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 July 2013

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 18 June 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:

- **Nursing Workforce (Minute 57/13/2 refers);**
- **Backlog of Clinic Letters (discussion under the Patient Safety report) (Minute 57/13/3 refers);**
- **Electronic Prescribing and Medicines Administration Update (Minute 57/13/8 refers), and**
- **Privacy & Information and Risk Management (Minute 59/13/5 refers).**

DATE OF NEXT COMMITTEE MEETING: 23 July 2013

Ms J Wilson
19 July 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON TUESDAY 18 JUNE 2013 AT 9:30AM IN THE LARGE COMMITTEE ROOM, MAIN BUILDING, LEICESTER GENERAL HOSPITAL

Present:
Ms J Wilson – Non-Executive Director (Chair)
Mr M Caple – Patient Adviser (non-voting member)
Ms E Meldrum – Assistant Director of Nursing (on behalf of Ms C Ribbins, Acting Chief Nurse)
Dr R Palin – General Practitioner (non-voting member)
Mr P Panchal – 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, Clinical Effectiveness
Miss M Durbridge – Director of Safety and Risk
Ms M Gordon – Patient Adviser (shadowing Mr M Caple, Patient Adviser)
Mr A Jones – Discharge Project Lead (for Minute 55/13/2)
Ms Z Jones – Representative from Trust Development Authority (observing)
Mrs H Majeed – Trust Administrator
Ms S Mason – Divisional Head of Nursing, Acute Care (for Minute 55/13/4)
Mr J Mclean – Clinical Skills Unit Manager (for Minute 55/13/3)
Dr P Rabey – Divisional Director, Acute Care (for Minute 55/13/4)
Mr I Reid – Non-Executive Director
Mr I Scudamore – Divisional Director, Women's and Children's (for Minute 55/13/1)
Mr C Walker – Clinical Audit Manager (for Minute 55/13/4)
Ms K Wilkins – Divisional Head of Nursing, Women's and Children's (for Minute 55/13/1)

RESOLVED ITEMS **ACTION**

53/13 APOLOGIES

Apologies for absence were received from Mr J Adler, Chief Executive, Dr K Harris, Medical Director, Mrs S Hotson, Director of Clinical Quality, Ms C O'Brien, Chief Nurse and Quality Officer East Leicestershire and Rutland CCG and Ms C Ribbins, Acting Chief Nurse.

54/13 MINUTES

Resolved – that the Minutes of the meeting held on 21 May 2013 (papers A & A1 refer) be confirmed as a correct record.

55/13 MATTERS ARISING REPORT

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

55/13/1 Women's and Children's Divisional Update on Complaints Performance and progress in achieving 10% reduction in formal complaints in 2012-13

The Divisional Director and Head of Nursing, Women's and Children's attended the meeting to present paper C. The Women's CBU had seen an increase in the number of complaints received in 2012-13, however, the figures for the Children's CBU remained static. The top five complaint themes were: Medical Care, Nursing Care, Communication, Staff Attitude and Waiting Times. It was also noted that the increase in activity in the Women's CBU did not account for the increase in complaints. It was suggested that the ratio of activity should be used as a measuring tool for complaints. The Women's CBU would be presenting the complaints action plan to the Divisonal Board in July 2013. The Committee Chair requested that the Division appropriately **DD, W&C**

scrutinised this and also reviewed the complaints rate by Speciality in order to get assurance.

Responding to a query from the Patient Adviser, it was noted that a discussion was usually held with the complainant prior to categorising a complaint as a 'concern' or a 'formal complaint'. Members were also advised that the 'reopened complaints' within the Division were of a smaller proportion.

Dr R Palin, GP queried whether the changes in the Deanery allocation of training grade doctors had led to the increase in medical care complaints – in response, the Divisional Director advised that this had not been the case. In response to a further query, it was noted that work was in progress to employ Staff grade and Trust Doctors in the Division.

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

(B) the Women's and Children's Divisional Board to ensure that the following were reviewed:- **DD,W&C**

- **action plans following the increase in complaints in the Women's CBU, and**
- **complaints rate by Specialty.**

55/13/2 Update on Discharge Performance

Mr A Jones, Discharge Project Lead presented paper D, an update on discharge performance within the Trust. Despite increasing numbers of admissions, more discharges were taking place earlier in the day.

There were currently two major projects (Emergency Care Pathway programme and the UHL Quality and Safety Strategy) within the Trust which contained discharge related work streams. In order to prevent duplication, facilitate integration and ensure continual improvement, the UHL Discharge Project plan had been reviewed and revised (Appendix 3 of the report refers). The revised plan identified seven time limited and outcome focused work streams which linked directly with other projects but also built upon existing work and continued to focus upon the embedding of good practice.

Responding to a query from Mr P Panchal, Non-Executive Director, members were advised that there had been a continued improvement in the percentage of TTOs submitted prior to the day of discharge and this was most notable within the Acute Care Division and the Medicine CBU in particular. However this improvement had not had as big an impact upon discharge before 11am and 1pm as expected. The Associate Medical Director highlighted that progress was being made in resolving issues in relation to the Electronic Prescribing and Medicines Administration (EPMA) system. A meeting had been scheduled on 21 June 2013 to discuss the user rights on EPMA for Pharmacists who were not Prescribing Pharmacists.

It was noted that a new Discharge Project Manager had been appointed who would be reporting to the Chief Operating Officer. An update on the follow-up of each of the discharge related workstreams would be provided to the QAC in September 2013. **DPL**

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

(B) an update on discharge related work streams be provided to the QAC in September 2013. **DPL**

55/13/3 Statutory and Mandatory Training Compliance Report

Mr J Mclean, Clinical Skills Unit Manager attended the meeting to present paper E, a position statement on statutory and mandatory training compliance for 2012-13 and an update on the detailed project plan to significantly increase compliance by end of March

2014.

In discussion on this report, Professor D Wynford-Thomas noted the benefits of e-learning but queried whether a bespoke OCB solution needed to be purchased given the costs (£56,000) and whether off-the-shelf modules of each of the training sessions would not be more appropriate. In response, it was noted that OCB medial would initiate plug in systems and by working in partnership with UHL – training modules could be developed so that the content could meet industry recognised standards. This solution would enable UHL to import/develop and edit content, record accurately all active participants and provide the add-in solutions required for reporting and exemption rules associated with all aspects of statutory and mandatory training. It was noted that some of the off-the-shelf modules were not always fit for purpose.

Dr R Palin, GP queried whether a trajectory was in place to improve resuscitation training compliance – in response, it was noted that the aim was to achieve 100% compliance by March 2014. Detailed proposals to improve resuscitation training compliance would be provided to the QAC in July 2013. It was also suggested that statutory and mandatory training compliance (particularly doctors training) be monitored by the Executive Team on a fortnightly basis. **CSUM** **DHR**

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

(B) the Clinical Skills Unit Manager be requested to provide detailed proposals to improve resuscitation compliance at the QAC meeting in July 2013, and **CSUM/ TA**

(C) statutory and mandatory training compliance (particularly doctors training) be monitored by the Executive Team on a fortnightly basis. **DHR**

55/13/4 <u>Clinical Audit Quarterly Report and Acute Care – Clinical Audit Presentation</u>

The Acute Care Divisional Director and Manager attended to present paper F1, an update on the Divisional clinical audit structure, dashboard, mandatory audits, successes and challenges. The Clinical Audit Manager presented paper F, the clinical audit 2012-13 quarter 4 report and dashboard.

Mr I Reid, Non-Executive Director noted that the results of the clinical audits were variable in terms of compliance with standards monitored and more than half of the first audits required action/improvement for the results to be within a 'best practice' range. He queried whether something could be done upfront (i.e. before the audit commenced) in terms of rigour, education and expectation standards. In response, the Clinical Audit Manager advised that this was reflective of the case mix of the audits and some of the audits were undertaken for assurance rather than quality.

Professor D Wynford-Thomas, Non-Executive Director queried the processes in place to approve the non-mandated audits that should be undertaken within the Trust – in response, it was noted that the Clinical Audit Leads usually liaised with the Clinical Audit team to ensure that the audit plan was reviewed and approved, as appropriate.

Dr R Palin, GP suggested that specialties which did not have any audits registered or completed within a particular quarter should be RAG rated 'red' on the dashboard – in response, the Clinical Audit Manager highlighted that this was not done as some of the smaller Specialities did not have audits due for completion each quarter or audits to register. Further to discussion, he agreed to rate these as 'red' and include a comment/narrative. **CAM**

<u>Resolved</u> – that (A) the contents of papers F & F1 be received and noted, and

(B) the Clinical Audit Manager to undertake the action outlined above. **CAM**

56/13 PATIENT EXPERIENCE

56/13/1 National Patient Survey

Paper G detailed the Trust's performance in the 2012 National Inpatient Survey. The results indicated that the Trust had performed about the same as other Trusts in all except two questions and the survey reported that UHL had not made significant improvements nor was there a decline in patient satisfaction levels in 2012.

The National Survey was undertaken two months after discharge and local survey was completed at discharge. Although the themes arising from both the surveys were the same, there seemed to be a higher satisfaction score from local patient survey.

The Clinical Audit Manager sought the Committee's support for a change in process of how the RAG rating of local patients' feedback was completed to help ensure that the Trust's local results drove improvement in the Trust's national patient survey scores.The new system would use bespoke targets for each Division and CBU. These targets would be based around performance in each area over the last 12 months so 'green' flags would be allocated only if an improvement in patient satisfaction was seen – irrespective of how high or low patient satisfaction levels were in that area. Likewise a 'red' flag would indicate a significant decrease in satisfaction. In discussion on the RAG rating, it was suggested that consideration be given to using the methodology (i.e. setting thresholds for RAG ratings and arrows for trends) used in the Trust's quality and performance report. It was also suggested that appropriate narrative/commentary be included within the reports. **CAM**

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

(B) the Clinical Audit Manager to consider using the methodology used in the quality and performance report for RAG rating of local patient surveys. **CAM**

57/13 SAFETY

57/13/1 Update on data reported in the NHS Safety Thermometer regarding 'harms' and Hospital Acquired Pressure Ulcers

The Assistant Director of Nursing presented paper H, an update on the NHS Safety Thermometer prevalence results for April and May 2013. She confirmed that the DoH had confirmed that the ST definition of a CAUTI currently being used by UHL was the correct definition (section 3.1 (a) of paper H refers). In line with national CQUIN guidance, UHL was no longer recording the prevalence of VTEs, as VTE incidence was already recorded within the Trust.

Paper I provided a quarterly update on the Trust's position with the elimination of avoidable hospital acquired pressure ulcers. The incidence data for grade 2, 3 and 4 avoidable pressure ulcers had shown no improvement. The following main causative factors had been identified:-

(a) additional bed capacity with reliance upon bank/agency nurses who were less familiar with UHL's documentation and ward processes;
(b) sub optimal staffing levels in areas where additional 'repositioning of patients' was required;
(c) emergency flow and increase in trolley waits both in the ED and CDU;
(d) incomplete nursing assessment and care planning documentation, and
(e) increased requests for pressure relieving mattresses and therapy products that were not fulfilled in a timely way.

A specific performance improvement framework for pressure ulcers had been developed for those areas where there were no mitigating factors that might explain why patients were developing avoidable pressure ulcers. A new UHL 2013-14 action

plan for the elimination of avoidable pressure ulcers had also been developed (appendix 1 refers). The plan would ensure that Divisions focused on the key challenges that were preventing UHL in eliminating avoidable pressure ulcers.

Responding to a query, the Assistant Director of Nursing outlined the situations (listed on page 7 of paper H) in which the performance improvement framework for pressure ulcers would be instigated. The Committee Chair queried the difference between the action plan developed before and the current action plan – in response, it was noted that the current action plan helped to track down the wards/individuals where there were no mitigating circumstances for the repeated incidence of avoidable pressure ulcers.

Resolved – that the contents of papers H & I be received and noted.

57/13/2 UHL Nursing Healthcheck and Nursing Workforce Report

Paper J provided the April 2013 status of individual ward positions relating to key monthly indicators and highlighted those wards where the indicators required a greater focus. The following issues were highlighted in particular:-

- the avoidable harm free rate was less than 90% in six ward areas;
- five clinical areas were noted to have lower metrics results, and
- weekly ward visits by the Corporate Nursing team were undertaken for lower performing wards.

Paper K provided an overview of the nursing workforce position for UHL – an A3 version of this report would be made available for future meetings. Ward 19 at the Leicester General Hospital was rated 'red' due to concerns regarding staffing levels. In discussion on this report, members suggested the following changes be incorporated into future iterations:-

(a) the wards on special support be listed;
(b) a tracker/trend for these wards be made explicit, and
(c) vacancy rates be included in the tracker.

The Director of Safety and Risk expressed concern that the details provided in paper K did not correlate with the complaints and SUI figures. In discussion, it was suggested that the Nursing and Complaints Team to consider this and devise a method of triangulation outside the meeting. **DSR/ ACN/ ADN**

The Committee Chair requested that future reports on Emergency Department staffing (appendix 3 refers) be more action focused and included details of recruitment plans rather than an update on the nursing workforce position. The Assistant Director of Nursing agreed to feedback the Committee's comments to the ED team.

Resolved – that (A) the contents of papers J & K be received and noted;

(B) the Assistant Director of Nursing to ensure that future reports on the nursing workforce position included the suggestions provided in points (a) to (c) above; **ADN**

(C) the Nursing and Complaints Team to discuss and devise a method of triangulation between nurse to bed ratio/vacancy rates, complaints and SUIs, and **DSR/ ACN/ ADN**

(D) future ED staffing reports to be more action focused and include details of recruitment plans. **ADN**

57/13/3 Patient Safety Report

The Director of Safety and Risk presented the patient safety report (paper L refers). The report provided details on May 2013 SUIs and RCAs, CAS performance for April 2013 and safety walkabout feedback. The following points were noted in particular:-

- cluster of incidents within the Emergency Department – these incidents indicated that senior clinical review, misdiagnosis, overcrowding/poor flow and lack of middle grade doctors were the key features;
- backlog of clinic letters – particularly in Ophthalmology, ENT and Breast Care. The risk score had increased to 20. It was suggested that an action plan from the Planned Care Division needed to be presented to QAC in July 2013; **PCD**
- 8 SUIs were reported in May 2013 – which included 5 patient safety incidents (one of these was a never event) and 3 hospital acquired pressure ulcers, and

In response to a query from Mr P Panchal, Non-Executive Director at the May 2013 QAC meeting, the Director of Safety and Risk had sought assurance about the information recorded on HISS (e.g. formal complaints by patient ethnicity) at the first Data Quality Forum (DQF) scheduled to be held on 21 May 2013 and reported that the DQF had confirmed that 99% of forms audited had included the full HISS mandatory data (i.e. information was captured as a matter of routine unless a patient refused to provide this information).

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

(B) the Planned Care Division to present the action plan to resolve the issue relating to backlog of clinic letters at the QAC meeting in July 2013. **PCD/TA**

57/13/4 Review of Complaints Handling

The Director of Safety and Risk reported that an external review of complaints processes had been previously proposed. However, further to discussion with the Medical Director, Director of Corporate and Legal Affairs and other colleagues, it had been decided to defer the external review of complaints handling at UHL, given the imminence of the Government's own review. The first such report was expected to be published by 18 July 2013. However, in the meantime, the Director of Safety and Risk highlighted that the following would be undertaken:-

(a) continued engagement with stakeholders – Patient Advisers, Health Watch, Patients Association, prospective Governors' forum and other organisations suggested by Mr P Panchal, Non-Executive Director;
(b) review the sign-off process of complaints noting that some complaints required sign-off by an Executive Director;
(c) review the categorisation of complaints, and
(d) establish an interim Patient Advice and Liaison Service (PALS)/front-door function.

The Committee Chair requested that an end to end process of 2-3 complaints be presented to QAC on a monthly basis. **DSR**

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

(B) an end to end process of 2-3 complaints be presented to QAC on a monthly basis starting from July 2013. **DSR**

57/13/5 Report by the Director of Safety and Risk

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

57/13/6 Report by the Assistant Director of Nursing

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

57/13/7 Critical Safety Actions – Clinical Handover

The Associate Medical Director presented paper N, an update on clinical handover and highlighted the following:-

(i) all wards were using the formalised electronic nursing handover system with the exception of Maternity Services, and
(ii) clinical handover for medical staff was not uniform:-
- Surgical CBU had trialled the Nerve Centre handover pilot jointly developed by UHL and Nerve Centre. An audit had been completed and results were awaited. A detailed report on the results of the Surgical Handover would be presented to the QPMG; **AMD**
- Paediatrics CBU was using the UHL updated electronic system, and
- Medicine CBU had piloted and agreed a handover proforma.

A business case was being prepared for the purchase of the Nerve Centre system. Dr R Palin, GP noted the need for lessons to be learned from previous such roll-outs particularly in terms of the licensing and hardware aspects. The Associate Medical Director agreed to take this into consideration and provide an update/roll-out plan to the QAC in December 2013. **AMD**

The Committee Chair requested an update on 'Critical Safety Action – Acting on Results' also be provided to a future meeting of the QAC. **AMD**

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

(B) the Associate Medical Director to provide:- **AMD**
- **a detailed report on the results of the Surgical Handover to a future meeting of the QPMG;**
- **an update/roll-out plan for the Nerve Centre handover project to the QAC in December 2013, and**
- **an update on 'Critical Safety Action – Acting on Results' to a future meeting of the QAC.**

57/13/8 Electronic Prescribing and Medicines Administration Update

Further to Minute 44/13/2 of 21 May 2013, the Associate Medical Director reported that since the EPMA system deadlocking issues arose, concerns about the Trust's IM&T systems connectivity had been expressed. It was noted that two patches had reduced the deadlocking issues. A further meeting with CSC was scheduled to take place 20 June 2013 to make a decision on whether the EPMA system would be continued on the Acute Medical Unit. Additional support was being sought from CSC in respect of quicker ways of using the system. In response to a query from Ms M Gordon, Patient Adviser – it was suggested that a discussion with the Associate Medical Director outside the meeting would be more appropriate. Mr P Panchal, Non-Executive Director suggested that lessons learned from this issue should be considered. An on-going monthly report on EPMA was requested to be provided to the QAC. **AMD**

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

(B) monthly updates on EPMA be provided to the QAC until further notice. **AMD**

57/13/9 Statutory Guidance to Safeguard Children

Paper O brought members' attention to the new statutory guidance 'Working Together to Safeguard Children 2013' and the implications for safeguarding services within the Trust and the multi-agency partnerships across LLR. The revised documentation had removed the existing statutory timescales for completing safeguarding assessments for Social Care. This was replaced with a single timescale to ensure that once a safeguarding referral was received by Social Care, they had only one day in which to

make an immediate assessment and report back to the referrer with their decision. The Trust was not compliant with this timescale and had written to Chairs of both the Safeguarding Boards to inform them of the Trust's position.

The Committee Chair queried the implications if the Trust was not compliant and also the timescales for when the Trust would be compliant. The Assistant Director of Nursing undertook to raise these queries with the Head of Safeguarding and provide an update to the QAC in July 2013. **ADN**

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

(B) the Assistant Director of Nursing to seek responses for the queries raised above with the Head of Safeguarding and provide an update to the QAC in July 2013. **ADN/TA**

57/13/10 Use of Copper as a Biocide in Water Treatment Systems – UHL Position

The Assistant Director of Nursing reported that the European Union had banned the use of copper in water control/disinfection systems. The LRI was the only UHL site with a copper/silver ionisation system. In response to a query, the Assistant Director of Nursing agreed to liaise with the Infection Prevention Team to check whether UHL was compliant with the new guidance and circulate an email to members of the Committee. If the Trust was not compliant, then an update on plans in place was requested to be provided. **ADN**

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

(B) the Assistant Director of Nursing to email QAC members to confirm whether the Trust was compliant in respect of the European Union's guidance in banning the use of copper in water control/disinfection systems. **ADN**

58/13 QUALITY

58/13/1 Month 2 – Quality and Performance Update

Resolved – that future meetings of the QAC be moved to a week later in order that the Quality and Performance report was available for review.

58/13/2 C Difficile Trajectory

Responding to a query from Mr I Reid, Non-Executive Director, the Assistant Director of Nursing advised that the year-on-year increase in C Difficile figures particularly at the LRI site might relate to the changes in the bed configuration and the move of Specialties from the LGH to the LRI. The Committee Chair requested that an update on C Difficile summarising the work of the Infection Prevention Team with the Divisions be provided in the July 2013 Quality and Performance report. **ADN**

Resolved – that an update on 'C Difficile' summarising the work of the Infection Prevention Team with the Divisions be provided in the July 2013 Quality and Performance report. **ADN**

58/13/3 Formal Response to Commissioner Visits

Paper P briefed members on the response to CCGs following quality visits. Dr R Palin, GP suggested that an update on the deanery visit feedback to the Emergency Department be provided to the QAC. AMD, CE

Resolved – that the Associate Medical Director, Clinical Education be requested to attend the QAC meeting in August/September 2013 to provide an update on the **AMD, CE**

deanery visit feedback to the Emergency Department.

58/13/4 CQC Self Assessment

Paper Q detailed the results of the quarter 1 self assessment against the CQC essential standards of quality and safety. In discussion on this paper, members noted that many of the actions had an imminent completion date and highlighted that a step-change in compliance would therefore be expected in quarter 2. The following inclusions were suggested for the quarter 2 self assessment report, which the Associate Medical Director agreed to feedback to the Director of Clinical Quality:- **AMD/ DCQ**

(a) an update on actions/ action tracker, and
(b) position against assessment as a result of the actions.

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

(B) the results of the quarter 2 self assessment report to include an update on actions agreed at the end of April 2013 and position against assessment as a result of the actions. **AMD/ DCQ**

58/13/5 Draft Quality Account and Draft Statement of Directors' Responsibilities

Paper R provided an update to the QAC on the development of the Quality Account ahead of formal adoption by the Trust Board. The Patient Adviser requested that future versions of the draft Quality Account be available at an earlier stage in order that any comments from Patient Advisers could be incorporated in a timely manner. Mr M Caple also queried whether Patient Advisers would be provided the opportunity to provide a statement under the 'Statement from Stakeholders and External Auditors' section of the Quality Account. The Committee Chair undertook to clarify this. **DCQ** **Chair**

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

(B) future versions of the Quality Account to be made available at an early stage to Patient Advisers for comments, and **DCQ**

(C) the Committee Chair to clarify whether Patient Advisers would be given an opportunity to provide a statement under the 'Statement from Stakeholders and External Auditors' section of the Quality Account. **Chair**

59/13 ITEMS FOR INFORMATION

59/13/1 Infection Prevention Annual report

Resolved – that paper S be received and noted.

59/13/2 UHL Annual Safeguarding Report

Resolved – that paper T be received and noted.

59/13/3 Accreditation Visits Update

Resolved – that paper U be received and noted.

59/13/4 Annual Health and Safety and Manual Handling Report

Resolved – that paper V be received and noted.

59/13/5 Privacy & Information and Risk Management – Annual Report

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

(B) the need for secure protocols that patient records were safe be raised at the Trust Board. **Chair**

59/13/6 Privacy and Information Risk Update

Resolved – that (A) paper X be received and noted, and

(B) the Privacy Team to ensure method for capturing patient and staff feedback regarding privacy risks and concerns and update the Director of Safety and Risk on key themes. **HoP**

60/13 MINUTES FOR INFORMATION

60/13/1 Finance and Performance Committee

Resolved – that the public Minutes of the Finance and Performance Committee meeting held on 29 May 2013 (paper Y refers) be received and noted.

61/13 ANY OTHER BUSINESS

61/13/1 Mr I Reid, Non-Executive Director

The Committee Chair noted thanks to Mr I Reid, Non-Executive Director for his support to the QAC.

Resolved – that the verbal update be noted.

62/13 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following items be brought to the attention of the Trust Board on 30 May 2013:-

- **Nursing Workforce (Minute 57/13/2 refers);**
- **Backlog of Clinic Letters (discussion under the Patient Safety report) (Minute 57/13/3 refers);**
- **Electronic Prescribing and Medicines Administration Update (Minute 57/13/8 refers), and**
- **Privacy & Information and Risk Management (Minute 59/13/5 refers).**

63/13 DATE OF NEXT MEETING

Resolved – that the that the next meeting be held on Tuesday, 23 July 2013 at 9:30am in the Large Committee Room, Main Building, Leicester General Hospital.

The meeting closed at 12.28pm.

Cumulative Record of Members' Attendance (2013-14 to date):

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	*3*	*1*	*33*	*R Palin**	*3*	*3*	*100*
*M Caple**	*3*	*3*	*100*	*P Panchal*	*3*	*3*	*100*
S Dauncey	*1*	*1*	*100*	*C Ribbins*	*2*	*1*	*50*
K Harris	*3*	*1*	*33*	*J Wilson*	*3*	*3*	*100*
S Hinchliffe	*1*	*1*	*100*	*D Wynford-Thomas*	*3*	*3*	*100*
*C O'Brien – East Leicestershire/Rutland CCG**	*3*	*2*	*66*				

** non-voting members*

Hina Majeed, **Trust Administrator**