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: 5 May 2016

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Dr S Dauncey, QAC Chair

DATE OF COMMITTEE MEETING: 24 March 2016

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

- **None**

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

- **None**

DATE OF NEXT COMMITTEE MEETING: 28 April 2016

Dr S Dauncey
Non-Executive Director and QAC Chairman
26 April 2016

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY, 24 MARCH 2016 AT 1:00PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Dr S Dauncey – Non-Executive Director (Chair)
Mr M Caple – Patient Partner (non-voting member)
Colonel Ret'd I Crowe – Non-Executive Director
Mr J Jameson – Deputy Medical Director (on behalf of Medical Director)
Ms D Leese – Director of Nursing and Quality, Leicester City CCG (non-voting member)
Ms J Smith – Chief Nurse

In Attendance:
Mr J Davison – Consultant Orthopaedic Surgeon (for Minute 27/16/1)
Miss M Durbridge – Director of Safety and Risk
Mr A Johnson – Non-Executive Director
Ms S Khalid – Clinical Director, CSI (for Minute 27/16/2)
Mrs H Majeed – Trust Administrator
Mr M Metcalfe – Deputy Medical Director (for Minute 27/16/3)
Mr R Moore – Non-Executive Director
Mr R Power – Clinical Director, MSS (for Minute 27/16/1)
Ms C Ribbins – Deputy Chief Nurse
Mr K Singh – Trust Chairman
Mr M Traynor – Non-Executive Director

RESOLVED ITEMS

25/16 APOLOGIES

Apologies for absence were received from Mr J Adler, Chief Executive, Mr A Furlong, Medical Director, Professor A Goodall, Non-Executive Director and Mrs S Hotson, Director of Clinical Quality.

26/16 MINUTES

The Chief Nurse requested that the following words (commencing in March 2016) be included at the end of the last sentence in the first paragraph under Minute 18/16/2 and 'an Associate Nurse role' be replaced with 'the National Associate Nurse role' in the same section. **TA**

Resolved – that the Minutes of the meeting held on 25 February 2016 (paper A refers) be confirmed as a correct record subject to the above amendments. **TA**

27/16 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 17/16/1a – the Trust Chairman advised that the Trust Board Thinking Day session to discuss public and patient involvement would be scheduled in July or August 2016;
(ii) Minute 3/16a – the Chief Nurse advised that she had had discussions with the

Director of Workforce and Organisational Development regarding the Committee's request for workforce data on other staffing groups to be included within the Nursing and Midwifery report. She advised that there had recently been a number of requests for workforce data at a number of Committees. As the production of the Nursing and Midwifery Safe Staffing report was a statutory requirement, they had agreed that it would not be appropriate to include other staffing group detail within this report. Therefore, a separate report would be produced with workforce data relating to Doctors and Allied Health Professionals in a similar format to the Nursing and Midwifery report and this would be presented to the Executive Workforce Board. The Committee Chair noted the need for this report to be presented to QAC also. The Chief Nurse undertook to inform the Director of Workforce and Organisational Development regarding the Committee Chair's request; **CN**

(iii) Minute 3/16/3– the Chief Nurse advised that at the Women's and Children's CMG Quality and Safety Performance meeting, it had been made clear to CMG colleagues that a process was required in order to provide an audit trail of patients cancelled in each priority score. In response to a query from the Committee Chair, the Chief Nurse undertook to liaise with the CMG colleagues and confirm when an update on this matter would be available to QAC, and **CN**

(iv) Minute 5/16/5 – the Director of Safety and Risk advised that UHL was looking to appoint a Local Freedom to Speak Up (F2SU) Guardian based on the national approach, however, the Freedom to Speak Up National Guardian for the NHS had resigned in March 2016. NHS England had indicated that they would not be recruiting until Autumn 2016. Members suggested that the UHL should go ahead with appointing a Local F2SU Guardian. The Director of Safety and Risk undertook to provide a further update on this matter to QAC in May 2016. **DSR**

<u>Resolved</u> – that the matters arising report (paper B refers) be confirmed as a correct record and any associated actions be progressed accordingly by the relevant lead. **CN/ DSR**

27/16/1 <u>Update following review of underperformance of the Fractured Neck of Femur (#NOF) Target (Minute 5/16/7 of 28 January 2016)</u>

Mr R Power, Clinical Director, MSS and Mr J Davison, Consultant Orthopaedic Surgeon attended the meeting to present paper C, a report providing an update on UHL's Fractured Neck of Femur performance. Members were advised that fixed theatre capacity and inadequate flexibility to meet variable demand remained the fundamental issues in achieving the target of operating on all fit and optimised hip fracture patients within 36 hours of admission. The shortfall in Ortho-geriatrician cover for the hip fracture service was also a key challenge.

The factors that had led to the non-achievement of the #NOF target in quarter 3 of 2015-16 were:-

- inability to clear hip fracture cases at weekends;
- delays in reversing Warfarin;
- lack of laminar flow in the trauma theatres at LRI which was a fundamental barrier in performing total hip replacements at the LRI site, and
- delay in clinical decision making.

Principal improvements that were proposed to deliver the target in 2016 were better IT systems support to profile and manage demand, improved deployment and skill mix of the surgical workforce and further improvements in efficient pre-operative patient workup. It was noted that the Chief Trauma Resident role which was introduced in August 2015 had improve senior cover and supervision for weekday hip fracture lists in particular. Members were also advised that the introduction of the Autonomous team project would assist in

achieving all of the #NOF related improvement actions.

The Director of Nursing and Quality, Leicester City CCG expressed concern that there was no recovery plan with appropriate 'pace' to resolve the issues identified. In discussion on this matter, members noted the need for a well-articulated recovery plan with appropriate Corporate support in ensuring that infrastructure in terms of flexible theatre list capacity was made available to support the service. A meeting had been scheduled for 29th March 2016 to discuss ways to make theatre capacity more flexible and responsive to match variable acute demand. The Chief Nurse undertook to inform the Chief Operating Officer regarding the Committee's concerns and the need for Corporate support to be offered to the CMG in order to assist the achievement of this target. **CN**

The Committee Chair suggested that an update on this matter should be scheduled on the agenda for all future QAC meetings until members were satisfied that an action plan was in place and progress was being made. **MD/ CD, MSS**

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

(B) the Chief Nurse be requested to inform the Chief Operating Officer regarding the Committee's concerns and the need for Corporate support to be offered to the MSS CMG in order to assist the achievement of the #NOF target, and **CN**

(C) an update on #NOF performance be scheduled on all future QAC meeting agendas until members were satisfied that an action plan was in place and progress was being made. **MD/ CD, MSS**

27/16/2 Radiology Discrepancy Management (Minute 120/15/4 of 26 November 2015)

Ms S Khalid, Clinical Director, CSI attended the meeting to present paper D, an update on progress being made against identified improvement actions with regard to Radiology Discrepancy Management. Considering work practices and behaviours from a human factors and ergonomics perspective had been helpful in identifying additional actions that could be taken and improving engagement within the Radiology community.

The Clinical Director, CSI advised that the Medical Director had noted his support for implementing a form of quality assurance and discussion had taken place regarding how this could be further rolled-out and the mechanisms by which assurance could be obtained. It was noted that, in order to evaluate a reliable method of quality assurance, the Radiology Service was conducting a PDSA cycle whereby up to 5% of reporting activity for CT colon examination was subject to a formal peer review process for a 6 month time period, as commencing from January 2016. CT colon examination reporting had been identified as the first test area as it was a new service implemented this year.

The action plan was making good progress and developmental work was underway to strengthen the quality assurance process. In respect of the 15 actions on the action plan, 9 were complete, 3 were on-track and 3 were delayed. Two of the delayed actions related to IT actions (i.e. implementation of additional reporting workstations and communicator module within EMRAD). The other non IT delay related to implementation of a professional behaviour pyramid. This had been designed to improve interpersonal dynamics and team communication systems. An update on the 3 delayed actions was requested to be provided to QAC in September 2016. **CD, CSI**

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

(B) an update on the three actions that had been delayed in the 'Radiology

Discrepancy Action Plan' be provided to QAC in September 2016.

27/16/3 Quarterly Update on Cancer Performance including an update on quality dashboard for measuring cancer performance (Minute 120/15/8 of 26 November 2015)

Mr M Metcalfe, Deputy Medical Director attended the meeting to provide a quarterly update on cancer performance. The cancer two week wait target had been achieved in December 2015 for the first time in 2015-16 and although January 2016 performance had dipped to 91.4%, it had been delivered in February 2016. Improvement had been made to the 62 day backlog with the latest backlog down to 61 (from a peak of 116 in January). While momentum was growing with regards to backlog reduction, the main pressures remained robust patient pathways and supporting processes (i.e. inadequate theatre capacity).

The Deputy Medical Director requested the deferral of the production of the quality dashboard to measure cancer performance – this was accepted by the Committee and an update was requested to be provided to QAC in August/September 2016. **DMD**

Responding to a query, it was noted that a qualitative analysis of the emergency admissions was being undertaken to ascertain whether the admission was appropriate or not.

Responding to a further query, members were advised that a root cause analysis was undertaken for all 62 day breaches and a harm report was prepared for cancer patients breaching 104 days. It was also noted that the Trust's recent emergency care pressures had resulted in a large number of elective surgery cancellations including cancellation of patients due for cancer surgery. A LiA event focussing on cancer was held in November 2015 and the key message from this was that patients needed to leave every appointment knowing what the next step was and having an appointment booked. The Trust had initiated a programme 'Next Steps' for cancer patients in 3 key tumour sites, which would start in April 2016, initially with one tumour site and would be rapidly rolled out to all three.

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

(B) an update on the quality dashboard for measuring cancer performance be provided to QAC in August/September 2016. **DMD**

27/16/4 Update on areas where the Trust should be statutorily complaint and whether or not the Trust was achieving this compliance

In discussion, QAC members confirmed that a report be presented to QAC in May 2016 providing assurance that elements of statutory compliance were being achieved and any further actions that were required to remedy any shortfalls. The Director of Safety and Risk advised that she was in discussion with the Director of Clinical Quality and the Director of Estates and Facilities and a review of this data was being undertaken. **DSR**

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

(B) the Director of Safety and Risk be requested to present a report to QAC in May 2016 providing assurance that elements of statutory compliance were being achieved and any further actions that were required to remedy any shortfalls. **DSR**

28/16 COMPLIANCE

28/16/1 Report on Compliance with CQC Enforcement Notice

The Chief Nurse presented paper E, a report providing position in respect of compliance with CQC Enforcement Notice. She had a recent meeting with CQC colleagues and they had indicated that the weekly report would need to continue until further notice.

In respect of time to assessment (15 minute standard), 90% was being achieved, however, focus needed to be maintained in respect of this indicator. It was noted that a 'Triage Officer' would be recruited whose role would assist in sustaining the 'time to assessment' standard. Progress in respect of effective sepsis management needed to improve and the CQC had queried the data in respect of 30 patients per week being put on the sepsis pathway, highlighting that this was quite high. The Director of Safety and Risk advised that further to the NHSLA bid, Sepsis Nurses had been appointed and the main purpose of their role was to ensure that the sepsis pathway was being followed.

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

28/16/2 Update re. CQC Comprehensive Inspection

Paper F provided an update on the project plan and governance arrangements associated with planning for the comprehensive CQC inspection in June 2016. The Chief Nurse advised that a formal Provider Information Request (PIR) had recently been received from the CQC and it was a very lengthy document requesting detailed information on each of the service lines at each of the Trust's hospital sites. The final date for submission was 19 April 2016. Members noted the need for appropriate review of the PIR by senior colleagues prior to sending it to the CQC. Responding to a query on whether the Trust was adequately resourced to complete the PIR, it was noted that there were sufficient resources currently. In preparation for the forthcoming CQC visit in June 2016, a number of engagement sessions with staff had already taken place and a public listening event had been scheduled on 11 May 2016.

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

29/16 SAFETY

29/16/1 Mortality Review Committee – Internal Audit Action Plan

Members received and noted the contents of paper G noting that progress was on-track.

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

29/16/2 Complaints Performance Report

The Director of Safety and Risk presented paper H, a report providing a summary of complaints activity and performance for February 2016. The Trust's performance in responding to 10 and 25 day formal complaints in December 2015 was 100% and 95% respectively and 45 day formal complaints in November 2015 was 100%.

Members noted the table which provided an update on learning from complaints and concerns and highlighted that CMGs needed to take responsibility in respect of ensuring that any learning from complaints was appropriately actioned.

Responding to a query in respect of whether complaints data was used to inform patient stories at the Trust Board, the Deputy Chief Nurse confirmed that a year's worth of patient stories had already been planned for the Trust Board and these included positive and negative stories and were informed through complaints information and other data sources

as well.

Appendix 1 provided a breakdown of complaints relating to waiting times (waiting for surgery / procedure / admission, waiting for appointment, waiting for departure, waiting for results etc.). The Patient Partner noted that two CMGs had a high waiting list for appointments and queried the actions that were being taken to address those issues in particular. In response, the Director of Safety and Risk advised that the Patient Safety team sent a report to all CMGs on a monthly basis providing the complaint activity for their CMG broken down by ward/department and this was discussed at the respective CMG Quality and Safety Board meetings. The Director of Nursing and Quality, Leicester City CCG advised that there was insufficient assurance on actions that were being taken by CMGs to address the waiting times issues identified through complaints. In discussion on this matter, it was highlighted that CMG colleagues needed to be demonstrating responsibility for taking learning from their individual waiting times issues and showing actions from those learning. The Committee Chair undertook to contact the Director of Performance and Information regarding the Committee's request for assurance on actions taken to resolve the issues identified through patient complaints relating to waiting times. An update on this matter be provided to a future meeting of the QAC, as appropriate.

Committee Chair/ DPI

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

(B) the Committee Chair be requested to contact the Director of Performance and Information regarding the Committee's request for assurance on actions taken to resolve the issues identified through patient complaints relating to waiting times. An update on this matter be provided to a future meeting of the QAC, as appropriate.

Committee Chair/ DPI

29/16/3 <u>Patient Safety Report</u>

The Director of Safety and Risk presented paper I, the patient safety report for February 2016. It was noted that this report was discussed at the EQB meeting in March 2016 and in reference to the Trust's most recent SUIs occurring out of hours, particularly over Bank Holiday weekends, all Clinical Directors had been requested to urgently review the arrangements in place within their CMGs over the upcoming Easter Bank Holiday weekend.

Particular note was made of the fact that NHS Improvement had provided further details on the Healthcare Safety Investigation Branch which would come into existence in April 2016 and the fact that a new 'learning from mistakes' league table had been published which rated UHL as 'poor'. Members discussed the particular indicators on which these findings had been predicated, one of which related to four questions posed within the 2015 NHS staff survey. In discussion on the 'learning from mistakes' league table, it was noted that staff needed to be empowered to report concerns and the culture needed change and this would be discussed with CMG colleagues at their respective CMG Quality and Safety Performance Review meetings. It was also noted that an LiA/staff engagement event on this issue would be held. It was also suggested that contact be made with Trusts who had scored well on the 'learning from mistakes' league table and any learning lessons be considered.

The Director of Safety and Risk reported that UHL had been awarded first place in a recent 'Human Factors, Safety Culture and Sharing Event'.

<u>Resolved</u> – that the contents of paper I be received and noted.

29/16/4 <u>Health and Safety Executive (HSE) Sharps Improvement Notice - Update</u>

The Director of Safety and Risk advised that the HSE had extended the deadline to 15 April 2016 by which time the Trust was to meet the requirements of the HSE Sharps Improvement Notice. A reminder communication to Heads of Service (copied to Clinical Directors and Heads of Nursing) emphasising the need for immediate removal of all 'unsafe' sharps had been issued.

Resolved – that the verbal update be received and noted.

29/16/5 Report from the Deputy Chief Nurse

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

29/16/6 AQuA Development Programme on 1 and 2 March 2016 – Action Plan

The Chief Nurse advised that UHL's Executive and Non-Executive Directors participated in the AQuA Board Development Programme which was held on 1 and 2 March 2016. Paper J1 was the action plan following this session – this was received and noted.

Resolved – that the contents of paper J1 be received and noted.

30/16 PATIENT EXPERIENCE

30/16/1 Patient Experience Triangulation Report (Quarter 3 – 2015-16)

The Deputy Chief Nurse presented paper K 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 addition of feedback from carers had been included in this quarter.

The Deputy Chief Nurse advised that the top theme for improvements overall remained around waiting times (for appointments, clinics, Emergency Department and treatment in the department) and was the focus of over a quarter of all feedback for improvements. The year-on-year trend showed that the number of improvements with regards to waiting times had risen for the last two quarters. The data showed a reduction in feedback for improvement around medical care and car parking which was positive. During quarter three, the top 3 themes from the triangulation of patient feedback during quarter 2 were examined. Each CMG had provided evidence of their response to these themes and this showed the extensive activity that had taken place over 3 months in response to patient feedback.

Section 5.11 provided a table with the actions that had been taken following the presentation of patient stories to the Trust Board in quarter 3 of 2015-16. Appendix 1 provided the full list of feedback received per quarter which members found valuable.

The Chief Nurse advised that the Trust was shortlisted for a FFT award based on the patient experience triangulation report.

Resolved – that the contents of paper K received and noted.

30/16/2 Friends and Family Test Scores – January 2016

The Deputy Chief Nurse presented paper L, a report on the friends and family test scores for January 2016. The 43.8% coverage in Maternity was impressive. The peer analysis for the Inpatient FFT data in December 2015 had ranked UHL in fifth position. It was noted

that the Outpatients coverage was an internal target and not a national requirement. The Deputy Chief Nurse advised that consideration was being given to ways by which outpatient coverage could be improved.

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

31/16 QUALITY

31/16/1 Items for the attention of QAC from EQB Meeting on 15 March 2016

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

31/16/2 Nursing and Midwifery Safe Staffing Report

The Chief Nurse presented paper N, a report providing the current nursing and midwifery staffing position within UHL for January 2016. There was a reduction in the number of Registered Nurse vacancies, however, an increase in the number of Healthcare Assistant vacancies was noted. The use of bank nurses had increased to 60% with a reduction of agency use to 40%. Nurse bank now had the ability to cover the equivalent of 200 registered nurse posts, this was previously 120. An update on the Chief Nurse's view on the wards highlighting any concerns was also provided.

In response to a query from Mr R Moore, Non-Executive Director, the Chief Nurse undertook to double-check the possible discrepant figures in relation to the 'night care staff fill-rate at GGH PICU' as outlined in the last page on appendix 1 of paper N and provide a response to him outwith the meeting. **CN**

Responding to a query, the Chief Nurse provided a brief update on the assistance being offered to health care assistant applicants in respect of the tests they were required to complete. She also advised that consideration was being given to recruiting health care assistants from overseas.

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

(B) the Chief Nurse be requested to double-check the possible discrepant figures in relation to the 'night care staff fill-rate at GGH PICU' as outlined in the last page on appendix 1 of paper N and provide a response to Mr R Moore, Non-Executive Director outwith the meeting. **CN**

31/16/3 CQUIN and Quality Schedule (QS) Update – Quarter 3 (2015-16) Performance and Predicted RAG and 2016-17 CQUIN and QS Schemes

The Chief Nurse presented papers O1 and O2, a report detailing CQUIN and Quality Schedule 2015-16 quarter 3 performance and 2016-17 schemes respectively. 13 Quality Schedule indicators had been RAG rated 'amber' and 5 'red'. 4 CCG monitored CQUINs had been rated 'amber' due to perceived lack of progress in quarter 3 of 2015-16. 2 of the National Schemes (i.e. AKI and Sepsis) had been rated 'red' due to not achieving locally agreed improvement thresholds. The 2016-17 guidance had been published with details of the National CQUIN schemes, the Specialised Services mandated and 'pick list' schemes and also the Local CQUIN schemes 'pick list'. Particular discussion took place on the following national CQUINs that would be applicable to UHL:-

- NHS staff health and wellbeing;
- Identification and early treatment of Sepsis;
- Cancer 62 day waits, and

- Antimicrobial resistance.

Ms D Leese, Director of Nursing and Quality, Leicester City CCG who chaired the Clinical Quality Review Group (CQRG) which monitored UHL's performance with the Quality Schedule and CQUIN indicators commented that in respect of the predicted performance for 2015-16, whilst there had been improvement for some of the indicators, there had also been deterioration for some indicators. From a quality and safety point of view, Commissioners would carry forward the end of year position so that this would not be lost. She highlighted that as far as CQUINs for 2016-17 were concerned, there was an intention to have the financial incentive remain and some of the indicators carried quite a large 'weighting' and therefore the Trust might want to focus on achievement of these. Local CQUINs had been discussed at CQRG and there had been a very collaborative approach.

Resolved – that the contents of papers O1 and O2 be received and noted.

31/16/4 First Draft of Quality Account 2015-16

The Chief Nurse requested members to feedback any comments on the first draft of the Quality Account 2015-16 (paper P) to the Director of Clinical Quality before end of 1 April 2016. Ms D Leese, Director of Nursing and Quality, Leicester City CCG advised that she would not be making any comments as she would be managing the consultation process – this was agreed.

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

(B) all members (except the CCG Representative) be requested to feedback any comments on the first draft of the Quality Account 2015-16 to the Director of Clinical Quality before end of 1 April 2016. **ALL**

31/16/5 Quality Commitment 2016-17 Update

The Chief Nurse advised that the 2016-17 Quality Commitment would be included as part of the Trust's Annual Operational Plan 2016/17.

Resolved – that the verbal update be received and noted.

31/16/6 Month 11 – Quality and Performance Update

Paper Q provided an overview of the February 2016 Quality and Performance (Q&P) report. The following points were noted in particular:-

(a) disappointing performance in respect of the achievement of the #NOF target;
(b) ambulance turnaround times;
(c) FFT – Emergency Department coverage continued to be low;
(d) 1 Grade 4 pressure ulcer;
(e) 1 Same Sex Accommodation breach – this was due to estates set-up. CMG colleagues had been requested to undertake an options appraisal;
(f) the latest published SHMI (covering the period June 2014 to June 2015) had fallen to 95 – this compared to a peak of 105;
(g) Cdiff performance remained within year to date trajectory, and
(h) concern was expressed in respect of readmissions within 30 days. In response, the Deputy Medical Director acknowledged the concerns and advised that a review was being undertaken.

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

32/16 ANNUAL REPORTS FROM EQB SUB COMMITTEES

32/16/1 Adverse Events Committee Annual Report

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

32/16/2 Thrombosis Prevention Committee Annual Report

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

33/16 MINUTES FOR INFORMATION

33/16/1 Executive Quality Board

Resolved – that the action notes of the 15 March 2016 Executive Quality Board meetings (paper T refers) be received and noted.

33/16/2 Executive Performance Board

Resolved – that the action notes of the 23 February 2016 Executive Performance Board meeting (paper U refers) be received and noted.

33/16/3 QAC Calendar of Business

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

34/16 ANY OTHER BUSINESS

34/16/1 Report following CQC's inspection of the Trust's Emergency Department

The Chief Nurse advised that the report following CQC's inspection of the Trust's Emergency Department in November 2015 was expected to be published week commencing 28 March 2016.

Resolved – that the verbal update be noted.

35/16 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality Assurance Committee be held on Thursday, 28 April 2016 from 1.00pm until 4.00pm in the Board Room, Victoria Building, LRI.

The meeting closed at 4:45pm.

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

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	12	8	66	*C Ribbins (Acting Chief Nurse capacity)*	4	1	25
I Crowe	12	12	100	*J Smith*	8	7	88

S Dauncey (Chair)	12	10	83	*J Wilson*	9	9	100
A Furlong	12	7	58				

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
M Caple	12	9	75	*K Singh*	12	11	92
C O'Brien – East Leicestershire/Rutland CCG	6	3	50	*M Traynor*	12	11	92
A Johnson	5	5	100	*R Moore*	12	12	100
D Leese – Leicester City CCG	6	5	83				

Hina Majeed, **Trust Administrator**