Trust Board Paper R

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 October 2016

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Mr A Johnson, Acting Chair

DATE OF COMMITTEE MEETING: 25 August 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:

- **Minute 83/16/6 – Nursing and Midwifery Quality and Safe Staffing Report – particularly recruitment and retention initiatives for Registered Nurses and Health Care Assistants;**
- **Minute 84/16/1 – Sepsis and Managing the Deteriorating Patient Update (within the Report on compliance with CQC Enforcement Notice and CQC Comprehensive Inspection Update), and**
- **Minute 85/16/4 – Freedom to Speak Up Update.**

DATE OF NEXT COMMITTEE MEETING: 29 September 2016

Mr A Johnson
Non-Executive Director and Acting QAC Chairman
22 September 2016

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY 25 AUGUST 2016 AT 1PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Mr A Johnson – Non-Executive Director (Acting Chair)
Mr J Adler – Chief Executive (from Minute 83/16/4)
Mr M Caple – Patient Partner (non-voting member)
Mr M Metcalfe – Deputy Medical Director (on behalf of the Medical Director)
Mr R Moore – Non-Executive Director
Mr B Patel – Non-Executive Director
Ms F Pimm – Acting Deputy Director of Nursing, Leicester City CCG (on behalf of Acting Director of Nursing and Quality)
Mr K Singh – Trust Chairman (until and including Minute 85/16/4)
Ms J Smith – Chief Nurse
Mr M Traynor – Non-Executive Director

In Attendance:
Miss M Durbridge – Director of Safety and Risk
Mr J Jameson – Deputy Medical Director (for Minute 85/16/1 and 85/16/2)
Mrs S Hotson – Director of Clinical Quality (until part Minute 83/16/6)
Mrs H Majeed – Trust Administrator
Ms C Ribbins – Deputy Chief Nurse
Ms L Tebbutt – Head of Performance and Quality Assurance (for Minute 83/16/1)

RESOLVED ITEMS

80/16 APOLOGIES

Apologies for absence were received from Colonel (Retired) I Crowe, Non-Executive Director (Chair), Dr A Doshani, Associate Medical Director, Mr A Furlong, Medical Director, Ms K Kingsley, Acting Director of Nursing and Quality, Leicester City CCG, and Ms L Tibbert, Director of Workforce and Organisational Development.

81/16 MINUTES

Resolved – that the Minutes of the meeting held on 28 July 2016 (papers A1 & A2 refer) be confirmed as a correct record.

82/16 MATTERS ARISING

Paper B detailed both the actions from the most recent meeting, and also any which remained outstanding from previous QAC meetings. Members agreed that Minute 3/16a of 28 January 2016 could now be closed as it had been superseded by the new IFPIC workforce update which had been developed. **TA**

Resolved – that the matters arising report (paper B refers) be confirmed as a correct record and any associated actions be noted and taken forward by the appropriate lead. **TA**

83/16 QUALITY

83/16/1 Facilities Update

The Head of Performance and Quality Assurance attended the meeting and advised verbally that improvements had been made since the the 1 May 2016 transfer of facilities management staff back to UHL employment from IFM. Many staff had taken up the option of increasing their working hours. It was noted that some staff currently on IFM contracts (who had been transferred to UHL) were re-applying to UHL contracts and were resigning from their current role once a UHL job offer was made. Some of these applicants who were not getting through the shortlisting stage via the UHL recruitment processes and in this case where being offered training/ learning and development support.

Members were also advised that assistance from the Human Resources team was being sought to consider the support that could be offered to facilities management staff whose first language was not English.

The UHL Cleaning Forum had been re-instated and improvements in cleaning standards had been reported by a number of areas. However, the results of the PLACE audits undertaken in March 2016, prior to the termination of the Interserve contract had been very disappointing – an update on this matter was scheduled to be provided to Executive Quality Board (EQB) and QAC in September 2016.

An action plan had been developed for each area following the issues highlighted by the PLACE audits and the in-house takeover of the service provision. The Director of Safety and Risk undertook to ensure that the Risk and Safety Manager liaised with the Director of Estates and Facilities to review the results of the PLACE audits to identify if there were any safety issues that needed to be addressed immediately. **DSR**

Responding to a query from the Patient Partner, the Head of Performance and Quality Assurance advised that she had not been notified of any complaints relating to high costs in respect of minor repairs. She also highlighted that she had good working relationship with the repairs team and any minor repairs were usually resolved quickly. In response to a further query in respect of the multi-skilled service provision of catering and cleaning services by domestic staff, it was noted that discussions were on-going with staff in respect of this provision and any members of staff who were not comfortable with this would be offered alternative arrangements. The Head of Performance and Quality reiterated that multi-skilled service provision was a good way forward provided staff were given the time to carry out their duties and also provided appropriate training.

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

(B) the Director of Safety and Risk be requested to ensure that the Risk and Safety Manager liaised with the Director of Estates and Facilities to review the results of the PLACE audits to identify if there were any safety issues that needed to be addressed immediately. **DSR**

83/16/2 <u>Quality Commitment 2016-17 Quarter 1 Report</u>

The Director of Clinical Quality presented paper C and advised that good progress had been made overall in quarter 1 of 2016-17 in respect of the overarching key performance indicators for Clinical Effectiveness, Patient Safety and Patient Experience within the Quality Commitment. Despite the headline measures being met, there was further work required to ensure that the following workstreams were appropriately managed – i.e. readmissions, sepsis, seven day services and managing the deteriorating patient. The measures for these quality commitment actions would be required to reflect current work programmes that had been put in place to manage this agenda.

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

83/16/3 2016-17 CQUIN and Quality Schedule Schemes

The Director of Clinical Quality presented paper D advising that this report had also been presented to the Clinical Quality Review Group in August 2016. There were 39 indicators in the 2016-17 Quality Schedule (QS) but most of these had more than one metric where performance was measured (i.e. Infection Prevention) and some had a suite of metrics within the indicator (i.e. #NOF). There were 3 nationally set CQUIN schemes applicable to UHL in 2016-17 and the Trust had agreed 5 local CQUINs with the CCGs, again most had several sub-indicators. There were two mandated NHS England Specialised Services (NHSE) CQUINs for 2016-17 and a third 'must do' scheme, with an additional eight schemes taken from the national 'pick list'.

In summary, it was noted that there were 11 QS/CQUIN indicators in respect of which the Trust had not achieved the 2016-17 quarter 1 thresholds. The Chief Nurse commented that it was unfortunate that the metrics measured by the national CQUIN were different from the NICE guidance and therefore separate reports had to be produced which was a time-consuming exercise.

In respect of the indicators which had been RAG rated 'red' in quarter 1, it was noted that (a) the Medical Director was working with colleagues to ensure compliance was improved with #NOF time to theatre thresholds ; (b) 'Stroke and TIA monitoring' – work was in progress to put actions in place to cope with varying demand in that service, and (c) the Clinical Utilisation Review tool was one of the NHS England Specialised Services CQUIN and because UHL had opted to pursue an 'in house solution' rather than subscribe to one of the 'NHSE framework company's software', the Trust would not be meeting the CQUIN thresholds for this indicator during 2016-17.

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

83/16/4 Whistleblowing Report

The Director of Clinical Quality presented paper E, an overview of the whistleblowing incidents reported between 1 April and 30 June 2016, the concerns raised and themes, learning/actions taken, and response/feedback. The incidents were identified through a number of whistleblowing routes (i.e. CQC, gripe tool and HR routes).

In discussion, members commented that given the size of UHL, the number of reported whistleblowing incidents seemed low. The Chief Nurse acknowledged this, however, highlighted that some issues were resolved locally. The Director of Clinical Quality undertook to consider whether a trend analysis could be included in future reports and it was highlighted that some of this information would be included in the safe staffing dashboard in future. **DCQ**

The Director of Safety and Risk provided a brief update on the gripes reported through the junior doctors' gripe tool. The gripes had been themed and majority of the gripes related to IT systems which were being resolved accordingly.

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

(B) the Director of Clinical Quality be requested to consider whether a trend analysis could be included in future whistleblowing reports. **DCQ**

83/16/5 Schedule of External Visits

The Director of Clinical Quality presented paper F, which detailed completed visits to the

Trust by external bodies along with a RAG rating describing progress against resulting actions and the second schedule detailed the forthcoming visits. In addition to being discussed at EQB, this report was also discussed at CMG Quality and Performance review meetings where CMGs were requested to report on progress with these visits.

A brief discussion took place regarding recommendations arising from peer reviews noting that a judgement needed to made on the absolute priorities, however, it was highlighted that the National Cancer Peer Review model was much more established and standardised.

A 2016 self-declaration process for both non-cancer specialised services and specialised services was underway and a summary report was expected to be presented to the Executive Strategy Board in October 2016.

The Director of Safety and Risk made members aware that a visit from Trading Standards was expected week commencing 5 September 2016 to review baby weighing scales – the Women's and Children's CMG had undertaken a brief self-assessment and it was expected that the Trust would be complaint with the standards.

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

83/16/6 Nursing and Midwifery Quality and Safer Staffing Report – June 2016

The Chief Nurse presented paper G, a report providing the current nursing and midwifery staffing position within UHL for June 2016. There continued to be a high number of wards within each of the CMGs that were triggering a level 1 concern predominantly due to non-achievement of the nursing metrics, which was an expected outcome of the changes made to the metrics. There were also an increased number of level 2 concern wards, again mainly due to the nursing metrics. There had been a number of occasions during June 2016 where wards had declared an unmanageable shortfall in staffing and required Director Support. The percentage of bank fill versus agency for June 2016 had maintained a 60/40 split, in favour of bank.

The Chief Nurse provided a comprehensive update on the recruitment and retention initiatives for Registered Nurses (RN) and Health Care Assistants (HCA) – the following were highlighted in particular:-

- student nurse recruitment to HCA Bank only posts;
- a challenge had been set for recruiting 100 HCAs prior to winter 2016;
- agreement with Derby University and HEE-EM to support a Leicestershire cohort for Return to Practice Nurses in November 2016 with resources to support advertising and recruitment (there were 5000 qualified nurses on this database);
- centralised recruitment activities;
- a bid had been placed for a Nurse Associate role, and
- the Chief Nurse was now a member of the National Supply Nurse Group.

A national approach to mentoring was being piloted with CMG Heads of Nursing and Matrons. Committee members also provided a number of suggestions to improve nurse recruitment. In response, the Chief Nurse acknowledged these, however, highlighted the need for internal recruitment processes to be streamlined and advised that she was liaising with the Director of Workforce and Organisational Development to resolve some of the issues. The Chief Nurse undertook to ensure that all these initiatives would be monitored and a regular consolidated report would be produced to provide update on progress. The Committee also noted ongoing discussions with De Montfort University in respect of the self-funded nursing courses.

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

83/16/7 Month 4 – Quality and Performance Update

The Committee received a briefing on quality and performance for August 2016 (paper H refers) from the Chief Nurse. The following points were highlighted in particular:-

(a) mortality – the latest published SHMI (covering the period January 2015 to December 2015) was 98 – below the Trust's Quality Commitment of 99;
(b) one unavoidable case of MRSA, however, discussions were on-going with Public Health England regarding which NHS Trust the case should be attributable to;
(c) deterioration in performance in respect of ambulance handovers and 62 day cancer standards;
(d) no grade 4 pressure ulcers, and
(e) 1 same sex accommodation breach.

Members commented that the new format Q&P report (appendix 1 of paper H) was good.

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

84/16 COMPLIANCE

84/16/1 Report on Compliance with CQC Enforcement Notice and CQC Comprehensive Inspection Update

The Chief Nurse presented paper I, a report on the Trust's compliance with the CQC Enforcement Notice in respect of ED and paper J, a report detailing the CQC comprehensive inspection.

The Committee was advised that weekly updates were being provided to the CQC in respect of Emergency Department (ED) time to assessment (15 minute standard), ED staffing and sepsis care bundle (screening and antibiotics) for patients presenting to the ED.

Further assurance had now been requested by the CQC following their 'announced inspection' in June 2016 in respect of both recognition and timely intervention for patients with 'red flag' sepsis and more generally the deteriorating patient within assessment units and inpatient areas. The Chief Nurse and Medical Director had agreed to provide further assurance on a weekly basis to the CQC in respect of compliance with the Trust's Early Warning Score (EWS) escalation process.

In order to facilitate this, the Nurse in Charge on each ward had been requested to complete an EWS monitoring proforma at shift handover (i.e. twice a day) that during their shift all patients' EWS had been reviewed and appropriate escalation had been undertaken. The proforma would also capture reasons/themes for any delays in timely recognition or intervention. This would be collated into a ward compliance report that would be reviewed on a weekly basis by the Medical Director and Chief Nurse and shared with the CQC on a weekly basis starting from 26 August 2016.

As an additional check, Matrons would be spot auditing the validity of the returns. The Trust was currently in the process of rolling out Electronic Observations (eOBs) system with clinical escalation triggers for both the deteriorating patient, using the EWS criteria. This would be in place in all clinical areas by end of October 2016 – eOBs was currently clinically 'live' on 35 / 89 of wards.

Discussion with Sherwood Forest NHS Foundation Trust had confirmed that introduction of

such an electronic system was one of the most important factors in providing real time oversight of the process and changing culture within the organisation.

In response to a suggestion from the Chief Executive, the Director of Safety and Risk undertook to liaise with the Chief Nurse in respect of including an additional question on the safety walkabout feedback form in respect of the new EWS monitoring at shift handover. **DSR**

NHSLA-funded sepsis nurses had been appointed to support identification and implementation of the Sepsis 6 care bundle actions and would be in place from end of September 2016.

Resolved – that (A) the contents of papers I and J be received and noted, and

(B) the Director of Safety and Risk be requested to liaise with the Chief Nurse in respect of including an additional question on the safety walkabout feedback form on the new EWS monitoring at shift handover. **DSR**

85/16 SAFETY

85/16/1 Seven Day Services Update

Mr J Jameson, Deputy Medical Director attended the meeting to present paper K, progress on seven day services workstream.

Members were briefed on the background to UHL being a Early Implementer Site for Seven Day Services, highlighting that Seven Day Services had also become a strand of the Urgent and Emergency Care Vanguard. The aim of the Early Implementer Programme was to offer Seven Day Services to 25% of the population in England by March 2017. The focus of the Early Implementer sites was on delivery of the 4 "priority" clinical standards in the 3 major specialities of General Medicine, General Surgery and Women's and Children's.

It had been assumed initially that in being part of this programme, there would be investment (pump priming) but in December 2015 NHS England had confirmed that there would be no funding for Early Implementer Sites. It was highlighted that UHL's overall view with respect of where the Trust's major challenges were in respect of Seven Day Services currently remained unchanged and these were - CDU and the cardiorespiratory base wards at GGH, Imaging at GGH and on-going review for medical patients at the LRI. NHS Improvement/NHS England (NHSE) had been informed of UHL's concerns about the workforce and financial implications for UHL of meeting the 4 "priority" clinical standards in the 3 major specialities by March 2017.

Members were advised that there would be a further joint meeting with NHS Improvement/NHS England and UHL on 14 September 2016. In preparation for this meeting, the Trust was preparing a joint report with NHSE that provided a validation of whether the approaches UHL had been taking to compliance were correct. In particular, whether the resource requirements had been correctly identified, and in doing so, confirm that this was the agreed approach to achieving compliance with each standard and provide a confirmation of the resource requirement. It was highlighted that the Trust would try and come to a joint position on what was achievable by March 2017 with no additional resource and if there was limited resource, would identify the priority areas.

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

85/16/2 Sepsis/Managing Deteriorating Patient Update

Members noted that an update on this matter had been covered under the 'Report on compliance with CQC Enforcement Notice and CQC Comprehensive Inspection Update' section (Minute 84/16/1 above refers).

Resolved – that (A) the position be noted, and

(B) the contents of paper L be noted.

85/16/3 Report from the Director of Safety and Risk (Paper M):-

- Patient Safety Report – July 2016
- Complaints Performance Report – July 2016
- Executive Safety Walkabout Report;
- NHSLA Safety Improvement Work Update, and
- Trust Board Serious Incident Vignette and Learning Bulletin.

Paper M appendix 1 detailed patient safety data for UHL for July 2016. Members were advised that the number of incidents being reported and the number of prevented patient safety incidents reported (near misses) had increased which reflected a good safety culture. However, the incidence of harm had decreased.

Paper M appendix 2 summarised complaints activity and performance for July 2016. There had been a further deterioration in complaints performance for 10 day complaints, however, 25 and 45 day complaints performance remained consistent. There had been some improvement this month in reducing the percentage of re-opened complaints. CMGs were requested to review their re-opened complaint themes and implement actions to better resolve issues identified by complainants. Positive feedback had been received from the Independent Complaints Review Panel that had met on 14 June 2016. Members were advised that consideration would be given to the Independent Complaints Review Panel undertaking a review of concerns and reopened complaints (highlighting that the panel currently only reviewed formal complaints).

Paper M appendix 3 provided an update on the patient safety walkabout programme. Safety walkabouts to sites other that the LRI in total made up 18% of the total walkabouts undertaken. It was highlighted that there needed to be more focus on walkabouts at the GH, LGH, Alliance and Satellite sites.

Paper M appendix 4 outlined the updated position for each work stream and the progress against action plan by RAG rating in respect of the NHSLA bid programme. University College London (UCL) had been commissioned by NHSLA to undertake an evaluation of the funding provided by them for the safety improvement work to NHS Trusts. UCL had contacted UHL in respect of this.

The Director of Safety and Risk advised that as part of the AQuA action plan, it was agreed that the Trust Board would receive a patient story vignette and recent serious incident learning bulletins every month (Paper M appendix 5 refers). It was proposed that the patient story slot at Trust Board would be used on a quarterly basis to consider a SUI starting from December 2016. Responding to a query from the Patient Partner, the Director of Safety and Risk advised that in respect of concerns reported, it was the wish of the patient/relative that these were not recorded as formal complaints. In discussion, the Director of Safety and Risk advised that she attended CMG Quality and Safety Board meetings at least once a year and provided feedback to CMG colleagues on discussions being held at these meetings and reiterated the level of focus that needed to be given to

discussions relating to patient safety aspects.

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

85/16/4 Freedom to Speak Up Update

The Director of Safety and Risk presented paper N, an update on the Government's response to the Francis 'Freedom to Speak Up Report' and an action plan in line with NHS Improvement (NHSI) requirements to appoint a local Freedom to Speak Up Guardian.

The Director of Safety and Risk advised that according to NHSI, all Trusts were required to develop plans for Freedom to Speak Up Guardian post by September 2016 and to have appointed the Guardian by March 2017. However, recent advice from the CQC had indicated that the F2SU Guardian should be nominated by October 2016.

The required internal consultation with staff with respect to the guardian role would commence in September 2016. A pulse-check survey would also be undertaken. A number of Trusts had been contacted to discuss the model that they were intending to use for the appointment of the Guardian – a combination of models was being used and the Director of Safety and Risk suggested that an integrated internal model might be best-fit for UHL. This model would have one internal member of staff as the main F2SU Guardian with a number of F2SU Ambassadors from different parts of the Trust who would work under the Guardian.

In response to queries about the role of the F2SU Guardian, the Director of Safety and Risk provided a brief update on the job description of this role highlighting that the appointed individual would develop strong and open working relationships with the Chief Executive, NEDs and other Directors, with direct access to Trust leaders as required.

The Chief Executive noted the need for a clear steer to be received through the staff consultation regarding whether an external appointment would actually be preferable to staff. Given the recent CQC advice to have the F2SU Guardian nominated by October 2016, the Chief Executive requested that an initial update on the programme be provided to Trust Board on 1 September 2016 with a further update to Trust Board on 6 October 2016. **DWOD**

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

(B) an initial update on the programme to nominate the F2SU Guardian be provided to Trust Board on 1 September 2016 with a further update to Trust Board on 6 October 2016. **DWOD**

85/16/5 Quarterly Mortality Report

The Chief Nurse presented paper O, quarterly mortality report on behalf of the Medical Director. The report provided details of UHL's mortality rates and the Trust's mortality review findings for 2015-16, where available. It also described actions that had been taken to reduce the Trust's mortality rates and in response to issues identified through mortality reviews.

Members were advised that the Medical Examiner process had commenced at the LRI on 4 July 2016. Whilst still in the early implementation phase, the Medical Examiners had already led to a significant increase in the number of deaths that were being 'screened' and positive feedback had been received from both junior doctors and bereaved relatives. There had been a reduction in SHMI and HSMR despite increase in activity.

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

86/16 PATIENT EXPERIENCE

86/16/1 National Cancer Patient Experience Survey (CPES) Results 2015

The Deputy Chief Nurse presented paper P, an overview of the National Cancer Patient Experience Survey (CPES) 2015 results for UHL. The publication of the CPES saw a good response rate from UHL and highlighted that 72% of responses of patient experience were comparable with similar size Trusts based on case mix variables including age, gender, ethnicity, deprivation and tumour group. The NHS Cancer Dashboard reflected four key patient experience domains including provision of information, involvement in decisions, care transition, interpersonal relationships and respect and dignity. UHL responses within these domains were within the expected range although the rating for overall care scored marginally lower than the national average. UHL had scored 10% higher than the national average when asking patients 'what name they preferred to be called by' and 9% higher in 'discussing cancer research with patients'. 24% of responses indicated areas for improvement.

Members were advised that this was the fifth iteration of the cancer patient experience survey undertaken at UHL. However, the format of the 2015 survey had significantly changed and therefore it had not been possible to compare the results of this survey with the previous years' results.

It was also noted that Ms J Pickard had been appointed as the Macmillan Lead Cancer Nurse and she was also a member of the Patient Involvement, Patient Experience and Equality Assurance Committee (PIPEEAC). The Deputy Medical Director highlighted that Ms Pickard's experience would assist in improving the patient experience of cancer patients.

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

86/16/2 Friends and Family Test Scores – June 2016

The Deputy Chief Nurse presented paper Q, an overview of FFT scores for June 2016. The 62% coverage in Maternity was impressive. SMS texting in outpatients had been trialled and full roll-out in all Outpatient clinics was expected to be completed by end of August 2016.

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

87/16 ITEMS FOR INFORMATION

Learning from Claims and Inquests

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

88/16 MINUTES FOR INFORMATION

Resolved – that the following Minutes/items be received for information:-

(A) Executive Quality Board – 2 August 2016 (papers S refers);
(B) Executive Performance Board – 26 July 2016 (paper T refers), and
(C) QAC calendar of business (paper U refers).

89/16 ANY OTHER BUSINESS

There were no items of any other business.

90/16 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that (A) a summary of the business considered at this meeting be presented to the Trust Board meeting on 1 September 2016, and

(B) the following items be particularly highlighted for the Trust Board's attention:-

- **Minute 83/16/6 – Nursing and Midwifery Quality and Safe Staffing Report – particularly recruitment and retention initiatives for Registered Nurses and Health Care Assistants;**
- **Minute 84/16/1 – Sepsis and Managing the Deteriorating Patient Update (within the Report on compliance with CQC Enforcement Notice and CQC Comprehensive Inspection Update), and**
- **Minute 85/16/4 – Freedom to Speak Up Update.**

91/16 DATE OF NEXT MEETING

Resolved – that (A) the proposed schedule of 2017 meeting dates be approved (as detailed in paper V), and

- **Thursday 26 January 2017;**
- **Thursday 23 February 2017;**
- **Thursday 30 March 2017;**
- **Thursday 27 April 2017;**
- **Thursday 25 May 2017;**
- **Thursday 29 June 2017;**
- **Thursday 27 July 2017;**
- **Thursday 31 August 2017;**
- **Thursday 28 September 2017;**
- **Thursday 26 October 2017;**
- **Thursday 30 November 2017, and**
- **Thursday 21 December 2017.**

(B) the next meeting of the Quality Assurance Committee be held on Thursday 29 September 2016 from 1pm until 4pm in the Board Room, Victoria Building, LRI.

The meeting closed at 4.10pm.

Hina Majeed – **Trust Administrator**

Cumulative Record of Members' Attendance (2016-17 to date):
Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	5	4	80	*A Johnson*	5	5	100
P Baker	2	0	0	*K Kingsley*	2	0	0
I Crowe	5	4	80	*R Moore*	5	5	100
S Dauncey (Chair)	3	3	100	*K Singh*	5	5	100
A Furlong	5	3	60	*J Smith*	5	3	60
A Goodall	2	0	0	*M Traynor*	5	5	100

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
M Caple	5	4	80	*D Leese – Leicester City CCG*	2	0	0
M Durbridge	5	5	100	*C Ribbins*	5	5	100
S Hotson	5	4	80	*L Tibbert*	4	1	25