Trust Board paper O2

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 5 July 2018

COMMITTEE: Quality and Outcomes Committee

CHAIR: Col (Ret'd) I Crowe, Non-Executive Director

DATE OF COMMITTEE MEETING: 24 May 2018

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

- **NHS Resolution Maternity Self-Assessment (Minute 75/18)**
- **UHL Quality Account 2017-18 (Minute 76/18)**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR CONSIDERATION/ RESOLUTION BY THE TRUST BOARD:

- that an abridged version of the mortality report would be submitted to the Trust Board in June 2018 (Minute 80/18).

DATE OF NEXT COMMITTEE MEETING: 28 June 2018

Col (Ret'd) I Crowe
Non-Executive Director and QOC Chair

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
MINUTES OF A MEETING OF THE QUALITY AND OUTCOMES COMMITTEE
HELD ON THURSDAY, 24 MAY 2018 AT 2:10PM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Voting Members Present:
Col. (Ret'd) I Crowe – Non-Executive Director (Chair)
Ms V Bailey – Non-Executive Director
Mr A Furlong – Medical Director (until and including Minute 82/18)
Ms E Meldrum – Acting Chief Nurse
Mr B Patel – Non-Executive Director
Mr M Traynor – Deputy Trust Chairman (on behalf of Trust Chairman (ex officio))

In Attendance:
Mr M Archer – Head of Operations, Clinical Support and Imaging (for Minute 79/18/3)
Dr D Barnes – Cancer Centre, Clinical Lead (for Minute 79/18/2)
Ms E Broughton – Head of Midwifery (for Minutes 75/18 and 81/18)
Mr M Caple – Patient Partner
Dr A Currie – Clinical Director, Musculo-Skeletal Services (for Minute 79/18/1)
Miss M Durbridge – Director of Safety and Risk
Ms J Edyvean – Outpatient Transformation and Reconfiguration Programme Manager (for Minutes 79/18/3 and 79/18/4)
Mrs S Hotson - Director of Clinical Quality
Ms D Mitchell – Integrated Services Programme Lead (for Minutes 79/18/3 and 79/18/4)
Mr W Monaghan – Director of Performance and Information (for Minute 79/18/2)
Ms C Ribbins – Deputy Chief Nurse

RECOMMENDED ITEMS

75/18 NHS Resolution Maternity Self-Assessment

The Head of Midwifery attended the meeting to present paper J. She advised that the Trust (as a provider of Maternity Services) had been informed of details of an incentive scheme for those delivering Maternity Services through the NHS Resolution, Clinical Negligence Scheme for Trusts (NHSR CNST). The process required Trusts to self-certify (with Board sign-off) their progress against 10 actions and discuss this with their Commissioners before submitting the completed template to NHSR by 29 June 2018. The incentive scheme would assess compliance against the actions and award a reduction in premium if the Trust could prove compliance.

The only area of challenge had been in relation to "90% compliance with multidisciplinary attendance at skills drills training for Maternity Care Assistants (MCAs) and Anaesthetists". In respect of MCAs, a plan to support training was in place and trajectory would be included within the report that would be submitted to the Trust Board in June 2018. In relation to engagement of Anaesthetists on maternity skills drills training, it was agreed that the Clinical Directors, Women's and Children's and ITAPS needed to put a plan in place.

It was noted that the Acting Chief Nurse would be the Executive Maternity Champion. Ms V Bailey, Non-Executive Director volunteered to become the Non-Executive Director Maternity Champion role subject to the Trust Chairman's approval in order to demonstrate compliance for the submission. **ACN/HoM**

Recommended **– that the Trust's self-assessment for submission to NHSR for a reduction on Maternity CNST premium subject to inclusion of a plan/trajectory to comply with attendance at skills drills training for Maternity Care Assistants (MCAs) and Anaesthetists be recommended to the Trust** **ACN/HoM**

Board in June 2018 for sign-off.

76/18 2017-18 Quality Account

The Director of Clinical Quality presented paper Q, the final draft of the quality account for 2017-18. All performance data and supporting narrative had been refreshed to reflect the year end position and stakeholder feedback had been included. Members were verbally advised that the results of the audit testing by Grant Thornton (the Trust's External Auditors) provided an unqualified opinion on the two indicators which had been tested, namely the rate of clostridium difficile infections and FFT patient element score. The External Auditor's opinion would be included verbatim within the quality account report when it would be submitted to the Trust Board on 7 June 2018. Once approved by the Trust Board, UHL was required to upload its 2017-18 Quality Account to the public NHS Choices website by 30 June 2018. The Committee endorsed the Quality Account 2017-18 accordingly for presentation to the June 2018 Trust Board. **DCQ**

Recommended – that the Quality Account 2017-18 and Statement of Directors' Responsibilities be endorsed for Trust Board approval on 7 June 2018. **DCQ**

RESOLVED ITEMS **ACTION**

77/18 APOLOGIES FOR ABSENCE

Apologies have been received from Mr J Adler, Chief Executive, Professor P Baker, Non-Executive Director, Mr D Kerr, Director of Estates and Facilities, Mr K Singh, Chairman (ex officio) and Ms C West, Director of Nursing, Leicester City Clinical Commissioning Group.

78/18 MINUTES

Resolved – that the Minutes of the meeting held on 26 April 2018 (paper A) be confirmed as a correct record.

79/18 MATTERS ARISING

Paper B detailed outstanding actions from the most recent and previous Quality and Outcomes Committee (QOC) meetings.

Resolved – that the action log (paper B) be confirmed as a correct record.

79/18/1 Fractured Neck of Femur – Quarterly Update (Minute 28/17 of 26 October 2017)

The Clinical Director, MSS attended the meeting to present paper C, which updated the Committee on performance against the agreed standards for operating on patients with fractured neck of femurs within 36 hours of presentation and the challenges that still remained. An action plan had been appended to paper C. He highlighted that whilst there had been progress with achieving the 72% target for patients being operated on within 36 hours over the last year, compared to previous years this had not been consistent. The treatment for reversal of anticoagulants had proved challenging, however, work had been on-going and it was hoped that clinical consensus would be reached imminently. The lack of resources and limitations in theatre capacity had particularly affected the Trust's ability to meet surges of demand. Two proposed changes in working patterns to improve Consultant presence across the Emergency Floor for trauma would be trialled for 3 months starting in September 2018. Members were advised that interviews for Orthogeriatricians were taking place on 24 May 2018.

In response to a comment from the Medical Director, the Clinical Director undertook to ensure that the action plan was updated to include deadline dates. Responding to a query, members were advised that it was recognised and acknowledged by the Consultant body that the way the Trauma service had been delivered required change. The changes in working patterns mentioned above would hopefully resolve the issues, although it was noted that it was a complex undertaking as most Trauma surgeons had elective or other commitments timetabled into their job plans. The next quarterly update would be provided to the Committee in August 2018 as scheduled on the work plan.

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

79/18/2 Cancer Quality Outcomes Dashboard Proposal (Minute 05/18 (D) of 25 January 2018)

The Cancer Centre, Clinical Lead attended the meeting to present paper D, a proposal for cancer quality outcomes and dashboard to be presented to the Committee in due course. The Committee agreed that the cancer quality outcomes dashboard should include the following outcome measures: - 1 year survival, 5 year survival, staging at diagnosis, emergency presentations and patient experience. The Medical Director commented that performance in respect of measures relating to 'staging of diagnosis' and 'emergency presentation' would apply not only on UHL but also primary care. It was proposed that the initial reports would be against the tumour sites which had either the largest volume of patients or were part of the National Cancer Alliance programme for earlier cancer diagnosis. These would be Urology, Lower GI, Lung, Gynaecology and Breast. In discussion on the best approach to present the data to the Committee, It was agreed that the CQC Insight report methodology (i.e. tabular approach) be used to report the STP outcomes benchmarked against national standards with an associated narrative and exception reporting for any measures which fell outside acceptable ranges. An initial draft of the dashboard would be provided to the Committee in September 2018, with the first annual dashboard being provided by May 2019. **CC,CL**

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

(B) an initial draft of the cancer outcomes dashboard be presented to the Committee in September 2018, with the first annual dashboard being provided by May 2019. **CC,CL**

79/18/3 Psychology Services Update (Minute 46/18(B) of 29 March 2018)

Further to Minute 46/18(B) of 29 March 2018, the Head of Operations, Clinical Support and Imaging Clinical Management Group attended and introduced paper E, updating the Committee that the contract performance notice (CPN) that had been issued from UHL to LPT in respect of the psychology services commissioned by UHL remained open. Medical Psychology had eliminated 52 week waits within the service. Neuro Psychology waiting lists still remained a challenge and a trajectory had been produced that would eliminate 52 week waits, although this required a part year investment of £55k to deliver £110k FYE. The Integrated Services Programme Lead advised that two workshops had been delivered in recent months by the UHL strategy team with LPT Neuropsychology clinicians and UHL Neurology clinicians to review neuropsychology longer term model of care.

An options appraisal paper would be presented to ESB in June 2018 for discussion and potential authorisation of the additional costs of the Neuro Psychology trajectory. This would also consider the options for the future service provision and whether this should be repatriated by UHL. Ms V Bailey, Non-Executive Director

noted the need for due diligence and cultural change where-in a short-term approach was put in place to resolve issues by LPT prior to the service being repatriated by UHL (if this was the case). An update on the future of this service would be presented to QOC in August 2018. **IPSL/ HoO, CSI**

The Acting Chief Nurse highlighted that there had been a number of contractual processes when the Chaplaincy Service was repatriated to UHL and suggested that the Integrated Services Programme Lead liaised with the Head of Chaplaincy in respect of this matter. **IPSL**

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

(B) the Integrated Services Programme Lead be requested to liaise with the Head of Chaplaincy to get a feel for the contractual processes involved when the Chaplaincy Service was repatriated to UHL, and **IPSL**

(C) an update on the future of the Psychology Services be provided to the Committee in August 2018. **IPSL/ HoO, CSI**

79/18/4 <u>Update on Outpatient Transformation (Minute 276/17/2 of Trust Board on 2 November 2017)</u>

The Outpatient Transformation and Reconfiguration Programme Manager and Integrated Services Programme Lead attended the meeting to provide a presentation (tabled) and an update on progress made in delivering UHL's Outpatient Transformation Programme in 2017-18 and the expected outcomes for 2018-19. A number of areas in 2017-18 had been successful (paper F refers). The progress of the programme had been hindered by the impact of emergency pressures over the winter months, however, momentum had been regained and projects were now being actively managed by the CMGs. An ambitious programme had been identified for delivery in 2018-19 which would be complemented and enhanced through the work undertaken with NHS Improvement. Further work remained particularly in the need to strengthen and finalise metrics for all work streams in 2018-19. The risks to the programme would be managed and mitigated as far as possible through the governance arrangements supporting delivery.

In respect of the incremental move towards a central model for Outpatient delivery core functional requirements, the Deputy Trust Chairman suggested that the patient journey be mapped as a horizontal flow diagram so that there was a better chance to identify any gaps. In response to a query from the Director of Safety and Risk in relation to neurology outpatients, the Outpatient Transformation and Reconfiguration Programme Manager advised that each CMG was developing an action plan, however, undertook to discuss this in detail outwith the meeting.

In response to a number of issues raised by members in relation to the Booking Centre, it was noted that a huge piece of analysis work had been undertaken and 'call response times' and 'calls not being answered' were being appropriately monitored.

The Integrated Services Programme Lead highlighted that a massive programme of change was being undertaken with less resource which in-turn affected the pace of the roll-out. In discussion on the customer care training, it was suggested that the apprenticeship levy might be able to offer some support.

A further update would be provided to the Committee in six months' time (i.e. November 2018). **OTRPM/ IPSL**

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

(B) an update on outpatient transformation be provided to the Committee in November 2018. **OTRPM/ IPSL**

79/18/5 Patient Story – Cognitive Functional Therapy (Trust Board Minute 274/17/1 of 2 November 2017)

Further to an action agreed at the Trust Board in November 2017 following a patient story on the life-changing impact of cognitive functional therapy (CFT) offered at UHL, the Acting Chief Nurse advised that the Head of Operations, CSI and Head of Therapy Services had been requested to support Mr C Newton, Extended Scope Practitioner to help translate CFT into clinical practice.

Resolved – that the verbal update be noted.

79/18/6 Mental Health Strategy Update (Minute 06/18(B) of 25 January 2018)

The Deputy Chief Nurse presented paper G, an update on the mental health work being undertaken across the Trust. This included the draft Service Level Agreement (SLA) between UHL and LPT for the provision of Medical and Neuro Psychology services (which was expected to be signed-off in June 2018), the comprehensive Mental Health assessment booklet which was in use within the Emergency Department (which included a risk assessment of mental health patients), and on the CQUIN relating to the need for acute hospitals to be equipped to detect and treat urgent mental health needs (where the primary presenting reason may be a physical health one). The Mental Health Strategy had been signed-off by the Mental Health Board on 21 May 2018. The Wave 2 transformation funding would run during autumn 2018 for a further £90m over 2019-20 and 2020-21. In respect of the joint CQUIN with Leicestershire Partnership Trust (LPT) for mental health patients attending the Trust's Emergency Department, there was a reduction in attendance rate by 46%.

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

79/18/7 Update on non-availability of medical records in Dermatology Service (Minute 07/18 (B) of 25 January 2018)

The Medical Director presented paper H and advised that although the action was in relation to the non-availability of medical records in the Dermatology Service, an Oversight Group had been established to monitor the action plan to address the wider issues in the Service around demand and capacity, workforce cultures, training, out of date equipment and environment. It was noted that significant progress had been made and the plan was to close the current action plan and develop a new one which would be presented to the next Oversight Group, further to which a decision would be taken on whether the Oversight Group would require continuing or could be disbanded. A further update would be provided to the Committee in August 2018. **MD**

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

(B) an update on the actions to address the wider issues in the Dermatology Service be provided to the Committee in August 2018. **MD**

79/18/8 **REPORT FROM THE ACTING CHIEF NURSE**

Resolved – that that this Minute be classed as confidential and taken in private accordingly on the grounds that public consideration at this stage would be prejudicial to the effective conduct of public affairs.

80/18 MORTALITY REPORT

The Medical Director presented paper I and advised that UHL's latest published SHMI at 98 and HSMR at 96 covered the time period October 2016-September 2017. Significant work had been undertaken to ensure UHL's mortality rates were closely monitored and any patient groups with a higher HSMR or SHMI were being reviewed and actions were being taken, where applicable. Progress was being made with screening of adult deaths by the Medical Examiners. 89% of Structured Judgement Reviews in quarters 1 and 2 and 54% in quarter 3 had been completed. The report summarised the areas of learning identified from the Medical Examiner screening process, completed clinical reviews, speciality mortality and morbidity reviews and bereavement support follow-up. A brief update on the locally commissioned LLR Clinical Quality Audit (looking at the care provided to patients who died either in LPT or UHL or within 30 days of discharge from UHL) was provided, noting that the findings would be provided to the Committee in August 2018. A mortality report (abridged version) would be presented to the Trust Board in June 2018. **MD** **MD**

Responding to a query from the Committee Chair, the Medical Director advised that there was no nationally prescribed method of reporting learning from deaths, however, UHL's methodology had been considered exemplar by some Trusts. Ms V Bailey, Non-Executive Director commented on the high numbers of end of life care patients being brought to hospital and noted the need for discussion with appropriate partner organisations to resolve the issues.

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

(B) an abridged version of the mortality report be presented to the Trust Board in June 2018, and **MD**

(C) the findings from the locally commissioned LLR Clinical Quality Audit (looking at the care provided to patients who died either in LPT or UHL or within 30 days of discharge from UHL) be presented to the Committee in August 2018. **MD**

81/18 NATIONAL STRATEGY ON SAFER MATERNITY CARE

Ms E Broughton, Head of Midwifery presented paper K which updated the Committee on the actions that had been taken by the Women's and Children's CMG prior to and since the publication of 'Safer Maternity Care -The National Maternity Safety Strategy (DOH 2017)'. A brief discussion took place on the three maternal deaths. The antenatal care of these patients had been reviewed and there was nothing untoward. There were no learning lessons from two cases and a report from the last case was awaited. In response to a query from Ms V Bailey, Non-Executive Director, the Head of Midwifery advised that although maternity services were provided across two hospital sites, the team considered it as one service.

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

82/18 REPORTS FROM THE DIRECTOR OF SAFETY AND RISK: (1) PATIENT SAFETY REPORT – APRIL 2018, (2) COMPLAINTS BRIEFING – APRIL 2018 (3) PATIENT SAFETY WALKABOUT REPORT, AND (4) UPDATE RE. FORMAL WARNING FROM THE ENVIRONMENT AGENCY

The Director of Safety and Risk introduced the patient safety and complaints briefing reports for April 2018, patient safety walkabout report and the report in respect of the formal warning from the environment agency as detailed in paper L. She reported that there had been four SIs in April 2018, one of which was a never event. The never event action plan was being reviewed and would be presented to the Committee in June 2018. A brief update was provided on two serious incidents that had been escalated in May 2018 – one was in respect of a patient undergoing unnecessary surgery due to a potential mix up of tissue biopsies and the other in relation to extraction of an incorrect tooth. Both of these serious incidents did not meet the criteria for never events. The investigation reports for the never events relating to the retained throat swab and unintentional connection of a patient requiring oxygen to an air flow meter in Paediatric Emergency Department would be presented to the Committee in June 2018. **MD**

In relation to the increase in complaints related to the Neurology service, an in-depth review highlighted the following issues: - delays in appointments related to capacity, Botox clinic waiting times for patients with migraine or spasticity and patients unable to get through to the service and no facility to leave messages. The Medical Director advised that the Clinical Director and Head of Operations for Speciality Medicine were aware of the issues and would be submitting an action plan to EQB and QOC in July 2018. **CD, ESM/ HoO, SM**

A formal re-launch of the safety walkabout would be undertaken and an update on the areas that had been visited and the Directors who had undertaken the safety walkabouts would be included within the Chief Executive's briefing in future.

The Director of Safety and Risk notified the Committee of an incident relating to an unauthorised disposal of a radioactive waste bin which constituted a contravention of Regulation 38 of the Environment Permitting Regulations, 2016. This breach had been formally reported to the Environment Agency on 6 March 2018 and they had issued the Trust with a Warning Notice on 13 April 2018 for failure to prevent the loss of any radioactive material or radioactive waste. The Committee Chair requested an action plan to be submitted to the Committee in June/ July 2018 by the Nuclear Medicine Service following this breach. **HMP/DSR**

Resolved – that (A) paper L now submitted, be received and noted;

(B) the investigation reports for the never events relating to the retained throat swab and unintentional connection of a patient requiring oxygen to an air flow meter in Paediatric Emergency Department be presented to the Committee in June 2018; **MD**

(C) an update and action plan following a deep-dive on the issues in the Neurology Service (as there had been an increase in complaints) be presented to EQB and QOC in July 2018, and **CD, ESM/ HoO, SM**

(D) the Head of Medical Physics (with support from the Director of Safety and Risk) be requested to submit an action plan to the Committee in June/July 2018 following the breach relating to an unauthorised disposal of a radioactive waste bin. **HMP/DSR**

83/18 NURSING AND MIDWIFERY QUALITY AND SAFE STAFFING REPORT

Paper M, presented by the Acting Chief Nurse, detailed triangulated information relating to nursing and midwifery quality of care and safe staffing, and highlighted those Wards, triggering Level 1 (20 wards) and Level 2 (6 wards) and Level 3 (no

wards) concerns. The report listed a number of wards which required corporate nursing support and oversight, however, the Acting Chief Nurse highlighted that some of those wards did not require oversight. The reason for this was that some wards had actually submitted the metrics but due to some administrative issues, this information had not been received. The Registered Nurse vacancies had increased in month and were reported at 575WTE. An infection prevention assurance report would be submitted to EQB and QOC in June 2018.

Resolved – that paper, now submitted, detailing triangulated information relating to nursing and midwifery quality of care and safe staffing, be received and noted.

84/18 INSULIN SAFETY UPDATE

The Acting Chief Nurse advised verbally that work was in progress to embed actions to improve insulin safety. The Diabetes team had been undertaking safety walkabouts to review the management of diabetic patients who were treated with insulin in all areas of the Trust. The insulin safety dashboard would continue to provide the Trust with an oversight on insulin safety.

Resolved – that the verbal update be received and noted.

85/18 CIP QUALITY AND SAFETY IMPACT ASSESSMENT

The Acting Chief Nurse reported that in 2017-18, the CIP quality and safety impact assurance process (paper N refers) worked well, all schemes had been reviewed by the CMG and those above £50k had been challenged by the former Chief Nurse and Medical Director.

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

86/18 CQC UPDATE

Paper O, presented by the Director of Clinical Quality provided the CQC's latest Insight Report. The Committee Chair requested a commentary on the Insight Report be provided within the covering report. It was also requested that for those indicators where UHL was either Worse or Much Worse by national comparison, an update be included on whether UHL was already aware of the issues and the actions that were being taken. **DCQ**

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

(B) the Director of Clinical Quality be requested to include a commentary on the Insight Report and for those indicators where UHL was either Worse or Much Worse by national comparison, an update be included on whether UHL was already aware of the issues and the actions that were being taken. **DCQ**

87/18 QUALITY COMMITMENT QUARTER 4 PERFORMANCE REPORT

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

88/18 CQUIN AND QUALITY SCHEDULE UPDATE

The Director of Clinical Quality presented paper R which provided an overview of achievements and the challenges associated with the CQUIN schemes in 2017-18. The Trust was unsuccessful in:- (a) achieving a 5% improvement in the NHS annual staff survey for positive action on health, staff experiencing MSK problems and staff

feeling unwell as a result of work related stress, (b) achieving a reduction in antibiotic consumption (there has been a 7% increase), and (c) increasing capacity within the Palliative Care team. Responding to a query from the Committee Chair, the Deputy Chief Nurse advised that during emergency pressures over the winter months, the senior palliative care team had been required to take-on clinical work.

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

89/18 CLINICAL AUDIT QUARTERLY REPORT

The Director of Clinical Quality presented paper S, the Clinical Audit Report for quarter 3 of 2017-18. It was suggested that the report took into consideration the triangulation between the clinical audit work, Trust's strategic priorities and CQC action plan. In response, the Director of Clinical Quality advised that the Clinical Audit strategy was being refreshed and this would be taken into consideration then.

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

90/18 QUALITY AND OUTCOMES COMMITTEE – ANNUAL WORK PLAN 2018-19

Resolved – that paper T, the Quality and Outcomes Committee annual work plan for 2018-19 be noted.

91/18 ITEMS FOR INFORMATION

91/18/1 Data Quality and Clinical Coding Report

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

92/18 MINUTES FOR INFORMATION

92/18/1 Executive Quality Board

Resolved – that the action notes and actions from the meeting of the Executive Quality Board held on 3 April 2018 and 1 May 2018 respectively (papers V1 and V2) be received and noted.

92/18/2 Executive Performance Board

Resolved – that the action notes of the meeting of the Executive Performance Board held on 24 April 2018 (paper W) be received and noted.

93/18 ANY OTHER BUSINESS

There were no items of any other business.

94/18 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 7 June 2018, and **Chair**

(B) the item of business referred to in:-

Minute 75/18 above – NHS Resolution Maternity Self-Assessment be recommended to the Trust Board in June 2018 for sign-off;

Minute 76/18 above – the Quality Account 2017-18 be recommended to the Trust Board in June 2018 for sign-off, and

Minute 80/18 above – an abridged version of the mortality report be submitted to the Trust Board in June 2018.

95/18 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality and Outcomes Committee be held on Thursday, 28 June 2018 from 1.15pm until 4.15pm in the Board Room, Victoria Building, Leicester Royal Infirmary.

The meeting closed at 4:55pm

Cumulative Record of Members' Attendance (2018-19 to date):

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
J Adler	2	1	50	E Meldrum	2	2	100
V Bailey	2	2	100	*B Patel*	2	2	100
P Baker	2	1	50	*K Singh (Ex-officio)*	2	0	0
I Crowe (Chair)	2	2	100	*C West – Leicester City CCG*	2	0	0
A Furlong	2	2	100				

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*%attendance*
M Caple	2	2	100	*S Hotson*	2	2	100
M Durbridge	2	2	100	*C Ribbins*	2	1	50

Hina Majeed
Corporate and Committee Services Officer