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: 7 July 2016

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Dr S Dauncey, QAC Chair

DATE OF COMMITTEE MEETING: 26 May 2016

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

- **Quality Account 2015-16 and Statement of Directors' Responsibilities** – to be recommended for approval by the 2.6.16 Trust Board and included on that agenda accordingly. The Quality Account had also been presented to the 25.5.16 Audit Committee and included comments from stakeholder and patient organisations. External Audit comments were still awaited and were hoped to be received by the 2.6.16 Trust Board. It was noted that the Quality Account 2015-16 was required to be published on the NHS Choices website by 30.6.16.

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

- **None**

DATE OF NEXT COMMITTEE MEETING: 30 June 2016

Dr S Dauncey
QAC Chairman
1 July 2016

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY 26 MAY 2016 AT 1PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Dr S Dauncey – Non-Executive Director (Chair) (up to and including Minute 52/16/2)
Mr J Adler – Chief Executive
Colonel Ret'd I Crowe – Non-Executive Director (Acting Chair from Minute 52/16/3)
Mr A Furlong – Medical Director
Ms D Leese – Director of Nursing and Quality, Leicester City CCG (non-voting member)

In Attendance:
Mr S Barton – Director of CIP and Future Operating Model (for Minute 53/16/5)
Mrs R Broughton – Head of Outcomes and Effectiveness (for Minutes 51/16/6 and 53/16/4)
Dr A Doshani – Associate Medical Director
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Mr A Johnson – Non-Executive Director
Mr D Kerr – Director of Estates and Facilities (for Minute 52/16/1)
Mr W Monaghan – Director of Performance and Information (for Minutes 51/16/1 and 51/16/2)
Mr R Moore – Non-Executive Director
Ms C Ribbins – Deputy Chief Nurse
Mr K Singh – Trust Chairman
Ms H Stokes – Senior Trust Administrator
Ms E Tebbutt – Head of Performance and Quality Assurance (for Minute 51/16/5)
Mr M Traynor – Non-Executive Director

RECOMMENDED ITEMS

46/16 QUALITY ACCOUNT AND STATEMENT OF DIRECTORS' RESPONSIBILITIES 2015-16

Paper G drew QAC's attention to the Statement of Directors' Responsibilities in respect of UHL's Quality Account for 2015-16, noting that the report had also been discussed at the Audit Committee on 25 May 2016. Paper G also outlined the structure of the Quality Account and detailed the process for seeking (and including verbatim) stakeholder feedback on that document. It was noted that the finalised Quality Account itself had not been circulated with this report, and it was agreed to send it round after the meeting today. The Quality Account 2015-16 would be presented to the Trust Board for approval on 2 June 2016 – External Audit's Opinion was not yet available but was expected to have been received for inclusion by that date. Once approved by the Trust Board, UHL was required to upload its 2015-16 Quality Account to the public NHS Choices website by 30 June 2016. QAC endorsed the Quality Account 2015-16 accordingly for presentation to the June 2016 Trust Board. **QAC Chair**

Recommended – that the Quality Account 2015-16 and Statement of Directors' Responsibilities be circulated to QAC members and endorsed for Trust Board approval on 2 June 2016. **QAC Chair**

RESOLVED ITEMS

47/16 APOLOGIES

Apologies for absence were received from Mr M Caple, Patient Partner, Ms D Leese, Director of Nursing and Quality Leicester City CCG, Ms J Smith Chief Nurse and Ms L

Tibbert, Director of Workforce and OD.

48/16 MINUTES

In lieu of the formal Minutes (which would be presented to the June 2016 QAC), paper A comprised a summary of the issues considered at the 28 April 2016 QAC – as reported to the May 2016 Trust Board.

Resolved – that the Minutes of the meeting held on 28 April 2016 be presented to the 30 June 2016 QAC. **TA**

49/16 MATTERS ARISING REPORT

Paper B detailed both the actions from the most recent meeting, and also any which remained outstanding from previous QAC meetings. In the absence of the Chief Nurse, it was agreed to defer an update on paediatric elective cancellations (Minute 3/16/3 of 28 January 2016) to a future QAC, following further discussion by the Women's and Children's CMG Quality and Safety Board. **CN**

Resolved – that the matters arising report (paper B refers) be noted and any associated actions be progressed by the relevant lead. **CN**

50/16 PATIENT EXPERIENCE

50/16/1 Friends and Family Test (FFT) Scores – March 2016

Paper C detailed the FFT scores for March 2016, noting that the expected coverage level had been achieved in all areas other than ED and outpatients. Although coverage in April 2016 had improved for ED following a meeting with staff, continued effort and local ownership was still required. The Audit Committee Non-Executive Director Chair noted that an Internal Audit report on outpatients (as presented to the 25 May 2016 Audit Committee) indicated that almost 32% of A&E outpatient FFT respondents would not recommend the department, and he asked that these two reports be appropriately reconciled. In discussion on this issue, members reiterated the usefulness of more realtime data to identify and resolve hotspots, emphasising the need also to be able to detect potential issues before they escalated. Members also noted plans to improve FFT coverage through texting. **CN**

Resolved – that data from an Internal Audit report on outpatients (as presented to the 25 May 2016 Audit Committee), and reconcile this with the FFT data. **CN**

51/16 QUALITY

51/16/1 Actions to Reduce Complaints about Outpatient Waiting Times

The Director of Performance and Information outlined the actions being taken at both Trust and CMG-level to reduce outpatient waiting times (paper D), recognising that this had been the most prominent 'improvement theme' identified through patient feedback in quarter 3 of 2015-16. A number of factors were now under review with the aim of reducing outpatient waiting times – these included Consultant job planning, increased use of the e-Referral Service [ERS], and a pilot of more scheduled patient transport arrangements to reduce post-appointment waits in clinic. A Listening into Action (LiA) event was also planned with Ophthalmology staff and patient representatives.

Following discussion and at the suggestion of Col (Ret'd) I Crowe Non-Executive Director, QAC proposed that a Trust Board thinking day should be held to consider outpatients

provision in detail. Such a session – proposed as being in August 2016 given that a session with patient organisations was already being held that day – should cover both the form and function of outpatients provision and should also discuss centralisation/ decentralisation questions, with appropriate senior CMG representatives present. The report at paper D would be a useful starting point for that session. **COO/ UHL CHAIR**

Resolved – that consideration be given to holding a Trust Board thinking day in August 2016 on outpatient service provision as outlined above, also involving CMG representatives. **COO/ UHL CHAIR**

51/16/2 Report from the Director of Performance and Information

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

51/16/3 Project to Reduce the Number of Community and Hospital Admissions for Recurrent UTIs in Frail Older People

It was noted that this project (paper E) had emerged from an August 2015 Trust Board DVD presentation on the patient benefits of the UHL Continence Service. The Trust Chairman commended the learning and staff initiative illustrated by this project, and the Deputy Chief Nurse advised that following the Trust Board's comments the staff had felt empowered to develop this UTI prevention pathway and initiate discussions with community colleagues. The pathway would be piloted on older people's wards within UHL, with a view to subsequent roll-out within the community. In response to a query from the Chief Executive, it was confirmed that the project was appropriately aligned to the Better Care Together programme.

The QAC Chair agreed to contact the Continence Nurse Specialists personally to thank them for their work on this key initiative. **QAC CHAIR**

Resolved – that the QAC Chair contact the Continence Nurse Specialists to congratulate them on this initiative. **QAC CHAIR**

51/16/4 Quality Commitment 2015-16 – Quarter 4 Update

Paper F from the Chief Nurse set out UHL's quarter 4 performance against the 2015-16 Quality Commitment, providing RAG ratings for all 4 quarters individually and the year as a whole. Those areas requiring ongoing attention would be addressed through the 2016-17 Quality Commitment, and included mortality, 7-day services, end of life care, sepsis, and early warning scores. Additional priorities for 2016-17 included readmissions, insulin safety, patient information and involvement in care, and improvement in outpatient correspondence and clinic wait times. The report at paper F had also been presented to the 3 May 2016 Executive Quality Board.

Resolved – that the quarter 4 update on performance against the 2015-16 Quality Commitment be noted.

51/16/5 Estates and Facilities Management Service Transition: Patient-Facing Services

The Head of Performance and Quality Assurance attended to advise QAC of the impact on patient-facing services of the 1 May 2016 transition of FM services back in-house. It was noted that the transition overall had gone smoothly, with no significant issues encountered in respect of key patient-facing services (including catering, portering and estates maintenance) and no adverse impact on service delivery to patients. Additional support

had also been put in place to ensure delivery of patient-facing services. The Head of Performance and Quality Assurance also outlined progress on recruitment and noted the need to review cleaning equipment allocations. In discussion, QAC members noted:-

(a) comments about catering and cleaning responsibilities, and discussed current establishment levels;
(b) the need for the incoming staff to be seen as core members of the integrated ward team;
(c) the need to update the process for reporting FM issues, as the logging system currently still directed staff to the previous service provider; **DEF**
(d) the need for a further update on security staffing issues for the Local Security Management Specialist report, which the Director of Safety and Risk was advised to discuss with the Director of Estates and Facilities outside the meeting, and **DSR /DEF**
(e) the view of UHL Matrons (as now shared by the Deputy Chief Nurse) that the transition had gone well. They particularly welcomed the mealtime service, as the protected mealtimes initiative could now be relaunched.

QAC also congratulated the Estates team on the smooth transition.

Resolved – that (A) the process for reporting FM service issues be reviewed, to ensure that it directed staff to an appropriate UHL contact, and **DEF**

(B) security staff queries (for the LSMS report) be pursued direct with the Director of Estates and Facilities outside the meeting. **DSR/ DEF**

51/16/6 CQUIN and Quality Schedule Update

Papers I and I1 respectively briefed members on the 2015-16 Quality Schedule delivery and CQUIN performance (noting some areas of exemplary performance such as Infection Prevention) and on the position to date for 2016-17. Much of the 2015-16 Quality Schedule had rolled forward to 2016-17, and the Head of Outcomes and Effectiveness noted concerns over the potential financial penalties associated with (eg) the flu vaccination indicator. The 3 May 2016 Executive Quality Board had also been advised of the potential financial risks associated with the 2016-17 Quality Schedule and CQUINs, and it was noted that the indicators and thresholds were not completely clear at this stage.

Resolved – that the CQUIN and Quality Schedule update 2015-16 and 2016-17 be noted.

51/16/7 Nursing and Midwifery Safe Staffing Report – March 2016

Paper J from the Chief Nurse detailed the March 2016 position re: nursing and midwifery staffing, noting that a new format report would be presented from the June 2016 QAC onwards focusing on the dashboard and on the quality and safety of ward areas. As outlined in paper J, over 90% fill rate had been achieved in March 2016 against planned staffing levels for registered nurses, bank usage had increased and agency use had reduced, and a task and finish group was being established to address key issues relating to the recruitment and retention of Registered Nurses and HCAs. QAC also noted ongoing discussions with De Montfort University regarding running a cohort of self-funded registered children's nurse training from September 2016.

The Chief Nurse had reviewed the level of concern triggers, and it was noted vacancies and pressure ulcers were areas for improvement. In response to a query on the apparent March 2016 rise in nursing vacancies (up to 450 whole time equivalents), the Deputy Chief Nurse suggested that this might reflect a year-end catch-up in HR documentation rather

than a specific issue in month 12, although recognising that Children's services vacancies remained challenging. QAC also discussed deployment and retention issues in respect of international nurses, noting that the more pressured medical areas remained the most difficult such placements.

Resolved – that the nursing and midwifery safe staffing report for March 2016 be noted.

51/16/8 Quality and Performance Report – Month 1

Paper K comprised the month 1 (April 2016) quality and performance report, which QAC reviewed from a quality and safety perspective. QAC noted continued good performance on UHL's SHMI (96), and welcomed the achievement of the fractured neck of femur target in April 2016. A further report on discussions re: strengthening the fractured neck of femur service would be provided to both the Executive Quality Board and QAC in August 2016, with ongoing verbal updates to each QAC in the meantime. The Medical Director also advised QAC that the April 2016 red indicator in respect of stroke (TIA clinic performance) was due to the impact of the junior doctors' strike that month. It was also noted that the Grade 2 and 3 pressure ulcer targets agreed with Commissioners as part of the 2016-17 Quality Schedule were very challenging. **MD**

Members also noted good month 1 performance in respect of infection prevention and the inpatient FFT scores.

Resolved – that (A) a further report on discussions re: strengthening the fractured neck of femur service be provided to both EQB and QAC in August 2016, and **MD**

(B) a verbal update on fractured neck of femur performance feature on each QAC agenda in the meantime. **MD**

52/16 COMPLIANCE

52/16/1 Update on Statutory Compliance

Paper L presented by the Director of Safety and Risk and the Director of Estates and Facilities outlined the current level of assurance available to the Trust in terms of its compliance with statutory requirements. A RAG-rated risk assessment was appended to paper L, and the Director of Safety and Risk reminded QAC that the request for this information had arisen from a previous SUI discussion.

Recognising the very significant number of such requirements and the difficulty of reflecting all of those meaningfully in a central database, QAC agreed with the Chief Executive that it would be helpful to focus on compliance in respect of regulatory/ enforcement bodies with prosecutory powers (as this would also ensure a focus on appropriate high-risk areas). It was also agreed to exclude HR-related issues at this stage. A report would be presented accordingly to the September 2016 QAC. Members also noted the need to ensure that partners were covered where appropriate. **DSR/ DEF**

In further discussion, QAC noted that the aim originally had been to understand potential 'unknowns', and commented that the already well-documented estates compliance requirements were perhaps less of a concern therefore.

Resolved – that a report be presented to the September 2016 QAC focusing on UHL compliance in respect of regulatory/enforcement bodies with prosecutory powers. **DSR/ DEF**

52/16/2 National Whistleblowing Policy and Freedom to Speak Up – Update

Paper M outlined the latest national guidance to Trusts regarding the Freedom to Speak Up Guardian role and an integrated policy on raising concerns/whistleblowing. A working group had been convened within UHL to progress the required actions, and would present a proposed plan accordingly to EQB and QAC in August 2016 prior to Trust Board consideration in September 2016 (as the date by which Trusts were obliged to have a plan in place). A workshop was also being held on 8 July 2016. The Director of Safety and Risk advised that Trusts were required to adopt the new national policy on this issue by March 2017 at the latest, and she confirmed that UHL was currently updating its own whistleblowing policy to reflect Freedom to Speak Up information. **DSR/ MD**

Resolved – that the plan from the UHL working group convened to progress the required actions be presented accordingly to EQB and QAC in August 2016 (prior to Trust Board consideration in September 2016). **DSR/ MD**

52/16/3 Report on Compliance with CQC Enforcement Notice including CQC ED Report

Paper N updated QAC on Trust compliance with the CQC Enforcement Notice in respect of ED. The Medical Director advised that due to staffing issues further work was needed on paediatric time to triage, with further recruitment now being planned accordingly. He noted good progress in embedding the use of the sepsis screening tool, although challenges remained in respect of the requirement for 90% of patients with red flag sepsis to receive IV antibiotics within 1 hour. Due to the small numbers involved any instances of non-compliance had a very significant impact, and the Medical Director also noted the importance of appropriate system flow issues. In response to a Non-Executive Director query, the Medical Director noted that an apparent recent dip in sepsis performance could be due to high activity levels over the Bank Holiday weekend and/or linked to flow.

Resolved – that the update on compliance with the CQC Enforcement Notice be noted.

52/16/4 CQC Inspection Update

The Director of Clinical Quality provided a verbal update on UHL's preparation for the June 2016 CQC inspection. The Trust was currently reviewing the 8 data packs received from the CQC, and continued to respond to ongoing CQC requests for further information. Further discussion on preparation for the CQC visit would take place at the June 2016 Trust Board thinking day, and QAC noted the ongoing (well-attended) staff engagement events being held. Focus group events would be held by the CQC in the week before the inspection, at which point the CQC would also undertake the Fit and Proper Person file testing. CQC posters and comment boxes would also be displayed throughout the Trust.

Resolved – that the update on the CQC inspection be noted.

53/16 SAFETY

53/16/1 Readmissions Risk Tool Pilot

The results of the preventing avoidable readmissions trial were presented for information at paper O, noting that a further report on the ensuing actions would be provided to Executive Quality Board and QAC in June 2016. This issue was noted to be part of the 2016-17 Quality Schedule. **MD/ HOE**

Resolved – that a report on the actions arising from the readmissions risk tool pilot **MD/**

(preventing avoidable readmissions) be presented to the June 2016 EQB and QAC meetings. **HOE**

53/16/2 Fractured Neck of Femur Performance and Action Plan

Resolved – it be noted that this item had been covered in the month 1 quality and performance update at Minute 51/16/8 above (paper P for this item already having been withdrawn from the agenda).

53/16/3 7-Day Services Update

The Medical Director provided a verbal update on this item, noting plans to submit a written report to the June 2016 Executive Quality Board. QAC discussed the significant resourcing challenges (both workforce and financial – indicative costs as now outlined by the Medical Director for the 4 priority standards) associated with 7-day services, which had also been raised with NHS England. A substantive report on 7-day services would be presented to a future QAC, and the Medical Director also agreed to confirm the position in other Trusts. **MD** **MD**

QAC also briefly discussed the scope of the Autumn 2016 GMC visit to UHL, noting that a similar data-collection exercise had been undertaken to that for the CQC visit. It was expected that the GMC would inspect training in cardiology, general medicine, gastrointestinal, oncology and anaesthetics, in addition to visiting the University of Leicester. In discussion, Non-Executive Directors queried the potential implications of any GMC findings.

Resolved – that (A) contact be made with other Trusts to ascertain their position re: 7-day services (readiness/resourcing issues), and **MD**

(B) a written update on 7-day services be provided to the June 2016 EQB. **MD**

53/16/4 Quarterly Mortality Report

Paper Q comprised the UHL mortality report which would be presented on a quarterly basis to QAC (and biannually to the Trust Board beginning in August 2016). It had also been discussed at the May 2016 Executive Quality Board. The report was structured around key aspects of NHS England guidance on mortality governance, and covered a wide range of issues relating to mortality rates and mortality governance. It had been presented in draft form to the March 2016 Trust Board thinking day and further refined in discussion with the QAC Non-Executive Director Chair and Healthwatch representatives. The Medical Director outlined key messages from the report as being:-

(a) a crude mortality rate lower than previously;
(b) a reduction in winter mortality;
(c) a UHL SHMI of below 100 (being 96);
(d) UHL's position comparative to other similar sized Trusts – although UHL had the largest number of deaths its SHMI compared favourably;
(e) the role of UHL's Mortality Review Committee, noting that a consultant from the Dr Foster's organisation also attended that Committee. Much scrutiny had taken place by the MRC regarding perinatal conditions – although there were some coding issues involved UHL was also reviewing MBBRACE data. As noted later in paper Q, the MRC also monitored diagnosis groups with the highest SHMI, noting the very small numbers involved;
(f) a focus on the 'out of hospital SHMI'; although this remained over 100 the Medical Director was confident that most of the deaths were expected ones, although recognising that there may also be end of life care aspects as highlighted through

the LLR Learning Lessons to Improve Care review, and

(g) continued improvements across all 3 UHL sites to the weekend SHMI, particularly at the LRI.

The Medical Director also provided an update on the issue of Medical Examiners, with approximately 10 applicants expected within UHL. A phased roll-out would be undertaken from July 2016, beginning with LRI adult patients.

QAC noted the need to present mortality information in an appropriately sensitive way when discussed at the public Trust Board in August 2016, and queried the scope to reflect geographic and demographic aspects. The Head of Outcomes and Effectiveness agreed to explore this further, although noting that these were primarily public health aspects. **HOE**

Resolved – that (A) the mortality report be discussed biannually at the public Trust Board starting in in August 2016, taking account of the need to present the information in an appropriately sensitive way, and **MD**

(B) the scope to include geographical and demographic information when presenting the report publicly to the Trust Board be reviewed. **HOE**

53/16/5 CIP Quality and Safety Impact Assessments – Q4 of 2015-16 and Process for 2016-17

In introducing paper R, the Director of CIP and Future Operating Model confirmed that a robust process existed to assessment the quality and safety impact of CIP schemes, noting CCGs' significant assurance with the Trust's procedure. Within the annual cost improvement programme (£35m in 2016-17) all schemes were linked to quality indicators, with all schemes over £50k requiring an appropriate quality impact review and sign-off by UHL's Chief Nurse and Medical Director. To date, 54% of relevant schemes were signed off for 2016-17. The Director of CIP and Future Operating Model also noted that some schemes had been rejected through that quality impact assessment process, further demonstrating the robustness of the approach.

Resolved – that the update be noted.

53/16/6 Complaints Performance Report

Paper S summarised complaints activity and performance, noting a drop in 25-day performance to 91% in February 2016 due primarily to staffing reductions in the PILS team. Although there had been a slight fall in the number of formal complaints in April 2016, overall complaints/concerns activity had not reduced. The Director of Safety and Risk confirmed that key trends/themes from complaints continued to be shared with CMGs, and she also noted the very useful feedback from the Independent Complaints Review Panel.

In discussion, QAC queried UHL's position relative to its peers in terms of levels of complaints received, noting that published data related only to the total number rather than (more meaningfully) to the rate per 1000 attendances. National 2015-16 comparative data would be reported to QAC once available. QAC also noted the need to learn from complaints. **DSR**

Resolved – that national 2015-16 comparative complaints data to be reported to QAC once available. **DSR**

53/16/7 Patient Safety Report – April 2016

Paper T presented patient safety data for UHL for April 2016 noting that this report had also been discussed in detail at the May 2016 Executive Quality Board. The Director of Safety and Risk drew a number of issues to QAC's attention in the report, namely:- (i) a decrease in safety harms by 36% in 2015-16 compared to 2014-15 (particularly in respect of harms relating to the deteriorating patient) – this would be covered in detail in the next Chief Executive's staff briefing; (ii) a major relaunch of sepsis throughout the Trust; (iii) an update on the use of the Junior Doctor Gripe Tool; (iv) increased incidents of no medical notes being available for patients in clinics and for patient procedures, and (v) a significant gap in resource/capacity within the Patient Safety Team.

As a result of the Trust Board's recent AQuA session, paper T also outlined a proposed template for reporting safety stories to the Trust Board (suggested to begin from August 2016**) including a 1-page 'serious incident learning bulletin'. The Medical Director noted how useful staff found this learning bulletin approach, commenting that the morbidity and mortality meetings also planned to start using it. Although welcoming the report, the Trust Chairman noted the need for clarity on the purpose of reporting such incidents to the public Trust Board. **MD/ DSR**

QAC also discussed the need to consider rationalising the number of individual reports being requested of the Patient Safety Team, given that team's staffing constraints.

post-meeting note: ** subsequently revised to September 2016

Resolved – that safety stories be reported to the public Trust Board (potentially from August 2016). **MD/ DSR**

53/16/8 Safety Walkabouts

QAC was advised of the 2015-16 quarter 4 patient safety walkabout programme (paper U for information), noting that involvement in such walkabouts was now part of Executive Directors' performance objectives. The report had also been presented to the May 2016 Executive Quality Board.

Resolved – that the verbal update be received and noted.

54/16 ITEMS FOR INFORMATION

Members noted update reports on claims and inquest activity, and on the schedule of external visits to the Trust, at papers V and W respectively. Non-Executive Directors requested that the RAG rating be reinstated within paper W from the June 2016 QAC onwards. With regard to the claims and inquest report, the Director of Safety and Risk outlined work to triangulate learning themes and make appropriate linkages to the Trust's Quality Commitment. Although recognising that it was not always within UHL's control, the Trust Chairman voiced concern at the length of time taken to close some litigation cases and the additional distress this could cause for patients and their families. **DCQ**

Resolved – that (A) the reports presented for information at papers V and W be noted, and

(B) the RAG rating system be reinstated for future reports on the schedule of external visits (paper W). **DCQ**

55/16 MINUTES FOR INFORMATION

Resolved – that the following Minutes/items be received for information:-
(A) Executive Quality Board – 5 April 2016;
(B) Executive Performance Board – 26 April 2016, and
(C) QAC calendar of business.

56/16 **ITEMS TO BE BROUGHT TO THE ATTENTION OF THE TRUST BOARD**

Resolved – that the following items be highlighted to the June 2016 Trust Board:- **QAC CHAIR**
(A) the recommended item in Minute xx/16 above;
(B) the confidential item in Minute xx/16/2 above (to be reported to the private June 2016 Trust Board);

57/16 ANY OTHER BUSINESS

There were no items of Any Other Business.

58/16 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality Assurance Committee be held on Thursday 30 June 2016 from 1pm until 4pm in the Board Room, Victoria Building, LRI.

The meeting closed at 4.40pm.

Helen Stokes – **Senior Trust Administrator**

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

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	2	1	50	*A Furlong*	2	2	100
I Crowe	2	2	100	*J Smith*	2	1	50
S Dauncey (Chair)	2	2	100				

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
M Caple	2	1	50	*R Moore*	2	2	100
M Durbridge	2	2	100	*C Ribbins*	2	2	100
A Goodall	1	0	0	*K Singh*	2	2	100
S Hotson	2	2	100	*L Tibbert*	1	0	100
A Johnson	2	2	100	*M Traynor*	2	2	100
D Leese – Leicester City CCG	2	0	100				