UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY COMMITTEE (QC) MEETING HELD ON THURSDAY 26 AUGUST 2021 AT 2:00PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Voting Members Present:
Ms V Bailey - Non-Executive Director (Chair)
Ms C Fox - Chief Nurse
Mr A Furlong – Medical Director
Ms D Mitchell – Acting Chief Operational Officer
Mr M Williams – Non-Executive Director

In Attendance:
Mr P Aldwinckle – Patient Partner
Ms S Bailey – CCG Representative
Ms G Belton – Corporate and Committee Services Officer
Dr H Brooks – Cancer Centre Lead Clinician (for Minute 75/21/4)
Ms E Broughton – Head of Midwifery (for Minute 75/21/3)
Ms L Cowan – Head of Operations, MSS (for Minute 75/21/2)
Miss M Durbridge – Director of Quality Transformation and Efficiency Improvement (from Minute 75/21/5)
Ms K Gillatt – Associate Non-Executive Director
Ms N Green – Deputy Chief Nurse
Dr A Haynes – Adviser to the Trust Board
Ms S Khalid – Clinical Director, RRCV (for Minute 75/21/1)
Ms B O'Brien – Director of Quality Governance
Mr I Orrell – Associate Non-Executive Director
Ms J Smith – Patient Partner

RESOLVED ITEMS

71/21 APOLOGIES

Apologies for absence were received from Ms C West, CCG Representative.

72/21 DECLARATIONS OF INTERESTS

Ms K Gillatt, Associate Non-Executive Director, declared her interests as Non-Executive Director of Trust Group Holdings Ltd and Non-Executive Director of the NHS Business Services Authority. With the agreement of the Quality Committee, Ms Gillatt remained present.

73/21 MINUTES

Resolved – that the public and private Minutes of the Quality Outcomes Committee (QOC) meeting held on 29 July 2021 (papers A1 and A2 refer) and the QOC Summaries from the same meeting (papers A3 and A4 refer) be confirmed as a correct record.

74/21 MATTERS ARISING

The contents of the Quality Committee Matters Arising Log (paper B refers) were received and noted. The Corporate and Committee Services Officer confirmed that all actions now completed (RAG-rated as '5' on the Log) would be removed and not feature in future iterations.

Resolved – that the Matters Arising Log (paper B refers) be received and noted.

75/21 ITEMS FOR DISCUSSION AND ASSURANCE

75/21/1 Cardiology Update

The Clinical Director (RRCV) attended the meeting to provide an update on the cardiology medical

workforce and issues facing the cardiology service as a whole (emergency and elective) – paper C refers. The Committee specifically received a progress update on initiatives to address concerns raised by HEEM in relation to Cardiology Trainees and was pleased to hear that following a recent HEEM visit, the issue had been de-escalated. Action was still required to: (1) substantively appoint to the Consultant and registrar medical posts for ward 15 (2) address rota issues in relation to CDU Trust Grades (3) review the acute cardiology model across site and (4) optimise catheter laboratory efficiency. In discussion on this item, members made note of the impact of increasing pressure in relation to Covid-19. The Acting Chief Operating Officer noted that her team would continue to work to support the RRCV Clinical Management Group in balancing emergency demand with elective recovery.

In response to assurance sought by Dr Haynes, Adviser to the Trust Board, the Clinical Director of RRCV advised that there was nothing currently flagging in the safety data to indicate an elevated risk, but anecdotal feedback from staff suggested further focus was required and collaborative working would continue. She also made reference to system work being undertaken around revised pathways, particularly with regard to atrial fibrillation and heart failure.

In response to a query raised by Mr M Williams, Non-Executive Director, as to which of the issues described were also applicable nationally or were unique to Leicester, the Clinical Director (RRCV) confirmed that an increased presentation of patients was a national issue, as was a shortage of Consultants in this field. The presentation of cardiology patients was a situation unique to Leicester. In most other Trusts, such patients presented through the Emergency Department, rather than through a dedicated Clinical Decisions Unit as was the case at UHL.

In concluding discussion on this item, the Quality Committee Chair thanked Ms Khalid for her report, acknowledging the positive progress made as demonstrated at the last HEEM visit, and commended the local and system-wide work being undertaken; the timeline relating to which would be helpful to receive in a future update. The Quality Committee Chair also acknowledged the need for an on-going focus on morale. The contents of this report were received and noted and it was agreed that a further update would be presented in four months' time (i.e. December 2021).

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

(B) a further update be presented to the Quality Committee in four months' time (to include the timeline relating to the local and system-wide work if available). **CD,RRCV**

75/21/2 <u>Ophthalmology Long Term Follow Up Update</u>

The Head of Operations (MSS) attended to present a report (paper D refers) which provided assurances that patient safety concerns relating to the impact of the Covid-19 pandemic on the number of Ophthalmology patients overdue for follow-up was being addressed, monitored and reviewed and to evidence the systems and processes that had been implemented to mitigate further risk.

Due to the impact of the Covid-19 pandemic, the number of ophthalmology patients overdue for follow up had increased to 31,000 patients in February 2021. This was an increase of 7,483 patients on the November 2020 position and an increase of 10,985 patients on the August 2020 position. Following an intensive period of concentrated, system wide working, this number had reduced to 23,903 by April 2021. At the end of July 2021 the backlog had reduced further to 20,185 (including paediatrics). In order to ensure that those patients waiting were not coming to any harm as a consequence, a process of manual administrative validation was completed, which was then followed by a clinical validation process. In the absence of a nationally defined risk stratification for out-patients, the Ophthalmology Clinical Team had agreed the criteria locally.

Subspecialty stratification and discharge hubs had been set up to support virtual clinical review of the patients. The Leicester, Leicestershire and Rutland Community Eye Service (LLRCES) had been created under the umbrella of UHL contracting to support the care of emergency patients in the community and reduce EED attendance, the long term funding of which required identification and work was on-going in relation to this. LLRCES was the foundation of a support system that

could significantly reduce the number of patients on the Glaucoma long term follow up waiting list. The Ophthalmology Service had applied for, and been granted, elective recovery funding for the community glaucoma funding scheme which would enable the transfer of a number of patients from the UHL Ophthalmology and Alliance follow up backlog into the community optometrist setting. The Cornea team had convened telephone clinics out of hours to review patients suitable for telephone follow up. Some of the general ophthalmology clinics in the Alliance had been converted into cornea clinics for high risk patients and the team had undertaken additional clinics at the weekend to ensure appointments for patients who needed to be seen within two weeks. The transfer of ophthalmology services into a community setting continued in order to deliver care closer to home and to create additional capacity within secondary care for high risk follow up patients on a sustained basis.

The Chief Operating Officer thanked the Head of Operations (MSS) and her team for the significant amount of work undertaken in this respect, acknowledging that whilst the backlogs were large, the amount of innovative and transformative work undertaken to address these was significant. The Committee acknowledged that this issue was being owned and addressed by the system, in light of which it was agreed that a further update report should only be presented again to the Committee in three to four months' time if there were fundamental issues for consideration. If work continued to reduce the backlog successfully then a further report was not required. The contents of this report were received and noted.

Resolved – that (A) the contents of this report be received and noted, and

(B) a further report be presented in four months' time only if there were fundamental issues for consideration (if work continued to reduce the backlog successfully then a further report was not required). **CD/ HoO,MSS**

75/21/3 Maternity HSIB and Maternity Safety Quarterly Report

The Head of Midwifery attended to inform the Committee of the progression of the Maternity Safety agenda, including Healthcare Investigation Branch (HSIB) reports, Serious Incidents and 72 hour reports for Q1 2021/22 (paper E refers). It also highlighted the common themes from Datix reporting and progress on these.

The Ockenden Report published in December 2020 specified as an 'essential and immediate' action, that the Trust Board and the Local Maternity and Neonatal System (LMNS) were sighted to any serious incidents occurring in the maternity service and made aware of the safety recommendations and learning from these incidents. Safety incidents in future would be included in the maternity safety report presented quarterly to the Executive Quality Board and Quality Committee, with any concerns or information escalated to the Trust Board. This process required embedding by December 2021, with the first review of evidence to assure the national team that UHL were compliant with the Ockenden recommendations taking place in July 2021. The main body of the report described the process for reviewing action plans and dissemination of learning with the reports and learning bulletins attached as appendices. The maternity risk strategy had been reviewed and a flow chart prepared to describe the reporting structure and governance processes to ensure compliance with the requirements described in the Ockenden Report. The contents of this report were received and noted and particular discussion took place regarding the learning from themes arising from specific HSIB reports and how this was being applied at UHL.

Note was made of the value of the inclusion of patient feedback in the reports, in terms of a patient's overall experience encompassing more than just their medical care, which had led to the decision to submit HSIB reports within an overarching maternity safety report so that staff could really understand the receipt of care from a patient perspective. Whilst acknowledging the lessons that could be learned from reviewing the detail of an individual's care, the Committee also noted the benefit from review of general themes arising, and work was planned in this respect.

Resolved – that the contents of this report be received and noted.

75/21/4 Cancer Performance Recovery

Dr Brooks, Cancer Centre Lead Clinician, presented an update on cancer performance recovery for the period ending June 2021 (paper F refers). Cancer delivery and performance continued to be a key priority for the Trust. Due to the impact of the Covid-19 pandemic, there had been changes to cancer pathways, a decrease in activity and an increase in the tracking of patients. The changes made followed the National and Tumour specific Society recommendations and ensured that patients were safe and received the time critical cancer treatments they required.

In June 2021, the Trust achieved four standards against the national targets. The most significant challenges remained 2 week wait (2ww) capacity, 31 day and 62 day waits for surgery and treatment due to an increase in demand and a decrease in capacity. Overall performance was deteriorating, however more patients were being booked and changes had been put in place by clinical leads to ensure safe pathways. In presenting this report, Dr Brooks noted the finding that currently patients were presenting late and at a later stage resulting in surgical treatment no longer being a viable treatment plan for some. Staffing issues were also being experienced due to vacancies and staff absence relating to Covid-19, which was resulting in a reduced theatre capacity. Significant work was being undertaken with system partners and internally to improve the position. The Acting Chief Operating Officer acknowledged that as the Trust improved its position with regard to backlogs, an increasing number of patients were coming through the system, requiring scarce resource to be directed to the areas where it would have the most positive impact, and this position, with its inherent risks, was reflected nationally as well as locally. The pathway had observed a very significant increase in referrals and the Trust was working with primary care colleagues on how to best address this in order to ensure that the right patients received access to the appropriate clinical care and she expressed her thanks to the teams working under Dr Brooks' leadership for their continued hard work and focus in this area.

Specific discussion took place regarding work on-going in relation to addressing required IT and audio-visual improvements. Note was also made of anecdotal information from patients regarding access to face to face GP appointments and assurances received from Primary Care that all relevant patients would have access to face to face appointments where appropriate. Note was also made of a particular annual non-recurrent funding stream which was to be discussed further at the Financial Recovery Board (FRB) meeting.

The contents of this report were received and noted and the Committee acknowledged the positive transformation processes implemented, albeit were concerned regarding the overall backlog, particularly in view of the increasing number of referrals. The Committee were content that the Trust continued to give scrutiny to what could be resolved internally at an early stage in the process. Following discussion, and in view of the fact that the Trust Board would now be reviewing the Quality and Performance report at each of its meetings, it was agreed that a monthly report on cancer performance was no longer required for submission to the Quality Committee and that a quarterly report which focused specifically on harm (resulting from the circumstances giving rise to any decrease in cancer performance metrics) would now be appropriate.

Resolved – that (A) the contents of this report be received and noted, and

(B) (as the Trust Board would now be reviewing the monthly Quality and Performance Report at each of its meetings) the Cancer Centre Clinical Lead and Assistant Director of Operations be requested to submit a report specifically focusing on harms to the Quality Committee on a quarterly basis (and no longer submit a monthly report on cancer performance). **ADoO/ CCCL**

75/21/5 CIP QIAs 21/22 – Quarter 1 Review

The Director of Quality, Transformation and Efficiency Improvement presented the first quarterly review of the Quality Impact Assessment (QIA process for the 2021/22 Cost Improvement Programme (CIP)) and thanked Ms H Harrison, Transformation Programme Manager for her work in this respect. As at the date of report submission: (1) 317 CIP schemes had been registered on the Transformation 2021/22 CIP tracker as requiring QIAs (2) 101 QIAs for 21/22 had been submitted to the Transformation PMO (3) 16 schemes did not require a QIA as one was

completed and approved when the scheme commenced on 20/21 or a QIA was not applicable (4) 43 schemes related to procurement; which equated to 108 QIAs across seven Clinical Management Groups, the Alliance and Corporate Teams. The outstanding PIDs for Procurement Schemes would be completed by the week commencing 30 August 2021 (5) 4 QIAs had been rejected and (6) 87 CMG and corporate area QIAs were outstanding. The Quality Committee were requested to: (a) note the progress with the completion and approval of QIAs for CIP schemes in 2021/22 (b) note that a further quarterly update would be presented in November 2021 and (c) note that the Director of Quality, Transformation and Efficiency Improvement would escalate concerns over any non-returns to the Chief Nurse and Medical Director.

In presenting this report, the Director of Quality, Transformation and Efficiency Improvement emphasised that it was an aim of the PMO to drive through cultural change, with the Quality Impact Assessments (QIAs) just one element of the process. She noted that schemes were added or suspended on a frequent basis and, as such, the number of schemes fluctuated accordingly. The table detailed under section 2.7 of the report detailed the QIAs submitted to the Transformation PMO by impact level. The Chief Nurse noted that there was to be external scrutiny of the QIA process as part of financial special measures to which the Trust was subject, and this would facilitate benefits in having the opportunity for an external view of the process. In response to a query, the Director of Quality, Transformation and Efficiency Improvement confirmed that all schemes had or were delivering with no or minimal risk and those for review by the Medical Director and Chief Nurse were sent to them in priority order. None of the 'red' schemes had commenced and would not do so until approval was received as nothing would be progressed 'at risk'.

The Committee received and noted the contents of this report, with the Committee Chair acknowledging that this report constituted a helpful first report detailing the context. She requested that future such reports to the Quality Committee focused on QIAs relating to quality and safety to facilitate an understanding of any pertinent risks relating to any decisions being taken, noting it was important not to duplicate the information discussed at the Finance and Investment Committee (FIC).

Resolved – that (A) the contents of this report be received and noted, and

(B) the Director of Quality, Transformation and Efficiency Improvement be requested to ensure that future such reports to the Committee focus on QIAs relating to quality and safety to facilitate an understanding of any pertinent risks relating to any decisions being taken. **DQTEI**

75/21/6 Patient Safety

75/21/6.1 Patient Safety Highlight Report

Paper H1, as presented by the Director of Quality Governance, detailed (1) the key points from the Framework for Involving Patients in Patient Safety (2) documented the patient safety reporting requirements for the Professional Standards of Care for Patients Waiting in Ambulances and how the Trust proposed to meet these (3) detailed the current position with regard to the Patient Safety Team staffing risk, including mitigating action and (4) detailed a proposal for future reporting to the Executive Quality Board (EQB) and Quality Committee (QC), including a monthly comprehensive Patient Safety Report, aligning the Complaints Reporting timescale with that of the Patient Experience Report and production of a Quarterly Patient Safety Update including regional and national updates and directives.

The Quality Committee was requested to: (a) note the key points from the Framework for involving patients in patient safety and the proposal that the Director of Quality Governance and the Head of Patient Safety, as the Patient Safety Specialists, convened a regular meeting with the Executive Director for Patient Safety to discuss the requirements of the strategy and plan the UHL approach (b) note the incident reporting requirements of the Professional Standards document. Dedicated support was requested to support the review of the POA cases. It was requested that the Executive Director for Patient Safety approach the system for support with this significant piece of work as this represented a system issue (c) note the actions being taken to resolve the current situation, with an appeal to CMG members to respond to their complaints by the required

deadline given to reduce a further administrative burden for the PILS team in chasing responses and (d) agree the proposed reporting changes which would commence for the September 2021 meetings.

Resolved – that the contents of this report be received and noted.

75/21/6.2 Patient Safety Briefing Report

The Director of Quality Governance presented H2; the Patient Safety Briefing report. Thirteen Serious Incidents (SIs) had been escalated in July 2021, including one Never Event. This maintained high number of SIs was largely due to a change in the way that inpatient falls incidents were being managed and the fact that every maternity referral to HSIB was now reported as an SI. There had been an increasing trend in the number of moderate and above harm incidents reported and validated harm incidents were also increasing (relating, this month, to reporting of some of the retrospective HCAI Covid-19 cases). There were fifteen incidents with evidence gaps in Duty of Candour which was consistent with the previous month, albeit it some were different incidents. No Safety Alerts had elapsed actions or had actions overdue their completion date during this reporting period. Specific discussion took place regarding the identification of three grade 4 pressure ulcers; two of which were Covid-19 device related and one which was not. Significant learning had been identified from review of these incidents and the Chief Nurse noted that she would be submitting the summary from the thematic review through the Quality and Safety process and would report on elsewhere within the Committee structure as appropriate. The contents of this report were received and noted.

Resolved – that the contents of this report be received and noted.

75/21/6.3 Complaints Briefing Report

Paper H3, as presented by the Director of Quality Governance, provided a summary of complaints activity for July 2021 and the most recent performance data. The number of formal complaints this month had decreased compared to the previous month. The Emergency Department was the specialty with the most complaints and concerns and General Surgery had the largest rise in the number of complaints and concerns received in July 2021. There had been a higher number of re-opened complaints and the number of GP concerns had decreased. Four new PHSO cases had been received and no PHSO cases were closed in July. There had been a poor performance for complaints responses due to a small residual backlog of complaints, increasing activity and Corporate Patient Safety team staffing pressures, as documented on the Trust Risk Register ID 3755 at score of 16. Complaint themes and trends were now included within the bi-annual Patient Experience report to ensure the triangulation of all patient feedback. This then allowed for focused speciality or organisational actions to be developed and implemented improving quality and safety.

In discussion, it was noted that the Trust did not take the view as to whether a complaint was upheld or otherwise as there were always valuable learning points, albeit it was noted that the Trust had a process for managing vexatious complaints. Note was also made of the inability to hold complaints resolution meetings during the pandemic which were frequently a very beneficial way of addressing and resolving complaints. The Quality Committee Chair noted the benefit in including within the report both the numbers, as well as percentages, of complaints. The contents of this report were received and noted.

Resolved – that the contents of this report be received and noted.

75/21/7 Deteriorating Patient, Resuscitation and End of Life and Palliative Care Quarterly Report

The Medical Director presented paper I, which provided an update on the work of the Deteriorating Patient Board, Resuscitation Committee and the End of Life and Palliative Care Committee that had taken place since the last update in May 2021. The dashboard was being moved to a 'live' environment so Clinical Management Groups could monitor their individual performance. The dashboard was being developed using an iterative process, with the aim being to facilitate understanding and ownership of the data by the individual CMGs and specialties with the view to having the data challenged and improved by those teams. The intention was for each CMG team to present their data at a selected Deteriorating Patient Board (DPB) meeting. Sepsis

data trends were broadly in line with the national picture with significant variation throughout the pandemic. UHL breached the upper control limit for mortality in coded sepsis patients in December 2020, January 2021 and February 2021, which was in line with the national picture and UHL returned to within control limits for March 2021. Insulin safety training compliance remained an issue for medical staff; targeted face to face training would now be undertaken to improve compliance. The role out of NerveCentre eMeds had meant that insulin prescribing would change which would reduce the number of insulin prescribing errors. The ICNARC Quarterly Quality report had demonstrated the spike in high risk admissions from wards but this was now back within control limits. Overall mortality increased, as expected, due to Covid-19 last year, this was particularly the case at Glenfield Hospital. Subsequent data analysis had demonstrated that outcomes were in line with the national picture. Tracheostomy ward rounds had recommenced following their suspension at the beginning of the pandemic. The service remained under pressure due to the fact that tracheostomy care was an aerosol generating procedure. Cardiac arrest rates and outcomes were currently within expected ranges. An amended risk assessment and SOP had been agreed at the Resuscitation Committee and Children's Board regarding the paediatric cardiac arrest provision on the Glenfield Hospital site. A new Palliative Care Consultant and End of Life Lead had commenced in post in April 2021. Work was underway to review the clinical vision, driver diagram and terms of reference for the Committee to ensure the right representation and reflect the learning from the Covid-19 pandemic. SPELTIP continued to provide a Clinical Nurse Specialist Service to the emergency floor areas. Medium term funding has been secured and a business case was being produced to secure longer term investment. The contents of this report were received and noted.

Resolved – that the contents of this report be received and noted.

75/21/8 Mortality and Learning from Deaths Quarterly Report

The Medical Director presented the Mortality and Learning from Deaths Report (paper J refers) the contents of which were received and noted. In discussion on this report, the Quality Committee Chair noted the benefit in including specific, rather than generalised, actions within an action plan, as these were more readily measurable. The contents of this report were received and noted and it was agreed to highlight specific elements of this report (namely the cover sheet and appendix 2) to the Trust Board for information.

Resolved – that (A) the contents of this report be received and noted, and

(B) particular elements of this report (the cover sheet and appendix 2) be highlighted to the Trust Board at its meeting on 2 September 2021. **CCSO**

75/21/9 Infection Prevention Annual Report

The Chief Nurse presented the Infection Prevention Annual Report (paper K refers) which reviewed the 2020/21 Infection Prevention successes and challenges for the Trust, and constituted a separate item on the public Trust Board agenda (paper I refers on the 2 September 2021 Trust Board agenda). The presentation of this report was a statutory requirement of the Trust and concluded that the Infection Prevention audit programme was compliant with The Health and Social Care Act: Code of Practice on the prevention and control of infections and related guidance. The audits included evidence based interventions to reduce the risk of infection to provide education and feedback to clinical staff. Section 3 of the Infection Prevention Annual Report outlined the measures taken by the Trust to ensure national and local policies and guidance were met and adhered to. In response to a query raised by Mr M Williams, Non-Executive Director, the Chief Nurse confirmed that the year-end position for UHL was 78 (out of an allotted trajectory of 108) Clostridioides Difficile Infections (CDI) cases. The contents of this report were received and noted.

Resolved – that the contents of this report be received and noted.

75/21/10 Quality and Performance Report – Month 4 2021/22

As the Month 4 2021/22 Quality and Performance Report (paper L refers) constituted an item for consideration on the agenda of the Trust Board meeting of 2 September 2021, its contents were

received and noted by the Quality Committee.

Resolved – that the contents of this report be received and noted.

75/21/11 Covid-19 Position – August 2021

The Medical Director and Chief Nurse reported verbally with regard to the Covid-19 position as at August 2021. The number of cases were, again, increasing; with the system 'running hot' at Escalation Level 3. There was significant pressure across the region in terms of ITU capacity, which was likely to lead to the taking down of elective activity to accommodate this. The Trust continued to review its surge plans and specific note was made of the continuing and on-going need to vaccinate people who had not yet taken up their vaccine. The Chief Nurse noted that the increasing community transmission of Covid-19 was likely to flow through to increased hospital admissions and she confirmed that a small number of outbreaks within the Trust had now been resolved.

Resolved – that this verbal information be noted.

76/21 ITEMS FOR NOTING

76/21/1 Falls Annual Report 2020/21

Resolved – that the contents of this report be received and noted.

76/21/2 Pressure Ulcers Annual Report 2020/21

The contents of the Pressure Ulcers Annual Report 2020/21 (paper N refers) were received and noted. The Chief Nurse highlighted that there had been a fundamental change to the way in which pressure ulcers were being monitored and measured, with the position being tracked through four quarters. There was an extensive improvement plan, with the use of QI methodology, and collaborative work was being undertaken alongside the Director of Quality, Transformation and Efficiency Improvement's team.

Resolved – that the contents of this report be received and noted.

76/21/3 Transfusion Committee Update

Resolved – that the contents of this report (paper O refers) be received and noted.

76/21/4 Radiation Safety Annual Report

Resolved – that the contents of this report (paper P refers) be received and noted.

76/21/5 EQB Action Notes – July 2021 (paper Q)

Resolved – that the action notes from the EQB meeting held on 20 July 2021 (paper Q) be received and noted.

77/21 ANY OTHER BUSINESS

Resolved – that there were no further items of business.

78/21 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that (A) the following items be recommended onto the 2 September 2021 public Trust Board for formal approval:

(1) Infection Prevention Annual Report (this featured as a separate standalone item on the Trust Board agenda for 2 September 2021), and

(B) the following items be highlighted to the 2 September 2021 public Trust Board via the summary of this Committee meeting for information:

(1) Cardiology Update;
(2) Ophthalmology Long Term Follow Up Update;
(3) Maternity HSIB and Maternity Safety Quarterly Report;
(4) Cancer Performance Recovery, in particular the intention for the Quality Committee

to receive quarterly harms reports in future rather than monthly performance reports, and
(5) Mortality and Learning from Deaths Quarterly Report. **QC Chair**

79/21 DATE OF THE NEXT MEETING

<u>Resolved</u> – that the next meeting of the Quality Committee be held on Thursday 30 September 2021 from 2pm via Microsoft Teams.

<u>The meeting closed at 3.57pm</u>

Gill Belton - **Corporate and Committee Services Officer**

Cumulative Record of Members' Attendance (2021-22 to date):

Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
V Bailey (Chair)	5	5	100	A Furlong	5	5	100
P Baker (until 29.7.21)	4	4	100	B Patel (until 24.6.21)	3	3	100
C Fox	5	5	100	M Williams (from 29.7.21)	2	2	100

Non-voting members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
P Aldwinckle (PP)	5	4	80	I Orrell	5	5	100
M Durbridge (from 29.7.21)	2	2	100	J Smith	5	3	60
K Gillatt (from 29.7.21)	2	2	100	C Trevithick/C West/ H Hutchinson (CCG Representative)	5	5	100
A Haynes (from 27.5.21)	4	4	100				