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 April 2016

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Dr S Dauncey, QAC Chair

DATE OF COMMITTEE MEETING: 25 February 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:

- UHL's request to the Health & Safety Executive for an extension to the Sharps Improvement Notice (Minute 16/16/5 refers).

DATE OF NEXT COMMITTEE MEETING: 24 March 2016

Dr S Dauncey
QAC Chairman
29 March 2016

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON THURSDAY, 25 FEBRUARY 2016 AT 1:00PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Present:
Dr S Dauncey – Non-Executive Director (Chair)
Mr J Adler – Chief Executive
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 J Smith – Chief Nurse

In Attendance:
Mr S Barton – Director of CIP and Future Operating Model (for Minute 16/16/1)
Dr A Bolger – Consultant Cardiologist (for Minute 16/16/2)
Dr A Doshani – Associate Medical Director
Miss M Durbridge – Director of Safety and Risk
Ms C Ellwood – Chief Pharmacist (for Minutes 15/16/2-15/16/3)
Ms S Hotson – Director of Clinical Quality
Mr A Johnson – Non-Executive Director
Dr D Ketley – Senior Improvement Scientist (for Minute 16/16/3)
Mrs H Majeed – Trust Administrator
Dr P McParland – Consultant Obstetrician (for Minute 15/16/1)
Mr R Moore – Non-Executive Director
Ms C Ribbins – Deputy Chief Nurse
Mr K Singh – Trust Chairman
Mr M Traynor – Non-Executive Director

RESOLVED ITEMS

13/16 APOLOGIES

Apologies for absence were received from Mr A Furlong, Medical Director, Professor A Goodall, Non-Executive Director and Ms D Leese, Director of Nursing and Quality, Leicester City CCG (non-voting member).

14/16 MINUTES

Resolved – that the Minutes of the meeting held on 28 January 2016 (paper A refers) be confirmed as a correct record.

15/16 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 3/16a – the Chief Nurse advised that the Director of Workforce and Organisational Development would be undertaking a scoping exercise as there had recently been a number of requests for workforce data at a number of Committees. The Committee Chair requested that an update on whether it would be possible to include an update on other staffing groups (i.e. Allied Health Professions) within the Nursing and Midwifery report be provided to QAC in April 2016; **CN**

(ii) Minute 3/16/3 – members expressed concern that the Women's and Children's CMG did not have a methodology for recording prioritisation scores and therefore there was no assurance whether the most appropriate cancellations were occurring from a clinical perspective. In discussion on this matter, the Chief Nurse undertook to raise this issue at the Women's and Children's CMG Quality and Safety Performance meeting and provide an update to QAC in April 2016; **CN**

(iii) Minute 6/16/2 – the Deputy Chief Nurse confirmed that the reason for the lower satisfaction rate in outpatients in respect of ESM CMG was mainly due to low coverage – only 155 surveys had been completed whereas a minimum of 552 surveys were required to achieve 5% coverage. Appropriate corporate support was being provided to the ESM CMG to improve performance in this area. It was agreed that this action be removed from the action log, and **TA**

(iv) Minute 93/15a – the Trust Chairman confirmed that Dame Julie Mellor, PHSO would be visiting the Trust on 23 May 2016. It was agreed that this action be removed from the action log. **TA**

Resolved – 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**

15/16/1 Update on Perinatal Mortality – MBBRACE Data (Minute 93/15a of 24 September 2015)

Dr P McParland, Consultant Obstetrician attended the meeting to present paper C, a report on perinatal mortality figures published by the new national reporting team, MBBRACE. The report was published in late 2015 and it was the first robust perinatal mortality figures for the year 2013. This report placed UHL as better than average in comparison to peer Trusts for overall perinatal mortality and stillbirths, however, UHL was rated slightly worse than average for neonatal mortality. There was an action plan in place to reduce the hypoxic ischaemic encephalopathy (HIE) rate at UHL.

Dr P McParland highlighted that there was currently a strong national drive to reduce perinatal mortality with new strategies and projects being developed including the use of customised centile growth charts to identify growth restricted babies, and a national audit to analyse and reduce mortality and morbidity due to intrapartum events in term babies. UHL was fully committed to participating in these projects. New guidance for management of reduced fetal movements, based on new national guidelines, had been implemented. A new guideline for detection of growth restricted babies was being developed alongside the implementation of customised centile charts. Members were assured with progress in respect of this workstream.

Responding to a query from the Chief Executive, Dr P McParland provided a brief background highlighting that perinatal mortality data collection was undertaken by CMACE until 2010 and there were no perinatal mortality benchmarking figures available between 2010 and beginning of 2013. It was also noted that long terms trends were quite essential, however, this would not be possible due to the lack of data availability. Members were advised that the data analysis by CMACE and MBBRACE was different and therefore it would not be possible to undertake a comparison of perinatal mortality figures in the long-run.

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

15/16/2 Update on Homecare (Minute 94/15/4 of 24 September 2015)

Ms C Ellwood, Chief Pharmacist attended the meeting to present paper D, an update on current position with supply of medicines through Homecare which had a risk score of 16

on the risk register. These risks included issues with external homecare companies, risks due to insufficient capacity in the pharmacy homecare team and risks associated with internal processes. Capacity issues within Pharmacy were being addressed with Commissioners and new homecare schemes were being restricted until the current issues were resolved. Where existing schemes were identified as high risk as a result of external factors, these schemes were reviewed and switched to alternative provision where feasible. Work was underway with relevant clinical specialities to resolve risks arising from internal processes.

Responding to a query from the Patient Partner, the Chief Pharmacist confirmed that the volume of complaints had reduced, however, she was unaware if patients had been informed of the issues with the supply of medicines through Homecare at their clinic appointments.

In response to a query from Mr A Johnson, Non-Executive Director, it was noted that the supply of medicines through Homecare was not a competitive market and other Trusts also faced similar issues.

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

15/16/3 Update on TTO Prescribing Issues (Minute 94/154/5a of 24 September 2015)

The Chief Pharmacist also presented paper E, an update on TTO accuracy and actions in place to address TTO prescribing errors. She highlighted that TTO accuracy was re-audited in January 2016 and although there had been a small decrease in errors compared to previous audits, the overall error rate was high. The current actions to improve TTO accuracy was targeted predominantly at improving inpatient prescription accuracy, as this had been shown to influence TTO accuracy. Actions were currently focused only on the Emergency and Specialist Medicine CMG and were principally pharmacy-led. A bid had been put forward to Health Education East Midlands (HEEM) for training UHL pharmacists as prescribers.

In response to a query, the type of errors detected by pharmacy staff was noted. The EPIFFany project would be extended to medical wards to assess whether the significant reduction in prescribing errors seen in renal wards could be replicated across a wider number of wards and with TTOs – an update on progress with this project would be provided to QAC in August 2016. **CP**

The Director of Safety and Risk advised that a human factors approach to improve medication safety was also being put in place.

Members expressed concern about the error rate and more assurance was sought. The Chief Pharmacist advised that further to discussion at the Executive Quality Board (EQB) in February 2016, Clinical Directors had been requested to nominate a lead from their CMG to support her in identifying and implementing actions for improving TTO prescribing accuracy. A number of pilot projects were also being undertaken to resolve the issues and an update on these would be provided to EQB and any exceptions would be reported to QAC accordingly.

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

(B) the Chief Pharmacist be requested to provide an update on progress of the EPIFFany project's extension to medical wards to the QAC meeting in August 2016. **CP**

16/16 SAFETY

16/16/1 CIP Quality and Safety Impact Assessment – Update

Further to Minute 120/15/7 of 26 November 2015, the Director of CIP and Future Operating Model attended the meeting to present an update on new quality sign-off and assurance process for the Cost Improvement Programme. Paper F particularly focussed on the risk and potential impact the CIP programme might have on quality in quarter 3 of 2015-16. There were a number of indicators showing adverse performance in relation to the emergency pathway workstream and one indicator in respect of the outpatients workstream. CIP benefits existed in both these areas. With regard to the emergency pathway, some additional inpatient capacity had been re-opened in January 2016, along with additional ICS capacity. A capacity planning exercise was underway to ensure more robust capacity and capacity variation planning for 2016-17. A robust demand and capacity plan for beds had been developed and this would assist in developing the 2016-17 bed capacity plan. The Outpatients' friends and family scores required further investigation and there was a CIP scheme to increase outpatient activity via booking slot utilisation.

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

16/16/2 Update on UHL's action plan in response to the external review of the East Midlands Congenital Heart Centre

Further to Minute 108/15/5 of 29 October 2015, Dr, A Bolger, Consultant Cardiologist attended the meeting to present paper G, an update on progress with actions following the external review of the East Midlands Congenital Heart Centre (EMCHC).He highlighted that significant progress had been made and evidence supporting actions in the EMCHC action plan had been submitted to NHS England (NHSE). NHSE had been assured that UHL was monitoring individual aspects of the action plan as part of business as usual. They had raised some queries in respect of the following areas:-

- **Results of the audit following review of perioperative factors that might lead to postoperative complications** – this had been completed and would be submitted to NHSE by 28 February 2016;
- **Consultant Anaesthetist gap analysis** – this had been undertaken and the service required a further 6 anaesthetic sessions per week and EMCHC would be working with ITAPS CMG to action this through possible job plan changes to existing staff and/or further recruitment;
- **Details associated with imaging backlog** – a paediatric cardiologist with MRI/CT imaging skills has been recruited and would be commencing in June 2016. Significant amount of work had been completed to resolve the issues and evidence would be sent to NHSE, and
- **MDT and decision making guidelines** – a robust process for MDT meetings had been established.

In discussion on the telephone/mobile communication issues at the Glenfield Hospital, it was noted that pagers had been ordered as a short term fix to improve contact with Duty Cardiologist.

In discussion on an IT solution to submit data to a national database, it was noted that a report had been submitted to the Capital Investment Committee but it had not been approved due to the high integration costs (approximately £200,000) to make it compatible with current UHL systems.

The Director of Safety and Risk commented that some actions on the action plan did not have a specific date. In response to a query, the Chief Nurse undertook to follow-up the

amber rated action (i.e. review workload for Deputy Head of Nursing and EMCHC Matron) on the action plan which had a completion date of November 2015. **CN**

The Committee Chair commended the EMCHC team for their efforts in taking forward the actions following the peer review. It was noted that NHS England had been satisfied with progress made in implementing improvements and particularly improved surgical outcomes.

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

(B) the Chief Nurse be requested to follow-up the amber rated action (i.e. review workload for Deputy Head of Nursing and EMCHC Matron) on the EMCHC action plan which had a completion date of November 2015. **CN**

16/16/3 Leicestershire Improvement, Innovation and Patient Safety Unit (LIIPS): The case of support

Dr D Ketley, Senior Improvement Scientist attended the meeting to present paper H. She highlighted that LIIPS aimed to facilitate improvement in the quality and safety of healthcare in Leicester, Leicestershire and Rutland by connecting people across health and academia with expertise and passion in the practice and science of improvement.

She requested suggestions for maximising the benefit of LIIPS. The following were provided:-

(a) LIIPS might be able to assist UHL in particular hot-spot areas;
(b) the research undertaken by LIIPS to have a tangible impact on quality and safety;
(c) explore wider learning from different organisations and LIIPS to be the link in developing cross collaborative learning between these organisations, and
(d) consideration be given to feeding in information from patient surveys into the LIIPS workstreams.

The Trust Chairman noted the need for LIIPS to develop a strategy, in response, Dr Ketley advised that a Steering Group had been established and the next meeting of this Group was scheduled on 26 February 2016 when discussion regarding strategy for 2016-17 would take place.

Members supported UHL's on-going relationship with LIIPS (as one of eight partners) including through staff input and the commitment of £10k funding for 2016-17. Members commented on the value of this partnership to UHL, and the opportunities it presented for the future, including its potential use as a vehicle for building capability.

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

16/16/4 Patient Safety Report

The Director of Safety and Risk presented paper I, the patient safety report for January 2016. The following points were particularly highlighted:-

(a) risks, safety and quality issues relating to the emergency pathway, and
(b) incidents relating to the failure in checking processes.

Members were briefed on the IRMER incidents, medication incidents and surgical incidents that had been reported in January 2016 which had revealed failures in checking processes. The Director of Safety and Risk advised that these incidents were being investigated and reviewed by the Safety team but CMGs had been requested to assure themselves that checking processes were robustly followed by all staff at every stage.

Members suggested that these issues should be cascaded to staff at the shop-floor and at safety huddles etc. Despite the issues highlighted, the safety data did not, at present, seem to suggest any increase in avoidable death or harm. Reviewing winter 2014-15 data against winter 2015-16 figures showed a decrease in harm incidents, half the number of never events and reduced crude mortality figures.

There had been an increase in incident reporting in January 2016 which was considered positive.

The Director of Safety and Risk provided a demonstration of the patient safety portal. She undertook to circulate to QAC members the link to the patient safety portal and requested members to provide comments on the portal to her outwith the meeting. **DSR**

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

(B) the Director of Safety and Risk (DSR) be requested to circulate to QAC members the link to the patient safety portal and members to provide comments on the portal to the DSR outwith the meeting. **DSR**

16/16/5 <u>HSE Sharps Improvement Notice - Update</u>

The Director of Safety and Risk presented paper J and advised that although significant progress had been made to comply with the 'Sharps' improvement notice, further work was required in respect of documenting risk assessments and developing standard operating procedures where 'safer sharps' devices could not be used due to clinical issues or where no safe alternative was currently available. Therefore, an extension to the deadline would be requested from the Health and Safety Executive and therefore the Trust would need to be fully complaint by 9 May 2016.

'Safer sharps' devices training was underway with manufacturers providing training to 3 or 4 members of staff on each ward who would subsequently be responsible for cascading this training to others.

The Chief Executive noted the need for 'positive certification' from Service Managers/Matrons in all CMGs confirming that all unsafe sharps had been removed from areas covering their CMG. He requested the Associate Medical Director and Director of Safety and Risk to send him a draft copy of the letter that would be sent to Service Managers/Matrons informing them of this requirement. **DSR/ AMD**

A further update on progress with the HSE Sharps Improvement notice be provided to QAC in April 2016. **DSR**

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

(B) the Director of Safety and Risk and the Associate Medical Director be requested to send to the Chief Executive, a draft copy of the letter that would be sent to Service Managers/Matrons requesting them to provide 'positive certification' confirming that all unsafe sharps had been removed from areas covering their CMG, and **DSR/ AMD**

(C) the Director of Safety and Risk be requested to provide a further update on progress with the HSE Sharps Improvement notice to QAC in April 2016. **DSR**

17/16 PATIENT EXPERIENCE

17/16/1 Patient Partner Activities

Mr M Caple, Patient Partner presented paper K, an update on Patient Partner activities in UHL. Patient Partners were members of the public who provided a lay perspective on the work of UHL. They were involved in a wide range of issues, from changes to services, advising on new developments, reviewing patient literature and attending Committee meetings. There had been 12 Patient Partners and the intention was to increase this number to 20 in 2016. Appendix A provided a summary of the key Patient Partner activities in 2015. Appendix B provided an update on behalf of Patient Partners for the Trust's Quality Accounts 2015-16.

The Chief Nurse noted that the role of the Patient Partners was very valuable. She would be discussing with the Medical Director regarding how Patient Partners could be involved in suitable ward-level initiatives.

Mr R Moore, Non-Executive Director suggested that a regular report be submitted to QAC in respect of a patient story related to a Patient Partner following the patient journey through a procedure or through an outpatient visit or similar. **PP**

The Director of Clinical Quality highlighted that the input from Patient Partners for the Trust's Quality Accounts was helpful and assisted in influencing the quality commitment priorities. Patient Partners contribution to the Independent Complaints Review Panel was also commended.

The Trust Chairman suggested that a Trust Board Thinking Day session be scheduled in summer 2016 to discuss patient and public involvement. **Trust Chairman**

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

(B) Mr M Caple, Patient Partner be requested to submit a regular report to QAC in respect of a patient story related to a Patient Partner following the patient journey through a procedure or through an outpatient visit or similar, and **PP**

(C) the Trust Chairman be requested to discuss with the Director of Corporate and Legal Affairs regarding scheduling a Trust Board Thinking Day session in summer 20 to discuss patient and public involvement. **Trust Chairman**

17/16/2 Friends and Family Test Scores – December 2015

The Deputy Chief Nurse presented paper L and advised that support was being provided to CMGs in the achievement of coverage targets and improving FFT scores particularly in the Emergency Department and Outpatients. The impressive 41.8% coverage in Maternity was commended.

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

18/16 QUALITY

18/16/1 Items for the attention of QAC from EQB Meeting on 2 February 2016

The contents of paper M were received and noted. The Chief Nurse advised that EQB supported the recommendation (based on the risks posed of alternative systems), to await the new international standard for non-luer connectors in April 2017.

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

18/16/2 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 December 2015. Work was underway to recruit to vacancies. The recruitment processes for Healthcare Assistants had been streamlined and the duration from interview to start date had been reduced to 8 weeks (previously 12 weeks). Discussions were in progress with colleagues in De Montfort University and it was highlighted that only 104/130 places had been filled for the nursing course.

The Trust had put forward itself to pilot an Associate Nurse role. A 'Return to Practice Programme' was being considered and the aim was to recruit atleast 15 nurses through this programme.

An update on wards highlighting any particular concerns would be included within future iterations of the Nursing and Midwifery report. The quality visits to wards as part of the CQC preparation was also assisting in identifying any issues in ward areas. A review of the Clinical Measures dashboard was being led by the Deputy Chief Nurse.

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

18/16/3 Quality Commitment 2015-16 – Quarter 3 Report

The Director of Clinical Quality presented paper O and highlighted that the 2015-16 quarter 3 performance against the Quality Commitment had been met for the overall key performance indicators for reducing preventable mortality, reducing the risk of error and adverse events and improving patients and their carer's experience of care. However, there were some areas within the overall KPIs where performance had not been met against specific actions and focus was required in order to meet the year-end targets. A Deputy Head of Outcomes and Effectiveness had been appointed and would be progressing the actions relating to mortality reviews.

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

18/16/4 Update on Quality Accounts

Members received and noted the contents of paper P which provided the project plan for the 2015-16 Quality Accounts. The contents of the Quality Account were informed by Department of Health guidance (toolkit) and regulations. The toolkit had not been updated, therefore the content would remain largely unchanged, however, a letter (appendix A refers) received by the Chief Executive had detailed a number of additional areas where information was required for 2015-16. The first draft of the 2015-16 quality accounts would be presented to QAC in March 2016 with the final version being submitted to the Trust Board in June 2016. **DCQ**

Responding to a query from Mr R Moore, Non-Executive Director, the Director of Clinical Quality advised that the intention was to include a feedback form at the end of the Quality Accounts. The Chief Nurse suggested that consideration would be given to preparing an 'easy-read' version of the Quality Accounts for the public.

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

(B) the first draft of the quality accounts be presented to QAC in March 2016 with the final version being submitted to Trust Board in June 2016. **DCQ**

18/16/5 Month 10 – Quality and Performance Update

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

- Fractured Neck of Femur performance was disappointing, a review was being undertaken and the results would be presented to EQB and QAC in March 2016. The Chief Executive undertook to liaise with the Director of Performance and Information regarding the corporate focus being provided to improve performance in respect of the fractured neck of femur indicator; **CE**
- Emergency Readmissions within 30 days – due to increase in readmissions within 30 days, a 3 month pilot of the Readmissions Risk Tool was being undertaken. Early feedback from this pilot indicated that the Trust was progressing in the right direction and patients were being given relevant advice on actions to prevent risk of readmission post discharge. A further update on this would be provided to QAC further to the completion of the pilot; **MD**
- there had been a significant reduction in hospital acquired pressure ulcers in 2015 in comparison to the previous two years, and
- UHL had the lowest number and rate of C Difficile infections regionally.

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

(B) the Chief Executive be requested to liaise with the Director of Performance and Information regarding the corporate focus being provided to improve performance in respect of the fractured neck of femur indicator, and **CE**

(C) an update on the Readmissions Risk Tool pilot be provided to QAC further to the completion of the pilot. **MD**

19/16 COMPLIANCE

19/16/1 Report on Compliance with CQC Enforcement Notice including an update on Progress with Recording Arrival Dynamic Priority Scores for Children

The Chief Nurse advised that in respect of the Dynamic Priority Scores for Children, a rapid cycle test between 5pm-10pm (as this was the time of peak activity) would be put in place week commencing 29 February 2016.

The Chief Nurse updated the Committee on progress with actions put in place following the CQC unannounced inspection of the Emergency Department (ED) at the LRI on 30 November 2015 (paper R refers). In respect of time to assessment (15 minute standard), 90% was being achieved. Progress in respect of effective sepsis management needed to improve. New sepsis guidance was expected to be published imminently.

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

19/16/2 Update re. general progress on CQC Inspection in June 2016

In respect of the forthcoming CQC inspection, the Chief Nurse highlighted that a weekly meeting on Mondays was held to discuss the plan for the week and a review was undertaken on Fridays. The self-assessment against 'safe', 'caring' and 'effective' key lines of enquiry would be presented to the March 2016 Trust Board Thinking Day (TBTD). The self-assessment of strengths and weaknesses would be presented to the April 2016 TBTD. The Trust Chairman noted that there were dedicated slots to discuss this matter at

the TBTD in March, April and May 2016 and suggested consideration be given to whether an additional session was required prior to the June 2016 CQC inspection. **CN**

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

(B) the Chief Nurse be requested to give consideration to whether an additional Trust Board Thinking Day (TBTD) session was required prior to the June 2016 CQC inspection noting that dedicated slots had been scheduled at the TBTD in March, April and May 2016. **CN**

19/16/3 Results of a self-assessment against the CQC ED Framework

The Director of Clinical Quality presented paper S advising that the Emergency Department (ED) team had completed a self- assessment against the core service framework for the paediatric and adult EDs identifying areas of good practice and areas for improvement. However, since the self-assessment had been completed, the CQC had published a revised set of core service frameworks and therefore the report would need to be updated. Progress in relation to this would be monitored through the ESM CMG Quality and Safety Performance Review meetings.

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

19/16/4 Leicester City CCG – Safeguarding Inspection

The Chief Nurse advised that the Leicester City CCG Safeguarding inspection had identified good practice, however, they had noted that capacity within the Trust's Safeguarding Team was limited. Some queries in respect of training numbers had been raised by the inspectors and responses to these would be provided accordingly. It had been a health-economy wide inspection, therefore feedback would be provided to all partners.

Resolved – that the verbal update received and noted.

20/16 ANNUAL REPORTS FROM EQB SUB COMMITTEES

20/16/1 Hospital Transfusion Committee Annual Report

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

21/16 ITEMS FOR INFORMATION

21/16/1 Complaints Briefing Report

The Director of Safety and Risk advised that the Complaints Briefing report was usually an item for information on QAC agendas but was a substantive item on the agenda every quarter. She highlighted that the CQC's requirement was for Trust Boards to review complaints performance. In discussion on this matter, it was agreed that the complaints briefing report (paper U) should feature as a substantive item on the agenda for the QAC meeting in March 2016. The Trust Chairman undertook to liaise with the Director of Corporate and Legal Affairs in respect of whether this report needed to feature on the agenda for future Trust Board meetings given the CQC' requirement. **DSR/ TA** **Trust Chairman**

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

(B) the Complaints Briefing Report (paper U refers) be included as a substantive

item on the agenda for the QAC meeting in March 2016, and **DSR/ TA**

(C) The Trust Chairman be requested to liaise with the Director of Corporate and Legal Affairs in respect of whether the Complaints Performance reports needed to feature on the agenda for future Trust Board meetings given that the CQC's requirement was for Trust Boards to review complaints performance. **Trust Chairman**

21/16/2 **Learning from Claims and Inquests**

Members noted the contents of paper V, a report on Inquests and Claims for quarter 3 of 2015-16. The Committee noted the Memorandum of Understanding issued in October 2015 which recorded a voluntary agreement between the Coroners' Society of England and Wales and the Care Quality Commission (CQC). The agreement was not binding and not intended to create legally enforceable rights, obligations or restrictions. Its intention was to promote and continue effective working relationships between Coroners and the CQC. The Chief Executive advised that he had had a recent meeting with the Coroner and the Coroner was complimentary on the working relationships between her office and the Trust and also the 'culture of openness' adopted by the Trust.

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

22/16 MINUTES FOR INFORMATION

22/16/1 Executive Quality Board

Resolved – that the action notes of the 2 February 2016 Executive Quality Board meetings (paper W refers) be received and noted.

22/16/2 Executive Performance Board

Resolved – that the action notes of the 26 January 2016 Executive Performance Board meeting (paper X refers) be received and noted.

22/16/3 QAC Calendar of Business

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

23/16 ANY OTHER BUSINESS

23/16/1 Revalidation Process for Nurses and Midwives

In response to a query from the Committee Chair regarding the Trust's progress with the requirement for revalidation of nurses and midwives, the Chief Nurse confirmed that all was in hand in respect of the revalidation project and discussions on this matter were being progressed through the Executive Workforce Board.

Resolved – that the verbal update be noted.

24/16 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality Assurance Committee be held on Thursday, 24 March 2016 from 1.00pm until 4.00pm in the Board Room, Victoria Building, LRI.

The meeting closed at 4:20pm.

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

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	11	8	73	*C Ribbins (Acting Chief Nurse capacity)*	4	1	25
I Crowe	11	11	100	*J Smith*	7	6	86
S Dauncey (Chair)	11	9	82	*J Wilson*	9	9	100
A Furlong	11	7	64				

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
M Caple	11	8	72	*K Singh*	11	10	91
C O'Brien – East Leicestershire/Rutland CCG	6	3	50	*M Traynor*	11	10	90
A Johnson	4	4	100	*R Moore*	11	11	100
D Leese – Leicester City CCG	5	4	80				

Hina Majeed, **Trust Administrator**