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: 6 August 2015

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Dr S Dauncey, QAC Chair

DATE OF COMMITTEE MEETING: 25 June 2015

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

- **Quality Account 2014-15 Board Representation Letter and Independent Auditors' Limited Assurance Report (Minute 56/15 refers)**

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

- **None**

DATE OF NEXT COMMITTEE MEETING: 30 July 2015

Dr S Dauncey
QAC Chairman
31 July 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY, 25 JUNE 2015 AT 1:00PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Dr S Dauncey – Non-Executive Director (Chair)
Mr M Caple – Patient Adviser (non-voting member)
Colonel Ret'd I Crowe – Non-Executive Director
Mr A Furlong – Acting Medical Director (until Minute 62/15/1 and excluding Minute 56/15)
Ms C Ribbins – Acting Chief Nurse
Ms J Wilson – Non-Executive Director

In Attendance:
Mr J Davison – Consultant Orthopaedics (for Minute 60/15/2)
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Ms S Leak – Head of Operations, RRCV (for Minute 60/15/3)
Mrs H Majeed – Trust Administrator
Ms E Meldrum – Assistant Chief Nurse (for Minute 60/15/4)
Mr R Moore – Non-Executive Director
Mr R Power – Clinical Director, MSS CMG (for Minute 60/15/2)
Mr K Singh – Trust Chairman
Ms L Tebbutt – Performance and Quality Assurance Manager (for Minute 60/15/1)
Mr M Traynor – Non-Executive Director

RECOMMENDED ITEM **ACTION**

56/15 QUALITY ACCOUNT 2014-15

The Director of Clinical Quality tabled the following reports:-

(a) Quality Account 2014-15: Board Representation letter, and
(b) Draft Independent Auditors' Limited Assurance Report on the Annual Quality Account.

The Board representation letter was agreed by the Quality Assurance Committee on behalf of the Trust Board. It was agreed that the letter would be signed-off by Mr A Furlong, Acting Chief Executive/Acting Medical Director on behalf of the Chief Executive.

In respect of the Independent Auditors' Limited Assurance report, the indicators for the year ended 31 March 2015 subject to limited assurance consisted of the following:-

(a) rate of clostridium difficile infections, and
(b) percentage of patient safety incidents resulting in severe harm or death.

Members endorsed both of the above reports and recommended them to the Trust Board for approval. **Chair**

Recommended – that the quality account 2014-15 Board Representation letter and independent Auditors' limited assurance report on the Annual Quality Account 2014-15 be endorsed and recommended to the Trust Board for approval. **Chair**

RESOLVED ITEMS

57/15 APOLOGIES

Apologies for absence were received from Mr J Adler, Chief Executive, Dr A Doshani, Associate Medical Director and Ms C O'Brien, Chief Nurse and Quality Officer, East Leicestershire CCG (non-voting member).

58/15 MINUTES

Resolved – that the Minutes of the Quality Assurance Committee meeting held on 28 May 2015 (paper A refers) be confirmed as a correct record.

59/15 MATTERS ARISING REPORT

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

(i) Minute 40/15/4 (CQUINs and Quality Schedule) - the Director of Clinical Quality confirmed that the recruitment of posts (to ensure achievement of the CQUIN indicator thresholds) would be completed by July 2015, and

(ii) Minute 111/14/1 (Triangulation of Patient Experience) – it was agreed that QAC would continue to receive the patient experience triangulation report on a quarterly basis and, depending on the themes emerging, QAC would ask for reports from the relevant Executives in order to provide assurance. It was agreed that this action should be marked as 'complete' and be removed from the log. **TA**

Resolved – that the matters arising report (paper B refers) be confirmed as a correct record.

60/15 QUALITY

60/15/1 Interserve Estates and Facilities Contract Quality Performance Report (Quarterly)

Ms L Tebbutt, Performance and Quality Assurance Manager attended the meeting to present paper C, the Interserve quality performance report for quarter 4 of 2014-15. A brief update was provided regarding the issues relating to the reporting of the quality of Interserve service delivery from the patient facing elements – i.e. cleaning, catering and portering services.

Members were advised that an electronic customer satisfaction survey was still not in place and National Specification for Cleanliness (NSC) targets were not being met in 'very high risk' areas at all three hospital sites and for 'high risk' areas particularly at the LRI site. Audit results had also indicated deteriorating standards.

The planned transformation of catering and cleaning services in the Kensington Building at the LRI site and Glenfield Hospital, which had commenced in May 2015 and which included the roll-out of a streamlined 'multi-skilled' service, had not achieved the results expected and had been paused.

Members were advised that Independent Auditors had been appointed by the Trust to undertake an audit of cleaning and this work was expected to commence on 1 July 2015. In discussion on this matter, the Acting Medical Director requested the Performance and Quality Assurance Manager to liaise with the Director of Estates and Facilities and the Director of Marketing and Communications and issue a Trust-wide communications regarding the Independent Auditors who had been appointed to undertake an audit of cleaning across the Trust. **PQAM**

In response to a query, members were advised that portering KPIs had been reported as achieving the required performance except for one indicator (i.e. routine service requests)

However, the KPI validation was challenging as it depended on inspection of manual records.

It was noted that the official results of the Patient Led Assessment of the Care Environment (PLACE) would be available in August 2015.

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

(B) the Performance and Quality Assurance Manager be requested to liaise with the Director of Estates and Facilities and the Director of Marketing and Communications and issue Trust-wide communications regarding the Independent Auditors who had been appointed by the Trust to undertake an audit of cleaning across the Trust. **PQAM**

60/15/2 Fractured Neck of Femur (#NOF) Performance – Impact to patients, action plan and expected improvement

Mr R Power, Clinical Director, MSS and Mr J Davison, Consultant Orthopaedics attended the meeting to present paper D, an update on the challenges experienced around the achievement of the #NOF target of admission to theatre in 36 hours. It was highlighted that the #NOF target was a multi-disciplinary team target which required input from Orthopaedics, Anaesthesia and Orthogeriatrics services.

Members were advised that a number of actions had been put in place to support #NOF patients although these plans were yet to realise to full benefit due to delays in recruitment of key staff. The service was already experiencing challenges currently and when there was an increase in admission of #NOFs or trauma cases, then the achievement of this target was at risk.

Mr J Davison highlighted performance with the 36 hour target was non-complaint, however, majority of patients were being operated on within 48 hours. The Acting Medical Director noted the need for review of spinal cases highlighting that one spine case would push back one whole list trauma list which would consist of approximately 6 patients. It was suggested that the flexibility in theatre schedules would have a big impact in resolving the issue.

Mr R Power provided a brief update on recruitment issues highlighting that discussions were on-going with other Trusts in respect of partnership working for spinal surgery. A Physician Associate was expected to start in November 2015. It was noted that the Chief Operating Officer's team was undertaking a deep dive of the underperformance against the #NOF target and an update was scheduled to be presented to the Integrated Finance, Performance and Investment Committee (IFPIC) in July 2015. Ms J Wilson, Non-Executive Director/IFPIC Chair requested that the MSS CMG HR Lead also accompanied MSS CMG colleagues at the IFPIC meeting in July 2015 to provide an update on workforce issues. **TA**

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

(B) the MSS CMG HR Lead be invited to attend the IFPIC meeting in July 2015 to provide an update on workforce issues pertaining to the #NOF underperformance. **TA**

60/15/3 Transplant Lab Accreditation – UKAS Visit

Ms S Leak, Head of Operations, RRCV attended the meeting to present paper E, an update regarding the transplant laboratory transition assessment by UKAS in June 2015. A brief update on the background of the Transplant Laboratory Service was provided.

Following the inspection, the CPA accreditation of the Transplant Laboratory had been

suspended for a period of 12 weeks with an 8 week period to improve and evidence actions which had been highlighted from the assessment. The Trust was required to notify all users that accreditation had been suspended and that the decision to use the service was at the user's discretion.

Work was underway to progress the actions in the action plan and the service was confident that the actions would be implemented within the 8 week deadline. Ms Leak queried whether the report and action plan could be shared with NHS England – this was agreed. **HOO, RRCV**

The Director of Safety and Risk suggested that there might be merit in undertaking a deep-dive of the Transplant Service to ascertain if there were any further issues and identify any patterns/clusters from a patient safety point of view. The Acting Medical Director suggested that discussion on this suggestion be held outwith the meeting and if a deep dive was undertaken, then a report be presented to EQB and any exceptions be reported thereafter to QAC, as appropriate. **DSR/ HOO. RRCV**

Members view was that, if this inspection would have been included on the list of external visits, accreditations and forthcoming visits, then it could have been better managed.

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

(B) the Head of Operations, RRCV be requested to share the report and action plan in respect of this visit with NHS England, and **HOO, RRCV**

(C) the Director of Safety and Risk and the Head of Operations, RRCV be requested to liaise outwith the meeting regarding the merit in undertaking a deep-dive of the Transplant Service to ascertain if there were any further issues - if a deep dive was undertaken, then a report be presented to EQB and any exceptions be reported thereafter to QAC, as appropriate. **DSR/ HOO, RRCV**

60/15/4 Update on Nurses and Midwives Revalidation

Further to Minute 26/15/3 of 26 March 2015, Ms E Meldrum, Assistant Chief Nurse attended the meeting to present paper F, a further update on revalidation for nurses and midwives. The final revalidation guidance was not yet available but it was expected in October 2015.

The Assistant Chief Nurse confirmed that she was confident that, as a Trust, nurses and midwives had been prepared for the revalidation changes ahead. The Acting Chief Nurse thanked the Assistant Chief Nurse for her significant efforts in taking forward this project and commented that, currently UHL was shown as an exemplar in respect of the proposed revalidation requirements.

Appendix 2 provided the results of the regional and national survey undertaken by the Trust Development Authority for the National Revalidation Board. The aim of the survey was to assess revalidation readiness in NHS Trusts. UHL did not appear to be an outlier in terms of progress being made with the implementation of revalidation.

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

60/15/5 Month 2 – Quality and Performance Update

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

- both cancer 14 and 62 day targets had not been met and it was anticipated that the 62 day target would not be met until September 2015 (previous deadline was

July 2015). It was noted that this deterioration in performance would be scrutinised by IFPIC in July 2015;

- a never event relating to a 10 x drug error was reported and a brief update on the issues leading to the never event was provided. A full root cause analysis would be undertaken and a report would be presented to EQB and QAC in August/September 2015, and **DSR**
- UHL's performance in respect of the NHS e-referral system (formerly known as Choose and Book) was inadequate, however, further to discussion it was agreed that priority needed to be given to other urgent issues where the Trust was currently underperforming.

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

(B) the Director of Safety and Risk be requested to submit the root cause analysis report of a recent never event relating to 10 x drug error to EQB and QAC in August/September 2015. **DSR/TA**

60/15/6 Nursing and Midwifery Report including an update providing detail around current and future nurse staffing levels, vacancies, recruitment and provider capacity

The Acting Chief Nurse presented paper H, which detailed information in respect of the latest nurse staffing in post figures, real time staffing, the current recruitment position, premium pay and nursing dashboard.

Appendix 2 detailed the real time staffing summary for April 2015. An increase in nursing vacancies (443WTE) was reported for April 2015 which was particularly due to unfunded beds now being funded specifically across ESM and ITAPS CMGs.

In April 2015, five clinical areas had not achieved the recommended nurse to bed ratio level. Wards 33a and 29 at Glenfield Hospital had fallen under the recommended level, however appropriate actions had been taken to support the staffing gaps. Wards 10, 11 and 14 within Children's Services had not achieved the recommended nurse to bed ratio level but beds had been flexed proportionally to the number of staff available, alongside the senior nursing team working clinically to support staffing gaps.

In respect of the midwifery staffing update, 11 WTE midwifery vacancies had been reported for April 2015. There had been a successful recruitment to vacant posts and the impact of this would be seen in the June 2015 vacancy figures.

Section 7 of paper H detailed the nursing and midwifery waterfall/bridge chart which provided clarity around the nursing and midwifery vacancies throughout 2014-15. The success of international recruitment/clearing house and general recruitment campaigns was also evident through the chart. Members noted the need for focus to be given to retention of nursing and midwifery staff and increasing training of nursing staff. It was suggested that the waterfall chart be used to inform the resourcing plan for nursing in the future.

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

60/15/7 Ward Performance Dashboard (Clinical Measures Dashboard)

The Acting Chief Nurse advised that the Clinical Measures Dashboard (paper I refers) incorporated performance thresholds designed to ensure that all wards could identify their standard of care in order to ensure it was safe, effective and of high quality. Any wards in special measures would be reported to EQB on a monthly basis via the Nursing and Midwifery report.

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

60/15/8 Friends and Family Test Scores – April 2015

Paper J detailed the friends and family test scores for April 2015. Responding to a query, it was noted that the challenging area for achieving minimum coverage was outpatients. The Acting Medical Director advised that IBM were trialling the 'My Out Patient Appointment (MOPA) Application Programme (app) and provided a brief update on the benefits of the app. UHL and seven other Trusts would be piloting this app.

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

60/15/9 CQC Registration Visit to National Centre for Sport and Exercise Medicine (NCSEM)

The Director of Clinical Quality provided a verbal update advising that the CQC registration visit to NCSEM had taken place on 3 June 2015 and no significant issues had been identified. The registration certificate would be completed as soon as the acceptance testing on the diagnostic equipment was signed-off.

Resolved – that the verbal update be received and noted.

60/15/10 External Schedule of Visits

Further to Minute 16/15/6 of 26 February 2015, the Director of Clinical Quality presented paper K, an update on the schedule of external visits. Following a request from QAC members, a RAG rating had been added to the schedule to represent the following:-

(a) action plan complete/ on track;
(b) some delay with the action plan but recoverable, and
(c) actions not met and remedial action/escalation required.

Colonel Ret'd I Crowe, Non-Executive Director noted that the RAG rating was in respect of the 'preparation for the visits' and suggested that consideration be given to incorporating RAG rating in terms of the 'preparedness for the visits'. **DCQ**

Members were advised that the JAG visit to the endoscopy unit at Leicester General Hospital (LGH) had not been included on the 'external schedule of visits' list because the view was that Endoscopy Unit at LGH would not be compliant with JAG accreditation and a strategic plan was being developed to move Endoscopy services off the LGH site and increase capacity at the LRI and Glenfield Hospital.

It was suggested that the CQC visit be included on the 2015-16 forthcoming visits list, even though a date for the visit was not yet known. **DCQ**

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

(B) the Director of Clinical Quality be requested to give consideration to incorporating RAG rating in terms of the 'preparedness for the visits' within the external schedule of visits report, and **DCQ**

(C) the Director of Clinical Quality be requested to include the CQC visit on the 2015-16 forthcoming visits list even though a date for the visit was not yet known. **DCQ**

61/15 SAFETY

61/15/1 Patient Safety Quarterly Report

The Director of Safety and Risk presented paper L, the quarter 4 (2014-15) patient safety data report as part of the 2014-15 quality schedule.

Members were particularly assured on the work being undertaken by the Corporate Safety team to work with the Clinical Management Groups (CMGs) to reduce overdue

incidents within the CMGs.

In response to a query from the Trust Chairman regarding the ways in which learning from incidents was cascaded, the Director of Safety and Risk provided the following update:-

(a) local teams – CMG colleagues discussed and shared learning through the CMG meetings;
(b) learning from experience group – each meeting of this Group reviewed a couple of incidents across the Trust and organisation wide learning and sharing was cascaded accordingly;
(c) the Adverse Event Committee reviewed any Regulation 28 (Preventing Future Death) reports and an action tracker was provided to track actions were being implemented and embedded;
(d) a patient safety portal was available on Insite (the Trust's intranet system) where key safety messages were regularly posted, and
(e) an incident training module (Dissemination through Animation) had recently been developed which was scheduled to be presented to EQB in July 2015.

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

61/15/2 Update on complaints performance

The Director of Safety and Risk provided a verbal update advising that there had been an overall improvement in the 10 & 25 day monthly complaint response performance with the Trust achieving 94% & 99% in February 2015 and 98% & 95% respectively in March 2015 (the Trust standard was 95%). However, she advised members that escalation of responses continued to be reinforced so that the Trust's performance in responding to re-opened complaints could improve. The re-opened complaints were mainly in relation to waiting times and cancelled operations.

Resolved – that the verbal update be noted.

61/15/3 Update re. workstreams put in place to resolve the emerging issues that had arisen through the learning from claims and inquests process

The Director of Safety and Risk provided a verbal update advising that the following were the key issues arising from inquests:

(a) failure to observe and monitor in accordance with patient needs;
(b) failure to properly assess the fitness for discharge and properly plan that discharge;
(c) inadequate communication between those who were responsible for the care and treatment of the patient;
(d) failure to undertake complete nursing observations/EWS, and
(e) staff wholly unaware of policy/guidelines or unaware of, and had no training in, the application of the policy.

It was highlighted that work continued to resolve these issues which had been appropriately captured in the Quality Commitment and associated workstreams.

Resolved – that the verbal update be noted.

62/15 **PATIENT EXPERIENCE**

62/15/1 Patient Experience Triangulation Report

The Acting Chief Nurse presented paper M which brought together a variety of patient feedback via formal complaints, verbal complaints, GP concerns, NHS Choices, Patient Opinion, Patient Surveys, message to matron and message through a volunteer.

The top three themes overall remained around waiting times for appointments, in clinic and ED and these three issues accounted for the top issue in seven of the eight CMGs. The fourth highest theme was around medical management of care and the fifth was cancellation of appointments both of which came mainly from patient complaints. The Acting Chief Nurse advised that patient feedback from the triangulation process illustrated that the improvement plans that the Trust currently had deployed were in line with the feedback and all staff should remain focused on these initiatives.

The Acting Medical Director requested that he would be interested in reviewing the themes arising from patient feedback in respect of the Discharge Lounge – the Acting Chief Nurse agreed to provide this. **ACN**

The Patient Adviser highlighted that at a recent Patient Involvement, Patient Experience and Equality Assurance Committee (PIPEEAC) meeting, the National Inpatient Survey had been included as part of the triangulation report – in response , the Acting Chief Nurse advised that the results of the National Inpatient Survey were scheduled to be presented to EQB in July 2015 and would then be presented to the subsequent QAC meeting.

Ms J Wilson, Non-Executive Director raised a query regarding limited staffing in the discharge lounge at Glenfield Hospital during weekends which was leading to delay in discharges – in response, the Acting Medical Director advised that work was underway to increase ancillary services (i.e. pharmacy, radiology etc.) support at Glenfield Hospital particularly at the weekends given that a numbers of services had now been transferred to this site as part of the Trust's reconfiguration programme. Responding to a further query in relation to the actions being taken in respect of the recurrent theme re. 'food and drink' – the Acting Chief Nurse advised that, from a nursing point of view, appropriate audits were undertaken and actions were put in place to ensure that patients' needs were appropriately met.

It was noted that a Trust Board Thinking Day re. 'Acting on Feedback/Learning from Patient Experience' had been scheduled in August 2015.

The Committee Chair thanked Ms H Leatham, Assistant Chief Nurse and Mr C Walker, Clinical Audit Manager for their efforts in consolidating paper M.

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

(B) the Acting Chief Nurse be requested to provide the Acting Medical Director with the themes arising from patient feedback in respect of the Discharge Lounge. **ACN**

63/15 ANNUAL REPORTS FROM EQB SUB COMMITTEES

63/15/1 Infection Prevention Annual Report 2014-15

Members commended the infection prevention annual report 2014-15 (paper N refers) and thanked Ms L Collins, Lead Infection Prevention Nurse and her team for producing this report.

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

63/15/2 Safeguarding Annual Report 2014-15

Members received and noted the contents of paper O. In response to a query re. whether the Annual Safeguarding Report needed to submitted to the Trust Board, the Trust Chairman undertook to liaise with the Director of Corporate and Legal Affairs and inform the Committee Chair of his response. A concern was also raised regarding no assurance being received whether Interserve staff had completed safeguarding training – in response, the Acting Chief Nurse advised that this had been followed-up by Human **Trust**

Resources colleagues and although Interserve had confirmed that their staff had completed the safeguarding training, no evidence (i.e. training records) had yet been provided to confirm this. **Chairman**

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

(B) the Trust Chairman be requested to liaise with the Director of Corporate and Legal Affairs and confirm to the Committee Chair whether the Safeguarding Annual Report 2014-15 should be submitted to the Trust Board. **Trust Chairman**

63/15/3 Clinical Audit Annual Report 2014-15

Members received and noted the contents of paper P. Dr S Dauncey, Non-Executive Director and Committee Chair noted that as clinical audit was a part of the Director of Clinical Quality's remit, clinical audit reports had been historically presented to QAC as the Director of Clinical Quality was a regular attendee at QAC.

Mr R Moore, Non-Executive Director/Chair of the Audit Committee advised members that it was the responsibility of the Audit Committee to provide the Trust Board with assurance against a number of criteria for good local clinical audit. Therefore, a regular report on clinical audit would also now feature on Audit Committee agendas starting from the meeting in September 2015. **DCQ/TA**

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

(B) clinical audit Reports now be scheduled as a regular item also on the agenda for Audit Committee meetings starting from September 2015. **DCQ/TA**

64/15 2016 QAC MEETING DATES

Resolved – that the schedule of meeting dates for 2016 (paper Q refers) be confirmed as follows:-

Thursday 28 January 2015;
Thursday 25 February 2015;
Thursday 24 March 2015;
Thursday 28 April 2015;
Thursday 26 May 2015;
Thursday 30 June 2015;
Thursday 28 July 2015;
Thursday 25 August 2015;
Thursday 29 September 2015;
Thursday 27 October 2015;
Thursday 24 November 2015, and
Thursday 22 December 2015.

65/15 ITEMS FOR THE ATTENTION OF QAC FROM EXECUTIVE QUALITY BOARD (EQB)

65/15/1 EQB Meeting of 5 May 2015 – Items for the attention of QAC

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

65/15/2 EQB Meeting of 2 June 2015 – Items for the attention of QAC

Resolved – that there were no items to be brought to the attention of QAC from EQB on 2 June 2015.

66/15 MINUTES FOR INFORMATION

66/15/1 Executive Performance Board

Resolved – that the action notes of the 26 May 2015 Executive Performance Board meeting (paper S refers) be received and noted.

66/15/2 Updated QAC Calendar of Business

Resolved – that the calendar of business for QAC (paper T refers) be received and noted.

67/15 ANY OTHER BUSINESS

Resolved – that there were no items of any other business.

68/15 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that the recommendations contained in Minute 56/15 above be highlighted for the Board's approval. **Chair**

69/15 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality Assurance Committee be held on Thursday, 30 July 2015 from 1.00pm until 4.00pm in the Board Room, Victoria Building, LRI.

The meeting closed at 4:07pm.

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

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	3	1	33%	*C Ribbins*	3	1	33%
S Dauncey (Chair)	3	2	66%	*J Wilson*	3	3	100%
A Furlong	3	2	66%				

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
M Caple	3	2	66%	*K Singh*	3	3	100%
I Crowe	3	3	100%	*M Traynor*	3	3	100%
C O'Brien – East Leicestershire/Rutland CCG	3	2	66%	*R Moore*	3	3	100%

Hina Majeed
Trust Administrator