University Hospitals of Leicester NHS
NHS Trust

**Trust Board paper BB**

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

**REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD**

**DATE OF TRUST BOARD MEETING: 26 June 2014**

**COMMITTEE: Quality Assurance Committee**

**CHAIRMAN: Ms J Wilson, Non-Executive Director**

**DATE OF COMMITTEE MEETING: 28 May 2014**

**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:**

- **RTT report – a section within this report to include an update on the safety implications and clinical quality risk assessments (Minute 32/14 (a));**
- **to propose at the Trust Board that the Trust's Quality Commitment was highlighted in any communication relating to the LLR Mortality Review, (Minute 33/14/1);**
- **discussion around administrative processes around partial booking (Minute 34/14/6), and**
- **triangulation of patient feedback (Minute 35/14/1).**

**DATE OF NEXT COMMITTEE MEETING: 25 June 2014**

**Ms J Wilson – Non-Executive Director and QAC Chair**
**20 June 2014**

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

**MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON WEDNESDAY 28 MAY 2014 AT 12:30PM IN THE LARGE COMMITTEE ROOM, LEICESTER GENERAL HOSPITAL**

**Present:**
Ms J Wilson – Non-Executive Director (Chair)
Dr S Dauncey – Non-Executive Director
Dr K Harris – Medical Director
Ms C O'Brien – Chief Nurse and Quality Officer, East Leicestershire CCG (non-voting member)

**In Attendance:**
Dr B Collett – Associate Medical Director (Clinical Effectiveness)
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Mrs H Majeed – Trust Administrator
Mrs C Ribbins – Director of Nursing
Mr I Scudamore – CMG Director, Women's and Children's (for minutes 34/14/1 and 34/14/3)
Ms K Wilkins – CMG Head of Nursing, Women's and Children's (for minute 34/14/2)

**RESOLVED ITEMS** **ACTION**

**29/14 APOLOGIES**

Apologies for absence were received from Mr J Adler, Chief Executive; Mr M Caple, Patient Adviser; Ms K Jenkins, Non-Executive Director; Ms R Overfield, Chief Nurse; Mr P Panchal, Non-Executive Director and Professor D Wynford-Thomas, Non-Executive Director and Dean of the University of Leicester Medical School.

**30/14 MEMBERSHIP OF QAC**

The Committee Chair advised that Ms K Jenkins, Non-Executive Director had stood down from QAC and Ms S Dauncey, Non-Executive Director had been included on the membership.

**Resolved – that the update on the membership be noted.**

**31/14 MINUTES**

In respect of Minute 22/14/3, the Director of Clinical Quality noted an amendment to the first sentence – 'three site based reports' be replaced with 'five reports'. **TA**

**Resolved – that subject to the above correction, the Minutes (papers A and A1) from the meeting held on 23 April 2014 be confirmed as a correct record.** **TA**

**32/14 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:- **TA**

(a) Minute 22/14/2 (b) (report to EQB re. RTT) – further to a brief discussion, it was suggested that one overall report re. RTT be prepared for discussion at the Finance and Performance Committee and a section within this report to include an update on the safety implications and clinical quality risk assessments which would need to be submitted to the EQB and QAC; **MD**

(b) Minute 23/14/3 (d) – a risk assessment in respect of ring fencing elective capacity be

presented to Executive Team in June 2014 noting that a regular update on this matter would also be presented to Trust Board; **MD**

(c) Minute 14/14/2 – the Director of Nursing advised that Information Boards were now in place in ward entrances. This action could now be removed from the log, and **TA**

(d) Minute 120/13/7 (regarding whether any support from QAC was required in terms of expediting a particular case to get 'full assurance') – the Director of Nursing informed members that this had been discussed at the Children's Safeguarding Board and further information was awaited from other parties. Therefore, this action could now be closed. The Director of Nursing advised that funding had been received to increase the staffing in the adults safeguarding team. **TA**

**Resolved – that the matters arising report (paper B) and the actions above, be noted and undertaken by those staff members identified.** **MD/TA**

**33/14 QUALITY**

33/14/1 Quality Commitment – Final Version

Further to Minute 22/14/6 of 23 April 2014, the Director Clinical Quality presented paper 'C', which detailed the refreshed quality commitment priorities for 2014-15. For each of the priorities, an action had been identified together with a programme/corporate lead, key performance indicators and frequency of reporting. The detail of the quality commitment would be monitored through the Executive Quality Board.

Ms C O'Brien, Chief Nurse and Quality Officer, East Leicestershire CCG requested that the recommendations from the impending LLR mortality review were mapped onto the quality commitment priorities accordingly. In response, the Director of Clinical Quality advised that the recommendations had been considered however wording to that effect had not been included in the Quality Commitment as the recommendations from that review were not yet in the public domain. The Committee Chair undertook to raise this matter at the private section of the Trust Board on 29 May 2014. **Chair**

In respect of the future arrangements for reporting against the Quality Commitment, it was noted that standard reporting templates were being developed which would include the key performance indicators (KPIs) incorporating an update on the narrative and the numbers. Ms C O'Brien requested that updates in respect of the Quality Commitment KPIs were included within the Quality Schedule reports to the Clinical Quality Review Group. **DCQ**

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

**(B) the Committee Chair to propose at the Trust Board that the Trust's Quality Commitment was highlighted in any communication relating to the LLR Mortality Review, and** **Chair**

**(C) an update on the Quality Commitment KPIs be included within the Quality Schedule reports to the Clinical Quality Review Group.** **DCQ**

33/14/2 Month 1 – Quality and Performance Update

Members received and noted the contents of paper 'D', detailing the quality and performance updates for the period ending April 2014 (Month 1).

The Medical Director/Director of Nursing highlighted the following:-

(a) performance for time to surgery within 36 hours for fractured neck of femur patients was below the target of 72%. The MSS CMG had been tasked to develop an action **MSS**

plan which would be presented to the Executive Team in June 2014 and monitored through the EQB. Further to discussion at EQB, assurance be provided to QAC, as appropriate; **CMG/ MD**

(b) a total of three maternal deaths in January and February 2014;

(c) an update on critical safety actions was provided. Dr Annamaneni had been appointed as the new Trust lead for the critical safety action relating to Early Warning Score;

(d) the friends and family score was 69.6;

(e) an update on the detailed expectation from Trusts on delivering nurse staffing information was scheduled to be presented to the Trust Board on 29 May 2014;

(f) in respect of the clinical measures dashboard, evidence of quality of care was being reviewed. In response to a query from Dr S Dauncey, Non-Executive Director regarding the sustainability in respect of the metrics review tool, the Director of Nursing advised that this had been discussed at the Nursing Executive Team (NET) meeting and the matrons had been requested to undertake the audits in the first month and be given the time to action the findings in order for this to be sustainable. The Committee Chair requested that the information regarding which wards were focused on and the main concerns in these wards be included in future versions of the Q&P report in addition to the whole ward performance dashboard, and **DN**

(g) responding to a query on improving pressure ulcer performance, the Director of Nursing advised that appropriate education and management of individual cases was being taken forward, and

(h) responding to a query from Ms C O'Brien, Chief Nurse and Quality Officer, EL CCG regarding the process for managing patients who had been waiting over 18 weeks for treatment, the Medical Director advised that the case notes of these patients would be reviewed to ascertain whether there had been any harm as a result of the additional delay. If the review indicated harm, then it would be reported as an incident. Ms C O'Brien raised further queries in respect of the tracking system for priority areas and the judgement that was being used to prioritise patients. Further to a brief discussion, Ms O'Brien undertook to liaise with the Medical Director and Chief Nurse outside the meeting to seek assurance regarding the Trust's processes for patients being prioritised based on clinical needs. **CN, ELCCG**

**<u>Resolved</u> – that (A) the contents of this report be received and noted;**

**(B) the MSS CMG be requested to present an action plan to improve fractured neck of femur performance to a meeting of the Executive Team in June 2014. The action plan be monitored through the EQB and assurance be provided to QAC, as appropriate;** **MSS CMG/ MD**

**(C) the Director of Nursing to ensure that information regarding which wards were focused on and the main concerns in these wards was included in future versions of the Q&P report in addition to the whole ward performance dashboard, and** **DN**

**(D) Ms C O'Brien , Chief Nurse and Quality Officer, East Leicestershire CCG be requested to liaise with the Medical Director and Chief Nurse outside the meeting in respect of the matter detailed in point (h) above.** **CN, EL CCG**

33/14/3 <u>Quality and Performance Report – Future Format</u>

The Director of Clinical Quality advised that a draft version of the new quality and performance report had been formulated by the Chief Nurse, Chief Operating Officer and the Assistant Director of Information. The next step was for a discussion to be held with the Executive Directors. Further to this, the future format of the Q&P report would be presented to the QAC in June 2014. **CN**

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

**(B) the future format of the quality and performance report be presented to the** **CN/TA**

**QAC in June 2014.**

33/14/4 CQC Report and Action Plan

The Director of Clinical Quality presented paper 'F', which detailed progress against compliance actions detailed in the CQC action plan. In respect of the monitoring progress against the action plan, it was noted that progress would be reported on a monthly basis at the EQB and QAC.

In respect of an area for improvement relating to 'reviewing medical staffing and support staffing for CDU', the Committee Chair noted that the deadline for reviewing the staffing model was currently October 2014 and she suggested that a phased approach be taken and some actions be put in place prior to October 2014. She suggested that this matter be discussed at EQB in June 2014. **DCQ**

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

**(B) the Director of Clinical Quality to ensure that a discussion was held at EQB in June 2014 in respect of bringing forward the deadline for reviewing the staffing model in respect of the area for improvement relating to 'reviewing medical staffing and support staffing for CDU'.** **DCQ/TA**

33/14/5 CQC Registration of Alliance Contract Locations

The Director of Clinical Quality presented paper 'G' which provided background to the set up of the Alliance and set out the governance and reporting structure in relation to UHL. Responding to a query, it was noted that regular/quarterly monitoring reports would be presented to EQB and the Alliance would be regarded as an eighth virtual CMG. **Alliance Director/ TA**

The Director of Safety and Risk reported that some members of her team have undertaken a walkabout on areas of the Alliance from a safety/risk point of view and members of the Alliance have welcomed this engagement.

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

**(B) regular monitoring reports in respect of the Alliance contract be presented to the EQB.** **Alliance Director/ TA**

33/14/6 CIP Schemes Quality Impact Assessment

The Medical Director presented paper 'H', which detailed the list of CIP schemes which had been approved further to quality impact assessments being undertaken. Members noted that quality impact assessments were sought automatically for any CIP scheme with a value greater than £50k or with a risk rating at 15 or above.

Responding to a query from the Chief Nurse, ELCCG regarding the process for monitoring the approved schemes, the Medical Director advised that specific additional KPIs had not been introduced, however, oversight in respect of these schemes was sought at the CMG performance management sessions and any issues would be escalated to EQB, by exception.

The Director of Safety and Risk queried the process for undertaking the quality impact assessments highlighting that the quality and safety had not been involved, in response the Medical Director advised that a PMO set up and process was now in place and undertook to circulate a report outside the meeting. **MD**

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

**(B) the Medical Director to circulate a report outside the meeting re. the PMO set up and process for undertaking quality impact assessments of CIP schemes.** **MD**

**34/14 SAFETY**

34/14/1 Update on Perinatal Mortality and Puerperal Sepsis

The CMG Director, Women's and Children's provided a brief background on perinatal mortality in UHL and presented paper 'I', providing assurance to the QAC that UHL perinatal mortality rate was being appropriately monitored, and that strategies were being developed to reduce the rate. A structure had been put in place for identification of perinatal deaths across the whole of UHL. All perinatal deaths were logged on a database, and an annual statistical review was undertaken. Perinatal mortality had been included on the quality dashboard and the run rate was routinely monitored and overseen by the Perinatal Mortality Working Group which was chaired by the CMG Director, Women's and Children's.

Data provided by Dr Fosters in 2013 suggested that UHL had a high perinatal mortality relative risk. On closer evaluation of the Trust's data in collaboration with representatives from Dr Fosters it became apparent that the Trust's high relative risk largely arose from a very low expected perinatal mortality based on the coding of babies born. Dr Fosters suggested that the Trust used an unusual pattern of coding, assigning codes associated with an increased risk of mortality to very few babies compared to other Trusts. Work was being undertaken to identify and code the diagnoses accurately and a methodology for this would be developed. Other Trusts would be contacted to ascertain the coding methodologies that they used. The Committee Chair noted the significant progress that had been made and requested that an update be provided to QAC in six months' time (i.e. November 2014). **CMG Director, W&C**

Further to Minute 87/13/2 of 25 September 2013, the CMG Director, Women's and Children's tabled the 'Puerperal Sepsis CQC Alert Action Plan'. Following the 2013 CQC alert, the CMG had worked with the clinical coders to improve the clinical relevance of the coding process and developed a flowchart to ensure that coding better reflected the actual levels of septic illness experienced by patients. Further to the Trust's response, the CQC had indicated that the alert would be closed however formal confirmation had not yet been received. The Director of Clinical Quality reported that she had a meeting scheduled with a CQC assessor on 2 June 2014 and if further details of the alert were provided to her then she could liaise with the assessor in respect of closing the alert. **CMG Director, W&C**

Responding to a query from the Chief Nurse, ELCCG, the CMG Director, Women's and Children's undertook to provide assurance outside the meeting in respect of whether spot audits were being undertaken for checking of perineal wounds by midwives. **CMG Director, W&C**

The Committee Chair requested that a verbal update on the implementation and effectiveness of the flowchart to improve accuracy of initial coded diagnoses in respect of puerperal sepsis be provided to the QAC in September 2014. **CMG Director, W&C/ CMG Rep**

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

**(B) the CMG Director, Women's and Children's to provide :-** **CMG Director, W&C/ TA**

- **an update on perinatal mortality to the QAC in November 2014;**
- **further details on the actions taken in respect of the perinatal mortality alert to the Director of Clinical Quality;**
- **assurance to the Chief Nurse, ELCCG outside the meeting in respect of whether spot audits were being undertaken for checking of perineal wounds by midwives, and**

**(C) the CMG Director Women's and Children's or a representative to provide a verbal update on the implementation and effectiveness of the flowchart to** **CMG**

**improve accuracy of initial coded diagnoses in respect of puerperal sepsis to the QAC in September 2014.** **Director, W&C/ CMG Rep**

34/14/2 Report by the Head of Nursing, Women's and Children's

**Resolved – that this Minute be classed as confidential and reported in private accordingly.**

34/14/3 SUI Report – Retained Vaginal Swab

Paper K provided a summary of events and update into a SUI relating to a retained vaginal swab and assurance that actions had been taken to prevent recurrence. The CMG Director, Women's and Children's provided a brief background in respect of this incident and the actions that had been put in place following a review.

Dr S Dauncey, Non-Executive Director noted that although a number of actions had been put in place, she queried whether an audit process was in place to ensure that the actions had been completed. The Committee Chair requested that an update be provided in six months' time on how the CMG sought assurance that the recommendations had been followed through and whether an audit mechanism was in place to monitor the actions been put in place following this incident. **CMG Director, W&C**

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

**(B) the CMG Director, Women's and Children's to provide an update to the QAC in November 2014 on how the CMG sought assurance that the recommendations from the review had been followed through and whether an audit mechanism was in place to monitor actions been put in place following the above incident.** **CMG Director, W&C**

34/14/4 Existing Process for the RCA Group and recommendations for the future

The Director of Safety and Risk advised verbally that when the governance arrangements were re-organised and the EQB and its sub groups were established, it was suggested that the Patient Safety Group had a subgroup to review and monitor implementation of actions arising from a root cause analysis action plans. Work was in progress for establishing this group which was expected to be in place by July 2014.

**Resolved – that the verbal update be noted.**

34/14/5 Patient Safety Report

The Director of Safety and Risk presented paper 'L', which detailed the monthly patient safety report. Members' attention was drawn to the following:-

- update on Five Critical Safety Actions;
- walkabout thematic review April 2014;
- 3636 Staff Concerns Report line – concerns reported for April 2014;
- CQC Whistleblowing Concerns raised;
- SUIs reported and closed in April 2014;
- CAS performance for April 2014, and
- 45 Day RCA Performance.

Particular discussion took place regarding the following points:

(i) the proposal that the Trust no longer continued to report all 10 x medication errors as serious incidents undertaking a full root cause analysis investigation (as this had been an internal decision applicable only to UHL) and instead in the future it was proposed that whilst all medication errors within the Trust continued to be reported, the grading criteria should be

properly applied and the appropriate reporting investigation process undertaken, i.e. 10 x medication error with no harm = not an SUI and not reported as such, 10 x medication error causing harm = SUI and appropriate reporting. This proposal had been supported by the EQB at its meeting on 7 May 2014 (note 7.1 refers). The QAC also supported this proposal noting that all medication errors would be continued to be monitored by the Medicines Optimisation Committee, and

(ii) a completed root cause analysis report and a consolidated action plan relating to two SUIs in ophthalmology department be presented to the QAC, when available. **DSR**

**<u>Resolved</u> – that (A) the contents of this report be received and noted,**

**(B) a completed root cause analysis report and a consolidated action plan relating to two SUIs in ophthalmology department be presented to the QAC, when available.** **DSR/TA**

34/14/6 <u>Out-Patient Follow-Up Arising from Backlog Letters Across the Trust</u>

The Medical Director re-iterated that this agenda item was in relation to a potential issue that had been identified in the way outpatient follow up appointments were being managed, where in some cases (approximately 20000) appointments had not been made in a timely way. Administrative processes around partial booking were not appropriately followed. CMGs had now been advised of the processes that should be followed for all patients who required follow up appointments. The CMGs had been asked to provide assurance that instructions provided had been implemented in all their Specialties and all patients awaiting follow up outpatient appointments had been captured on the Trust's HISS system. A task and finish group had been convened to oversee and provide assurance in relation to concerns about delays and loss of patients to follow up UHL outpatient services. The Committee Chair requested that a report on the outstanding follow-up appointment numbers by Specialty, clinical importance and the steps taken to resolve the issues be presented the QAC in June 2014. The Chief Nurse, EL CCG noted the need for clinical oversight and scrutiny to ensure that such issues did not re-occur. In response, the Medical Director advised that monitoring processes were now in place to ensure that procedures were being followed. The Committee Chair undertook to raise this matter at the Trust Board in May 2014. **MD**

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

**(B) the Medical Director be requested to present a report on the outstanding follow-up appointment numbers by Specialty, clinical importance and the steps taken to resolve the issues to the QAC in June 2014**. **MD/TA**

34/14/7 <u>Use of Non-Luer Devices for Non-Chemotherapeutic, Spinal, Epidural and Regional Anaesthetic Procedures</u>

Further to note 7.5 of EQB on 7 May 2014, the Associate Medical Director presented paper 'M' which provided a background on the 2009 National Patient Safety Agency (NPSA) patient safety alert recommending healthcare organisations to use non-luer devices for spinal (intrathecal), epidural and regional procedures (i.e. neuraxial procedures) and the NHS England patient safety alert which superseded the 2009 NPSA alert.

In relation to managing the risks, there were two options currently available to the Trust:

- continue to use luer equipment for epidural and regional anaesthesia with the existing controls in place (as listed in appendix one of paper M) until such time that the ISO specification was agreed, and
- use the currently available non-luer devices by 'mixing and matching' the

acceptable components from different manufacturers. Some inherent risks must be considered with this option in as much that by connecting together components from different manufacturers meant that the Trust had created a new device and therefore product liability was transferred to the Trust. In this instance if there was a physical failure of any of the components leading to patient injury, then the Trust would be liable for any future claim without any further recourse to the original manufacturer.

Further to discussion at EQB, the risk score had been increased to 15. The EQB had referred this matter to the QAC for appropriate consideration. Further to discussion, it was noted that as this was a clinical decision it needed to be referred to the Medical Devices Group. The Committee Chair requested that the Medical Devices Group considered this matter and the recommendation from this Group be discussed with the Director of Corporate and Legal Affairs' team for ratification. **Medical Devices Group**

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

**(B) the Medical Devices Group be requested to consider the options in respect of the use of Non-Luer Devices for Non-Chemotherapeutic, Spinal, Epidural and Regional Anaesthetic Procedures and discuss its recommendation with the Director of Corporate and Legal Affairs' team for ratification.** **Medical Devices Group**

34/14/8 Quarterly Health and Safety Report

Paper N detailed the 2013-14 quarter 4 (January-March 2014) health and safety report. An update on RIDDOR reporting, health and safety services training and claims was provided.

Members noted that security staff had been instructed by Interserve's senior management teams not to accede to requests from clinical staff to intervene in cases where patients required some form of physical restraint. This was on the basis that security staff were not insured for these actions and therefore were liable to prosecution and/or litigation should they intervene on such occasions. This has resulted in the issue being raised on the Trust's Risk Register with an initial risk rating of 25. However, further to discussions with Interserve, the risk score had been downgraded to 16. A request for an addendum to the Interserve contract had been made – the Committee Chair requested that a verbal update under 'matters arising' be provided to confirm whether this had been actioned. **CN**

Responding to a query from the Committee Chair, the Director of Safety and Risk undertook to discuss at the June 2014 Health and Safety Committee regarding any health and safety key performance indicators that needed to be included in the quality and performance report. **DSR**

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

**(B) the Chief Nurse be requested to provide a verbal update under matters arising at the June 2014 QAC meeting regarding whether the addendum to the Interserve contract in respect of security staff had been accepted, and** **CN/TA**

**(C) the Director of Safety and Risk undertook to discuss at the June 2014 Health and Safety Committee regarding any health and safety key performance indicators that needed to be included in the quality and performance report.** **DSR**

**35/14 PATIENT EXPERIENCE**

35/14/1 Triangulation of Patient Feedback

Further to Minute 24/14/4 of 23 April 2014, the Director of Nursing presented paper 'O'

which detailed work recently undertaken for the purpose of routinely triangulating patient feedback which was focused upon the qualitative elements of feedback and excluded the National Patient Survey results, local Patient Experience Survey question results and other questionnaire based surveys.

The main 'negative' theme arising from the triangulation of feedback related to waiting times and the main 'positive' theme was staff attitude.

The Director of Nursing advised that this report was labour intensive and recommended that the CMGs received this information on a monthly basis, however a strategic level report be provided to the QAC on a quarterly basis. This was agreed. **DN**

Responding to a query from the Director of Safety and Risk, the Committee suggested that complaints data (rate, trend and numbers of complaints by CMG) either be included in the patient experience triangulation report or in the quarterly patient safety report but noted the need for both these reports to be presented to the QAC in the same month. **DSR**

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

**(B) the triangulation of patient feedback report now be presented to the QAC on a quarterly basis, and** **DN**

**(C) specific complaints data (to include rate, trends and numbers by CMG) be included in future iterations of the triangulation of patient feedback report or as part of the quarterly patient safety report. If the latter, then both the reports to be presented to the QAC in the same month.** **DSR**

**36/14 MINUTES FOR INFORMATION**

36/14/1 Executive Quality Board

**Resolved – that the Minutes of the Executive Quality Board meetings held on 2 April 2014 and 7 May 2014 (papers P and P1 refer) be received and noted.**

36/14/2 Finance and Performance Committee

**Resolved – that the public Minutes of meeting of the Finance and Performance Committee held on 23 April 2014 (paper Q) be received and noted.**

36/14/3 Executive Performance Board

**Resolved – that the Minutes of the Executive Performance Board meeting held on 22 April 2014 (paper R refers) be received and noted.**

**37/14 ANY OTHER BUSINESS**

**Resolved – that there were no further items of business.**

**38/14 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD**

**Resolved – that the QAC Chair be requested to bring the following issues to the attention of the Trust Board at its meeting the following day:**

- **RTT report – a section within this report to include an update on the safety implications and clinical quality risk assessments (Minute 32/14 (a));**
- **to seek the Trust Board's view on the value of sharing the recommendations arising from the LLR Mortality Review within the Trust's Quality Commitment (Minute 33/14/1);**

- **report by the Head of Nursing, Women's and Children's (Minute 34/14/2);**
- **discussion around administrative processes around partial booking (Minute 34/14/6), and**
- **triangulation of patient feedback (Minute 35/14/1).**

**39/14 DATE OF NEXT MEETING**

**Resolved – that the next meeting of the Quality Assurance Committee be held on Wednesday 25 June 2014 from 12.00noon until 4.00pm in the Seminar Rooms 1A and 1B, Clinical Education Centre, Leicester General Hospital.**

The meeting closed at 3.30pm.

**Cumulative Record of Members' Attendance (2014-15 to date):**

| *Name* | *Possible* | *Actual* | *% attendance* | *Name* | *Possible* | *Actual* | *% attendance* |
|---|---|---|---|---|---|---|---|
| *J Adler* | 2 | 1 | 50 | *R Overfield* | 2 | 1 | 50 |
| *M Caple** | 2 | 1 | 50 | *P Panchal* | 2 | 1 | 50 |
| *S Dauncey* | 2 | 1 | 50 | *J Wilson (Chair)* | 2 | 2 | 100 |
| *K Harris* | 2 | 2 | 100 | *D Wynford-Thomas* | 2 | 0 | 0 |
| *K Jenkins* | 1 | 0 | 0 | | | | |
| *C O'Brien – East Leicestershire/Rutland CCG** | 2 | 1 | 50 | | | | |

- ** non-voting members*

Hina Majeed
**Trust Administrator**