair/ DSR**

Resolved – that (A) the contents of this report be received and noted;

(B) the end to end complaints process of 3 randomly selected complaints be reviewed by the QAC in April 2013; **DSR**

(C) the Chief Nurse/Deputy Chief Executive (in liaison with the Chief Executive, Medical Director, Director of Nursing, Associate Medical Director, Director of Safety and Risk) to present proposals for an interim review of the complaints process, and **CN/DCE**

(D) the Committee Chair and Director of Safety and Risk to discuss options for developing an on-going tracker of actions arising from never events/SUIs. **Chair/ DSR**

27/13/3 Report by the Director of Safety and Risk

Resolved – that this item be classed as confidential and taken in private accordingly.

27/13/4 Report by the Director of Safety and Risk

Resolved – that this item be classed as confidential and taken in private accordingly.

27/13/5 CCG Visit Feedback

The Chief Nurse/Deputy Chief Executive advised that currently 14 wards were on a monitoring regime - 11 wards had been rated 'amber' due to staffing issues (vacancy and recruitment related), 2 wards were 'red' rated due to staffing issues and one ward had been 'red' due to poor metrics results. The CCG representatives had visited two of these wards at the Leicester Royal Infirmary on 5 March 2013 and had raised concerns about care quality at UHL. The staffing related issues would be resolved over the next 6 weeks as 92 HCAs, 20 staff nurses and 43 registered nurses had been recruited and the 11 'amber' rated wards would then be graded 'green'. The action plans for three 'red' rated wards would be monitored by the Executive Team. It was suggested that the monthly staffing report to the QAC included a narrative on the position of the 'red' rated wards. **DN**

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

(B) the monthly report on 'intended staffing level and skill mix' include a narrative on the position of the 'red' rated wards. **DN/TA**

27/13/6 Report by the Director of Nursing

Resolved – that this item be classed as confidential and taken in private accordingly.

27/13/7 Update on data reported in the NHS Safety Thermometer regarding 'harms'

Paper H provided an update on the NHS Safety Thermometer (ST) results for January and February 2013 and members made note of the following:-

a. the total number of harms increased in February 2013. The increase was solely attributed to a change in the way Catheter Acquired Urinary Tract Infection (CAUTI) were reported on the ST. The increase in the prevalence of CAUTIs had reduced the Trusts percentage of harm free care to 91.11%;
b. the prevalence of new pressure ulcers (i.e. hospital acquired) had reduced, and
c. slight increase in new VTEs and the prevalence of falls had remained the same.

In response to a query from Mr D Tracy, Non-Executive Director, it was noted that the SHA's ambition was to have zero avoidable pressure ulcers by 31 December 2012, this was then overlapped by a CQUIN which required 95% reduction by 31 March 2013. However, nationally the target was to achieve upto 50% reduction.

Resolved – that the contents of this report be received and noted.

27/13/8 Review of UHL Inpatient Falls

Further to Minute 110/12/2 of 22 October 2012, the Director of Nursing advised that work had continued to progress the inpatient falls reduction plans (paper I). 12 wards had seen a significant reduction in the number of falls from quarter 1 to quarter 3. A confirm and challenge process would be established for the 19 wards that had not seen a reduction replicating the approach that had been taken to reduce avoidable pressure ulcers. Reduction in patient falls was an integral part of the Quality Goal -Avoiding Harm. Section 3.4 of the report identified the highest number of falls by location. The ambition was to achieve a 50% reduction in falls across the organisation.

Members noted that the next update on 'falls' was scheduled to be presented to QAC in September 2013, therefore it was suggested that the report on 'NHS ST regarding harms' scheduled to be presented to the April 2013 meeting of the Committee included an update on the actions that had been put in place to achieve a reduction in falls. **DN**

Resolved – that (A) the contents of this report be received and noted, and

(B) the update on 'NHS ST Regarding Harms' scheduled to be presented to the April 2013 meeting include an update on the actions that had been put in place to achieve a reduction in falls. **DN**

27/13/9 Report re. intended staffing level and skill mix for each ward

Paper J provided an overview of the nursing position and covered:- nurse to bed ratio by ward, budgeted and actual nurse to bed ratio, current bed base, bank and agency usage, skill mix and summary of five wards which fell below 1.1 nurse to bed ratio for February 2013.

Resolved – that the contents of this report be received and noted.

27/13/10 Update on nursing rate in Emergency Department (ED)

Paper K provided an overview of the nursing workforce position within ED - current vacancies were 55.44 WTE which included the recent uplifted establishment to staff the assessment area within ED. Budgeted establishment was 199 WTE, this did not include nurses working as advanced autonomous practitioners within ED. 20 WTE had been recruited and waiting to commence employment (subject to appropriate checks). Dedicated working with the Human Resources team was in place to fast-track recruitment.

The Director of Nursing reported that ED had the largest off-duty in the Trust. Block agency contracts were in place, enhanced rate of overtime was offered to substantive staff to ensure that there were sufficient appropriately skilled nurses to fill the gaps on the rota.

The Medical Director highlighted that the report indicated that it was impossible to recruit to budgeted nurse to bed ratio - in response, the Director of Nursing advised that as there were recruitment difficulties, the figures indicated included an inflated establishment. Acuity reviews were usually undertaken annually, however, a significant change in acuity would instigate an additional review. Responding to a query on ED pressures and the support provided to staff, it was noted that regular meetings were held and wider-level support was also offered. The Chief Executive noted that ED had an extraordinary vacancy rate and noted the need for appropriate monitoring. He suggested that the monthly staffing report included an adjunct on ED staffing. **DN**

The Committee Chair noted that the staffing on the Cardiac Renal ward was also less than the budgeted establishment and requested that a brief update on the mitigating actions be included within the monthly staffing report. It was suggested that the staffing report used the 'RAG' ratings on the following basis:- **DN**

- 'Red' - staffing below budgeted position, and
- 'Amber' - staffing below the budgeted establishment, however if it was not considered an issue then a narrative be included to state the reasons for this.

The Committee Chair noted that she could not find an appropriate correlation between the 25% vacancy rate in ED and the 50% bank and agency usage - it was noted that some of this linked to sickness and maternity leave, however, the Director of Nursing agreed to double-check the figures with the ED Lead Nurse. **DN**

Resolved – that (A) the contents of this report be received and noted;

(B) the Director of Nursing to ensure that future monthly nurse staffing reports to the Committee included:- **DN**

- **an adjunct on ED nurse staffing;**
- **the RAG ratings described above;**
- **a brief update on the mitigating actions put in place to resolve issues in wards which had staffing less than the budgeted establishment (e.g. Cardiac Renal ward), and**

(C) The Director of Nursing to check the correlation between the vacancy rate and bank and agency usage in ED. **DN**

27/13/11 Electronic Prescribing and Medicines Administration (EPMA) Update

Paper L provided an update on the implementation of EPMA within UHL. Training Consultants, trainee doctors, locums and agency nurses was an on-going issue, however initiatives had been undertaken to ensure that this was taken forward appropriately. Responding to a query, the Associate Medical Director reported that there were issues that needed to be resolved with CSC (the supplier of the EPMA software)

noting that progress was slow. Issues relating to discharge letter connectivity between EPMA and ICE (Supplier – Sunquest) were also not progressing at an appropriate pace. It was suggested that the Acting Director of IM&T be requested to take forward discussions with CSC and Sunquest to resolve the issues and a verbal update be provided to the QAC in April 2013. **AMD**

Resolved – that (A) the contents of this report be received and noted, and

(B) the Associate Medical Director to request the Acting Director of IM&T to take forward discussions with CSC and Sunquest to resolve issues relating to discharge letter connectivity between both the systems (EPMA and ICE) and a verbal update be provided to the QAC meeting in April 2013. **AMD/TA**

28/13 QUALITY

28/13/1 Month 11 Quality Report

The Chief Nurse/Deputy Chief Executive provided an overview of patient safety and quality performance for February 2013. The following were highlighted in particular:-

- there were no MRSA cases. 4 cases of C Difficile were reported;
- presentation on the Quality Mark scheme for selected UHL wards to be presented to the April 2013 Trust Board meeting;
- National Staff Survey 2012 – the Committee Chair noted the need to explore the scope for increasing the Trust's score in response to question KF12 surrounding the availability of hand washing materials. **CN/DCE**

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

(B) the Chief Nurse/Deputy Chief Executive to explore the scope for increasing the Trust's score in response to question KF12 surrounding the availability of hand washing materials of the 2012 national staff survey and provide an update to the QAC in April 2013. **CN/DCE/ TA**

28/13/2 Application to vary a condition of registration (Termination of Pregnancy Services)

Resolved – that the contents of paper N – appendix A be approved and signed-off, as appropriate. **DCQ**

28/13/3 Update on SHMI

The Medical Director brought members' attention to the graph on page 2 of paper O, the latest SHMI covered the period July 2011 to June 2012 and UHL's SHMI was 105 which was above the national but 'within expected' control limits. Whilst the Trust's SHMI remained at 105 for the last 3 'rolling 12 month figure', there had been a small incremental improvement with each published SHMI.

In addition to including 'deaths within 30 days of discharge', the SHMI also differed from the Hospital Standardised Mortality Ratio (HSMR) in that the 'all diagnosis groups' were included and the SHMI risk-adjustment model did not adjust for 'palliative care'. It was noted that a Board Development session on SHMI was to be scheduled.

Resolved – that the contents of this report be received and noted.

28/13/4 Performance Monitoring and Escalation process for LLR FM Services

Mr A Powell, Head of Performance and Quality Assurance, LLR FMC attended to present paper P, an update on the LLR FMC performance monitoring and reporting process of FM services to the UHL Trust Board. The report confirmed that the contract

was underpinned by key performance indicators that would be audited and monitored and any failures would incur a financial penalty and the issuing of warning notices to Interserve FM Ltd. who had been appointed as the Trust's FM Private Sector Provider (PSP).

In response to a query raised by the Director of Safety and Risk, it was noted that Interserve would be responsible for receiving and addressing any complaints (relating to facilities management) and the FMC would monitor this. The Chief Executive agreed to discuss this matter with the Acting Director of Facilities to ensure that it was appropriately taken forward. **CE**

Resolved – that (A) the contents of this report be received and noted, and

(B) the Chief Executive to liaise with the Acting Director of Facilities to consider and agree the formal process for monitoring of facilities management related complaints. **CE**

28/13/5 Management of Food Safety within the LLR FM Shared Services Contract

The Head of Performance and Quality Assurance confirmed that the control measures and management systems that were included and specified within the LLR FM contract with regard to food safety (paper Q refers).

It was noted that Interserve had comprehensive arrangements in place to assure the safety of foods supplied through the contract. These arrangements included bespoke food safety management systems developed for the successful delivery of food safety within the contract.

Responding to a query from Dr R Palin, GP in relation to the provision of catering services in ED, it was noted that interface between facilities and nursing was essential to ensure that this service was appropriately fulfilled.

Resolved – that the contents of this report be received and noted.

28/13/6 Patient-Led Assessment of the Care Environment (PLACE)

Under the new outsourced arrangements for the provision of Estates and FM Services, it was noted that LLR FMC would be responsible for the management of the PLACE assessment process (which replaced the PEAT inspections) with effect from 1 April 2013. The details of the key changes to the process and the dates of the assessments were provided in paper R. The September 2013 Trust Board would receive a report detailing outcomes and action plans to address any issues raised. **HPQA**

Resolved – that (A) the contents of this report be received and noted, and

(B) the results of PLACE and action plans to address any issues be provided to the Trust Board in September 2013. **HPQA**

29/13 MINUTES FOR INFORMATION

29/13/1 Finance and Performance Committee

Resolved – that the public Minutes of the Finance and Performance Committee meeting held on 27 February 2013 (paper S refers) be received and noted.

30/13 ANY OTHER BUSINESS

30/13/1 Report by the Director of Safety and Risk

Resolved – that this item be classed as confidential and taken in private accordingly.

30/13/2 Red Trays

Responding to a query, the Chief Nurse/Deputy Chief Executive agreed to check position with the 'red trays' for patients at risk of mal-nutrition or requiring assistance with eating or drinking and provide an update to QAC members, via email. **CN/DCE**

Resolved – that the Chief Nurse/Deputy Chief Executive to undertake the above action. **CN/DCE**

30/13/3 Co-Location of IVF and Pregnancy Termination Clinics

Mr I Reid, Non-Executive Director reported that following an executive walkabout to the Gynaecology department, he had raised concerns with the senior management team that it was not appropriate for the IVF and Pregnancy Termination clinics to be co-located. However, he had received a response indicating that it would be difficult to change the location of the clinics. Members noted that it was only a re-organising issue and it was suggested that the Interim Director of Operations be contacted to take this forward and he provide an update on position, via email to QAC members. **IDO**

Resolved – that the Interim Director of Operations to undertake the above action. **IDO**

31/13 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that there were no items to be brought to the attention of the Trust Board.

32/13 DATE OF NEXT MEETING

Resolved – that the that the next meeting be held on Tuesday, 16 April 2013 at 9:30am in the Large Committee Room, Main Building, Leicester General Hospital.

The meeting closed at 12.50pm.

Cumulative Record of Members' Attendance (2012-13 to date):

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
D Tracy (Chair until Feb 2013))	*11*	*10*	*91%*	*M Lowe Lauri*	*3*	*2*	*67%*
J Adler	*3*	*3*	*100%*	*P Panchal*	*11*	*7*	*64%*
J Birrell	*5*	*0*	*0%*	*C Trevithick**	*11*	*6*	*56%*
D Briggs/R Palin**	*11*	*5*	*45%*	*S Ward*	*11*	*5*	*45%*
*M Caple**	*11*	*6*	*56%*	*M Wightman*	*11*	*4*	*36%*
K Harris	*11*	*8*	*78%*	*J Wilson (Chair from Mar 2013)*	*11*	*9*	*82%*
S Hinchliffe	*11*	*9*	*89%*	*D Wynford-Thomas*	*11*	*6*	*56%*

** non-voting members*

Hina Majeed, **Trust Administrator**