NHS
North East and North Cumbria

North East and North Cumbria Integrated Care Board
Quality and Safety Committee meeting held on 14 September 2023 from 9.00-12.00pm in the Joseph Swan Suite, Pemberton House.
Minutes

Present:
Professor Eileen Kaner, Independent Non-Executive Member (Chair)
Dr Maria Avantaggiato-Quinn, Director of Allied Health Professionals
Professor Hannah Bows, Independent Non-Executive Member (virtually)
Ken Bremner, Foundation Trust Partner Member
David Gallagher, Executive Area Director Tees Valley & Central
Annie Laverty, Executive Director of Improvement and Experience (virtually)
Dr Saira Malik, Primary Medical Services Partner Member (virtually)
Louise Mason-Lodge, Director of Nursing (virtually)
Dr Rajesh Nadkarni, Foundation Trust Partner Member (virtually)
Dr Neil O'Brien, Executive Medical Director
Chris Piercy, Director of Nursing
David Purdue, Executive Chief Nurse
Claire Riley, Executive Director of Corporate Governance, Communications and Involvement
Richard Scott, Director of Nursing
Dr Mike Smith, Primary Medical Services Partner Member
Dr Annie Topping, Director of Nursing
Jenna Wall, Director of Nursing

In Attendance:
Christopher Akers-Belcher, Regional Co-ordinator, Healthwatch
Tony Roberts, Director of North East Quality Observatory (NEQOS)
Lisa Anderson, Senior Involvement and Engagement Lead (virtually)
Neil Hawkins, Head of Corporate Affairs, (Central and Tees areas)
Jan Thwaites (minutes)

QSC/2023/09/01 Welcome and Introductions

The Chair welcomed members to the meeting and a round of introductions were made.

QSC/2023/09/02 Apologies for absence

Apologies were received from Ann Fox, Director of Nursing, Jean Golightly, Director of Nursing, Jeanette Scott, Director of Nursing.

QSC/2023/09/03 Declarations of Interest

Members had submitted their declarations prior to the meeting which had been made available in the public domain.

QSC/2023/09/04 Quoracy

The meeting was confirmed as quorate.

QSC/2023/09/05 Minutes of the meeting held on 20 July 2023

RESOLVED:
The Committee **AGREED** the minutes from the meeting held on 20 July 2023 were accepted as a true and accurate record.

QSC/2023/09/06 Matters arising from the minutes and action log

The notes from the Patient Voice Subgroup (the Subgroup) had not been approved by the chair at the time of this meeting so could not yet be circulated. It was confirmed that the Subgroup had met to review its terms of reference and membership and an update would be brought to the next meeting on this.

In terms of a patient experience update, these would be taken to the Subgroup first in future so they could be considered alongside other sources of patient feedback. These would then be summarised and submitted formally as an integrated report from the Subgroup to the Committee.

A query was raised in relation to the action concerning the development of a plan on a page for the C.difficile work mentioned on the action log. It was confirmed that this action was now complete.

The work on Continuing Healthcare (CHC) and complex case management and safeguarding would remain on the action log and would be planned for a future meeting.

Thanks were given to Dr Mike Smith for his contribution to the committee. Due to a change in the terms of reference he would be attending the Finance, Performance and Investment Committee (FPIC) as a Primary Medical Services Partner Member.

The action log was discussed and updated and would be brought to the agenda setting meetings for update.

ACTION:
Chris Piercy to share the deep dive/ plan on a page in regard to C.difficile with the committee.

ACTION:
With regards to ICB compliance with NICE guidelines, there would be a re-audit of this work and this would come to the Committee in future. This was to be added to the action log.

QSC/2023/09/07 Patient Story

The Committee welcomed the storyteller to the meeting who had agreed to discuss their own journey through the health system and the difficulties they had faced when receiving treatment for their mental health conditions.

The patient story detailed the journey from first presentation of symptoms to treatment throughout the entire health system.

It was acknowledged that the storyteller had a passion for the value of lived experience and noted it was vital that healthcare was humanised in this country to achieve a cultural change.

The storyteller recounted various episodes throughout their journey within the health system, including in-patient care, accessing various community and crisis services, collecting countless diagnoses and medications. There were also encounters with the police, social services, and the ambulance service. Whilst the story-teller originally welcomed referral for mental health treatment, some of the subsequent experiences had been challenging and were perceived as re-traumatising.

The Committee acknowledged that a different way of looking at these issues was required, and trauma informed approaches were potentially part of the solution. Embedded at a system level they would prioritise and facilitate healing relationships.

The Chair declared an interest in her research area of trauma informed approach with vulnerable people who had experienced homelessness.

There was a hope that change would be affected in the way mental health patients were seen through the value of healing, the need for a trauma informed system and the value of patient leadership and co-production.

Thanks were given for this important and thought-provoking contribution from the storyteller. A comment was made in relation to patient safety, and it should not just be about the safety of the system.

It was noted that going forward patient stories would influence the agenda. Part of the reason for the patient story today was in preparation for a planned ICB Board meeting dedicated to mental health.

A question was asked concerning how a network of lived experience could be built, in an authentic and influencing way covering many services in the commissioning cycle. In response it was noted that a lived experience board had been developed with 25 members from across the North East working in a peer or lived experience role. Work was being undertaken on a new surveillance technology; each member of the board had taken a questionnaire back to their local forum to gather feedback and ensure patient and public voices can be heard.

A question was raised as to what could be shared from a clinician's personal experience when interacting with patients given professional restrictions on sharing information and how can we support clinicians to better support their patients. In response it was noted that there was a lot to learn from the expansion of the peer workforce and work was ongoing to share experiences safely in a way that would be beneficial for both sides.

ACTIONS:

A meeting was to be arranged with the storyteller and the Executive Director of Corporate Governance, Communications and Involvement to discuss lived experience and a network to support future ICB involvement work.

A discussion to address the trauma informed care approach in future meetings was to be held and include colleagues with expertise in the meeting.

RESOLVED:
The Committee **HEARD** and **REFLECTED** upon the lived experience account, and thanked the patient again for sharing their story.

QSC/2023/09/08 ICB Quality Report

The chair brought to members' attention that a supporting reference pack had been created for some main agenda items. This was to help manage the volume of information available for members whilst ensuring essential information and assurance was included within covering reports.

The Place Nursing leads are working closely together and will alternate in terms of who delivers this report. The Director of

Nursing for Tees Valley delivered this item with overarching themes structured as per the strategic aims of the National Patient Safety Strategy i.e.by *Insight, Involvement* and *Improvemen*t.
Complex care continued to be a challenge across the organisation, particularly around care and treatment reviews in the South of the region. It was noted that the Care and Treatment Review team in Durham was under pressure, however plan had been developed to backfill posts whilst recruitment options were being explored.

Continuing Healthcare (CHC) continued to experience pressures due to staff vacancies and sickness/absence. Support had been offered from across the system to assist with these issues.

Safeguarding continued to carry vacancies and work was ongoing to arrange cover between various geographies within the ICB to fill any gaps as effectively as possible. The teams were also looking at a more robust approach to recruitment.

Learning from Lives and Deaths (LeDeR) reviews continued to be an area of pressure within the ICB with an increasing number of reviews being required. A new workforce model was being developed to improve timeliness of reviews and to share the learning across the ICB area.

A number of challenges were noted in relation to health care associated infections (HCAI), particularly around C.difficile but the ICB was in a better position than last year. A plan on a page had been developed and this would be shared with the Committee for assurance.

Several 'deep dives' were planned for other HCAI rates with associated plans being developed in consultation with local foundation trusts. It was noted that all 11 foundation trusts had engaged with this approach and had shadowed each other to identify learning and share best practice.

A software issue had been reported at South Tyneside and Sunderland Foundation Trust (STSFT) around radiology and information systems. The Committee was assured that staff were working to find solutions to this. A comment was made that more concrete actions should be developed and shared in response to incidents such as these.

The new quality report format was well received and it was noted that the themes and issues were laid out more clearly.

A discussion took place highlighting that seeking assurance on the effectiveness of plans and actions implemented in relation to issues

that were flagged within bi-monthly quality reports was not always easy when returning to these issues in future reports. It was agreed that future reports would provide more specificity on actions implemented to address any issues identified, how improvement or not was understood and if/when the committee needed to escalate matters for Board attention.

In terms of granularity within the report, it was noted that the challenge was the timeline for improvement. In the future a move to a more thematic report on quality may help to capture improvement and insight.

ACTIONS: The Directors of Nursing would ensure all reports would continue be structured into three headings going forward: insight, involvement, and improvement in line with Patient Safety Incident Response Framework (PSIRF) principles. A reference would be made to the previous report to provide assurance on progress being made.

A comment was made on terminology and whether using the word unexpected would be better explained as either avoidable or unavoidable.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) had reported 15 unexpected deaths in June/July. A question was raised whether this was a high number and how it was being benchmarked. Assurance was provided that these issues would be looked at in terms of serious incidents (SIs) and further work with CNTW would take place to understand whether the numbers were statistically significantly above what might be expected in a reporting period.

Concerns were raised in relation to Durham paediatrics and an increasing number of unaccompanied asylum seeker children coming into both in and outpatient settings. Assurance was given that this issue was being looked at using a model developed in West Yorkshire by a multiagency health group. There was a need to ensure that the correct information was available to all to support asylum seekers when they arrive in an area.

Concerns were raised in relation to the risk of the shortage of staff for the Deprivation of Liberty (DOLs) assessments and the issues this brought across the system. The ICB were working with partnership Local Authorities to greater understand the requirements to provide a safe effective service.

Conversations were being held with the relevant local police forces and the mental health trusts in reference to the national police

strategy 'right care right person', including the timing of the implementation of the strategy to understand the impact on services.

Over a four-year period Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) had a number of outstanding SIs reports that had not been signed off by the previous CCG. The ICB undertook a thematic review of the outstanding SI reports and had worked through the backlog to sign off the outstanding SIs. There was a robust process to look at any new themes and the team now had additional support from North East Commissioning Support (NECS) to ensure they remained on track with SI reporting in a timely manner.

ACTIONS:

Future reports to provide updates on actions implemented to drive improvement in identified issues within the quality report.

The Executive Chief Nurse to bring back information on what had been developed to support asylum seekers arriving in the area to the next meeting.

Enquiries to be made across other paediatric units across the patch to verify if this issue was being picked up and overall support was being given to this population.

RESOLVED:
The Committee **RECEIVED** the report for information and assurance.

QSC/2023/09/09 Maternity Report

The Director of Nursing (Midwifery) introduced the maternity report which provided a triangulation of quality data; information from trusts' self-declared position; and information following assurance visits by the Local Maternity and Neonatal System (LMNS) quality leads.

A themes and risks overview was highlighted within the report noting where trusts were compliant. One trust was highlighted an outlier in relation to postpartum haemorrhage. This was being audited by the LMNS quality group to further explore the issues identified.

The Complaints and Patient Advice and Liaison Services (PALS) were undertaking a deep dive into communication, which appeared to be an emerging theme. The work involves reviewing both

communication between staff groups and between staff and families. Any training identified would be supported by the LMNS.

All services had undergone their CQC inspections. There had been some change of ratings across the ICB with several now reporting 'requires improvement' or under the Maternity Safety Support Programme (MSSP). The Q1 data highlighted four Trusts declaring full compliance with all 7 immediate and essential actions: namely (North Cumbria, Northumbria, Gateshead and South Tyneside & Sunderland).

In the absence of a national approach in supporting trusts with a change of rating, a meeting had taken place with the Chief Midwifery Officer for England to agree the NENC approach to managing the change of ratings. It had been agreed the ICB would offer support to link providers into the clinical network and use the existing governance framework to measure improvement and performance.

It was noted that the figures for noncompliance raised issues of staff not being released for training. The ICB was working to make this easier by creating a training syllabus that could be adopted by all providers.

In relation to peer review visits to STSFT and North Tees NHS Foundation Trust (NTFT), the ICB had invited the MSSP leads to ensure a more simplified approach to these visits.

Through discussion, the issue of a staff attitude/care culture within the trusts was raised. Data relating to patient complaints suggested that staff attitudes and possible ‘empathy fatigue’ may need to be considered and potentially addressed. In terms of the Bill Kirkup Report, the Committee was keen to understand if there was anything it should be aware of from a cultural perspective. In response it was noted that one organisation had been identified as having some potential cultural issues to address. A piece of work was still required around the professional relationship between obstetricians and midwives and how this working relationship and communication could be improved. Cultural surveys were being carried out to look at where the issues were to gain a baseline.

The first of the Ockendon peer review visits had commenced with Gateshead which had been positive. These visits gave the opportunity to speak to all staff and working together to support proactively any issues identified.

It was noted that the scoring derived from the staff cultural survey was complicated but all organisations had received these previously so should be familiar with the process.

It was noted that the cultural issues did not just relate to maternity care. A brief would be presented to the next confidential ICB Board meeting looking further into the issues raised. It was acknowledged that for every single contact in any pathway it was difficult to know what had occurred. To really understand the experience within a pathway was a huge task and would require significant investment.

It was explained that the clinical dashboard information contained within the report was important, but the team were working on a more overarching dashboard also including staff and patient experience.

ACTIONS:
The Director of Nursing (Midwifery) to bring the alliance model and a headline report on the maternity cultural surveys being carried out within local trusts to a future meeting of the Committee.

RESOLVED:
The Committee **RECEIVED** the report for information and assurance and **NOTED** the planned actions and ongoing workstreams.

QSC/2023/09/10 Immediate actions from Lucy Letby

A letter had been sent to all providers from the key leaders in the NHS in response to the Lucy Letby verdict and findings. In response the ICB had carried out a detailed review of the data from all eight neonatal units within the region.

Newcastle University Teaching Hospital Foundation Trust was an outlier in terms of mortality against their peer review group, the national average was 2.6 per 1000 live births and they were at 3.5.The ICB was working with specialised commissioning to undertake a multi-professional assurance visit to the trust.

Ockendon peer review visits had been planned and would include a review of neonatal services.

The Learning and Improvement Group would focus on how to improve the view of data and soft intelligence to identify risks.

All providers had been asked to feedback on their Freedom to Speak Up (FTSU) arrangements and assess the process against

the national policy. They would also be asked to audit two FTSU processes and feedback to their local quality group. The Executive Director of Experience and Improvement was looking to design a self-assessment tool using the FTSU Guide & Planning Tool.

The ICB board had a planned discussion on the Letby findings in November to review any actions needed.

A question was raised as to how the ICB was assured that the processes put in place were robust and ensured the safety of patients. In response, this was why the audits against standards had been requested to provide assurance on this. This would be discussed in more detail at a future confidential meeting of the Committee to further explore the findings of the Letby case when the information was available.

In the context of the learning, members queried whether the ICB understood which of the services would be most vulnerable and where patients could potentially come to the most serious harm. In response, it was shared that there had been a national meeting around openness of organisations and sharing of information. There was a mixed picture across the ICB concerning willingness to share information as common practice and further work was required with trusts in this area.

It was noted that PSIRF would apply across all organisations which should lead to further work from all organisations on this agenda and primary care would need to be included in this.

In terms of issues and risks, there was concern around the resulting public view of neonatal services and the nursing profession. The Letby Case had resulted in some very negative comments and perceptions of the profession in light of the media coverage which could potentially be harming to professional morale and future recruitment. There was a need to support nursing colleagues. The consequences of Letby were yet to be seen, however nursing applications were down by 50% from recent historical standards.

At a recent Quality Review Group meeting at County Durham and Darlington Foundation Trust (CDDFT), it was highlighted that they had spoken to all parents and asked for feedback on their experience with the maternity services. The responses had been positive, with many happy with the care provided and the competence of the staff.

ACTION:
The Executive Chief Nurse to ensure the findings from the Lucy Letby case are discussed further at a future confidential committee meeting when the information becomes available.

RESOLVED:
The Committee **RECEIVED** the report for information and assurance.

QSC/2023/09/11 Equality Impact Assessment

Staff demographic data in relation to equality impact assessments was presented to the Committee. The Equality Act 2010 applied to all organisations within the UK and due regard must be made to any policy or service delivery changes that required an equality impact assessment. The nine protected characteristics were shown in the graphic.

The NHS under the Health and Social Care Act had additional provisions around health and inequalities.

A reminder was made to ensure staff declared their data on Electronic Staff Record (ESR) and when engaging with patients and service users to support the gathering of information. This information could be used to monitor and understand any positive or negative benefits to policies and service delivery.

It was highlighted that an equality impact assessment was required to be completed at the beginning of the process.

As shown in the slides, staff had declined to declare some characteristics within their personal information held by the ICB. A campaign to gather data was underway to understand the reasons for this and encourage staff to share data whist explaining how and why that data would be used.

Training sessions for the completion of Equality Impact Assessments for Executive Directors had been arranged with the first session completed and two further sessions planned. An impact assessment toolkit would be shared in the future.

It was noted that a clear explanation was required on how and why the information was to be used to ensure individuals were aware that their information would be used for improvement purposes. Trusts had undertaken these assessments for several years; the aim was to improve collection rates but recognise that no organisation would achieve 100% completion rates. It was noted that it would be useful to map staff numbers against the general

population to understand how the demographics of staff compared. A question was raised as to the pay band and genders and whether this included medical staff. It was clarified that the slides only covered ICB members of staff.

Regarding the request of mapping staff against the general population, there were challenges to this as the ESR system had limitations. It would only capture male and female not alternate genders.

RESOLVED:
The Committee **RECEIVED** the update for information and assurance.

QSC/2023/09/12 Medicines Optimisation Annual Report

The first medicines optimisation quality and safety annual report was presented to the Committee. There was a new medicines governance structure in place, with a single process for prescribing and formulary, which would make a significant improvement to access.
Regarding patient safety, Valproate was a risk in pregnancy and there had been a national patient safety alert which had set out a series of mandated actions for anyone prescribed this drug who might be at risk of becoming pregnant. Work was ongoing to ensure patients were asked whether they were taking Valproate when booking appointments. This work was being undertaken by the Medicines Safety Group and was one of 16 national medicines optimisation opportunities, along with the uptake of NICE approved therapies, which would lead to the creation of a national dashboard.

ACTIONS:
The Medicines Safety Group would bring the national dashboard on NICE approved therapies to the Committee once available.

The Committee was informed of long-term shortage of GLP1, a type 2 diabetes medication which had recently been found to assist in weight management. Due to a global demand, there could be a possible 12-month shortage period. A rapid response to the shortage had been undertaken to prioritise patient need. It was noted that this had been managed without any patient harm, good communication, education, and training in the system from a multi-disciplinary approach.

Anti-microbial resistance targets were difficult to achieve. NENC was the highest prescriber in the country, although targets on broad spectrum antibiotics were being met. Opioids had challenges due to

de-prescribing being resource intensive and the issue of capacity was impacting on delivering this, although it was showing significant improvement.

The 'stopping over medication of people' (STOMP) and 'support treatment and appropriate medication in paediatrics' (STAMP) business plan had been approved to develop clinical leadership to support this.

A significant piece of work had been undertaken to support both Queen Elizabeth (QE) Hospitals and North East Ambulance Services (NEAS) with medicines incidents.

It was noted that the contextual information was welcomed, however further assurance was needed around the ongoing actions and outcomes and progress with the opioid issues.

Regarding the methotrexate issue, a question was raised as to why the 10mg dose existed. It was noted that this was used in other countries and in a small number of instances due to the number of other medications taken, a 1 x 10mg was found to be appropriate.

Due to the increase in virtual appointments in the pandemic the prescribing of antibiotics increased. A 'Seriously Resistant' communications campaign would shortly commence across the whole ICB area.

In relation to the pharmacy first scheme, members asked whether there was any data for patients being referred onto primary care from pharmacies. This information would be included in the next report, including data on how many patients move between other services.

It was noted that if the statistics were available it would help from a behavioural change perspective to build confidence to go to pharmacy first. This was a core part of the winter messaging. This would be picked up in the Primary Care Strategy Group and fed back to the communications team.

RESOLVED:
The Committee **RECEIVED** the annual report for information and assurance.

QSC/2023/09/13 Excess Mortality report

The Director of North East Quality Observatory (NEQOS) presented an overview of excess mortality in the population and the various measures currently in use in the UK, along with possible causes.

The slides would be produced on a quarterly basis going forward and based on summary hospital led mortality indicator (SHIMI) data from NHS England. It was noted that excess mortality had returned to near normal.

County Durham and Darlington Foundation Trust (CDDFT) was noted as an outlier from the SHIMI data as they were fractionally above the upper control limit. Northumbria Healthcare NHS Foundation Trust (NHFT) were inside the lower control limit and Gateshead Hospitals NHS Foundation Trust (GHFT) were below it.

Regarding comorbidity by trust, CDDFT was down in quarter 4. In combination with a slightly higher observed mortality, the expected rate was possibly affected by the implementation of Cerner Electronic Patient Records (EPR) in December 2022 which adversely affected the coding for January to March 2023. Where EPR had been implemented in trusts, there had been a drop in recording of co-morbidity when moving from one system to another.

A question was raised in relation to deaths in care homes and whether this was an upward trend. It was noted that North Tyneside did have a high proportion of deaths in care homes but this had reduced due to the closure of homes. Overall, a shift from deaths in hospitals had been seen.

It was noted that SHIMI data was less reliable due to the three year period of the pandemic.

ACTIONS:
A summary front sheet to be added to the excess mortality report and presentation for future meetings.

Introduction of Cerner Electronic Patient Records - a request was made to include data on the number of organisations who have introduced the new patient recording system and when that was introduced. This would be added to the future report

RESOLVED:
The Committee **RECEIVED** the update for information.

QSC/2023/09/14 Pharmacy, Optometry and Dental (POD) update

The ICB has delegated responsibility from NHS England for the commissioning of pharmacy, optometry, and dentistry services as of 1 July 2023. An established system was in place to manage the quality of these services, along with identifying any risks associated with this.

Regarding pharmacy services and access in general, an offer of support was made from Healthwatch to support the ICB from a patient and public involvement point of view to help reduce pressure in the system.

Conversations were being held with Health and Wellbeing Boards to ensure patients were being directed to the correct services and information had been included in the winter communications campaign. There would be a focus on people with children and young people and the engagement of Healthwatch would be greatly appreciated.

An event was to be held by Healthwatch to signpost people to the correct services. Speakers would include GPs around enhanced pharmacy access and urgent care. An invitation was extended to the ICB and the event would be advertised in the Pulse magazine.

RESOLVED:
The Committee **RECEIVED** the update for information.

QSC/2023/09/15 Risk Register

The latest risk management report was presented to the Committee which provided the updated position of the current risk register, focussing on those risks which align to the quality and safety portfolio.

There were three new risks in this reporting period:

1. Learning from Lives and Deaths (LeDeR) reviews
2. British Pregnancy Advisory Service (BPAS) termination of pregnancy pathways
3. Primary care quality reporting

There were two closed risks, both related to the transition of POD services from NHS England to the ICB and were now closed as the transition was complete.

Work was underway with risk owners to challenge the risk scores to ensure residual risk scores appropriately reflected the mitigations put in place to reduce the initial risk scores.

ACTIONS:
Regarding place based registers, there were 13 risks in the North area which was a notably larger number than reported for the other 3 Places. This may be related to the differing population size and service provision and so a variation in risks was expected. However this was an area that needed to be

reviewed to ensure the variability was appropriate. The Director of Nursing North would look into this issue.

RESOLVED:
The Committee **RECEIVED** the report for assurance.

QSC/2023/09/16 Integrated quality, performance, and finance report

The NENC Integrated Delivery Report provided an overview of quality and performance, highlighting any significant changes, areas of risk and mitigating actions. The report used published performance and quality data covering June 2023 for most metrics and July 2023 for others, unless otherwise specified. Finance data is for July 23 (Month 4).

RESOLVED:
The Committee **RECEIVED** the report for information.

QSC/2023/09/17 Area Quality and Safety sub-committee minutes

The minutes from the North Cumbria Area Quality Subcommittee meeting held on 13 June 2023 were received.

RESOLVED:
The Committee **RECEIVED** the minutes for assurance.

QSC/2027/09/18 Quality Review Group minutes

The following minutes were received:

- Gateshead Health NHS Foundation Trust minutes of the meeting held on 2 May 2023
- North East Ambulance Service minutes of the meeting held on 26 May 2023
- Northumbria Healthcare NHS Foundation Trust minutes of the meeting held on 9 May 2023
- Newcastle upon Tyne Hospitals NHS Foundation Trust minutes of the meeting held on 4 May 2023

RESOLVED:
The Committee **RECEIVED** the minutes for assurance.

QSC/2023/09/19 System Quality Group minutes from 15 June 2023

RESOLVED:
The Committee **RECEIVED** the minutes for assurance.

QSC/2023/09/20 Central Area Quality and Safety sub-committee terms of reference

RESOLVED:
The Central Area Quality and Safety sub-committee terms of reference were **RECEIVED** for assurance.

QSC/2023/09/21 Healthcare Acquired Infection (HCAI) Sub-committee minutes from 5 July 2023

RESOLVED:
The Committee **RECEIVED** the minutes for assurance.

QSC/2023/09/22 Any other business

The Paediatric Hearing Services Improvement Programme would be issuing communications to trust chief executives and services in the region to complete a baseline assessment of paediatric audiology services. The baseline reporting would be completed by the end of October 2023.

An improvement plan would be developed in partnership with NHS England North East and Yorkshire region and the ICB.

This work had been undertaken due to some lack of hearing being identified within children and some staff undertaking the testing were not fully qualified.

QSC/2023/09/23 Date and time of next meeting

Thursday 9 November 2023, 9.00-12.00pm in the Joseph Swan Suite, Pemberton House.

The meeting closed at 12.00pm.

Signed: Hannah Bows

Position: Chair

Date: 09.11.23