NHS
Lancashire and South Cumbria
Integrated Care Board

Approved 15 February 2023

Minutes of the ICB Quality Committee Held on Wednesday, 18 January 2023 via MS Teams

Name	Job Title	Organisation
Members		
Sheena Cumiskey (SC)	Chair/Non-Executive Member	L&SC ICB
Professor Jane O'Brien (JO'B)	Non-Executive Member	L&SC ICB
Roy Fisher (RF)	Non-Executive Member	L&SC ICB
Professor Sarah O'Brien (SO'B) – Left after Item 16	Chief Nursing Officer	L&SC ICB
Dr David Levy (DL) - Left after Item 14	Medical Director	L&SC ICB
Kathryn Lord (KL)	Director, Quality Assurance and Safety	L&SC ICB
Dr Geoff Jolliffe (GJ)	Primary Care Partner - GP, Barrow-in-Furness	L&SC ICB
Debbie Corcoran (DC)	Chair, Patient Involvement and Engagement Advisory Committee	L&SC ICB
Mark Warren (MWa)	Local Authority Lead - Strategic Director, Adults and Health	Blackburn with Darwen Council
Attendees		
David Eva (DE)	Independent Member	L&SC ICB
Dr Arif Rajpura (AR) - Left during Item 12	Public Health Representative - Director of Public Health	Blackpool Council
Angela Allen (AA)	VSCE Representative - Chief Executive, Spring North	Spring North
Caroline Marshall (CM)	Associate Director of Patient Safety	L&SC ICB
Claire Lewis (CL)	Associate Director, Quality Assurance	L&SC ICB
Margaret Williams (MWi) - Left after Item 9	Director of Safeguarding (Job Share)	L&SC ICB
Ann Dunne (AD) - Left after Item 9	Director of Safeguarding (Job Share)	L&SC ICB
Andrew White (AW) - Arrived during Item 6	Chief Pharmacist	L&SC ICB
Simone Anderton (SA) (named deputy for Peter Murphy) - Left during Item 12	Acute Provider Representative - Deputy Director of Nursing and Quality	Blackpool Teaching Hospitals NHSFT
Stephen Sandford (SS) - Arrived during Item 6/Left during Item 12	Chief Allied Health Professions Officer	L&SC ICB
Hayley Michell (HM) - For Item 6	Director	L&SC ISNDN
Elaine Day (ED) - For Item 6	ISNDN Manager	L&SC ISNDN
Louise Talbot (LJT)	Corporate Governance Manager	L&SC ICB

Item No	Item	Action
1.	**<u>Welcome, Introductions and Chair's Remarks</u>** The Chair welcomed everybody to the meeting advising that it would be a longer than usual meeting in order to address the meeting cancelled in December due to matters relating to the industrial action and system pressures. Recognising the challenges across the system, the Chair conveyed her thanks to everybody for their continued support. The Chair advised that SO'B would provide an update later in the meeting relating to quality assurance in the current crisis.	
2.	**<u>Apologies for Absence</u>** Apologies had been received from Peter Murphy (Simone Anderton attending as his named deputy), David Blacklock and Lindsay Graham.	
3.	**<u>Declarations of Interest</u>** **RESOLVED: That there were no declarations of interest relating to the items on the agenda.** **(a) Quality Committee Register of Interests –** Noted.	
4.	**<u>Minutes of the Meeting Held on 16 November 2022, Matters Arising and Action Log</u>** **Minutes:** **RESOLVED: That the Quality Committee approve the minutes of the meeting held on 16 November 2022.** **Matters Arising:** • **Assurance of Secure and Non-Secure Services –** The item had been deferred to the February committee meeting. **Action Log:** A number of actions had been closed since the previous meeting and other actions were listed for future meeting agendas. Particular reference was made to the following: • Committee Terms of Reference - Patient Safety Partners – Included on the meeting agenda. • Risks and Escalations – Quality oversight and involvement of the Lancashire Learning Disabilities Consortium – SO'B would circulate an update. • Update on the Foxton Centre – Included on the meeting agenda. • CHC Business Case – Update report included on the meeting agenda. • Quarterly Quality and Safety Report – Included on the meeting agenda. **Actions/Outcomes from the Foxton Centre –** Following on from a patient story considered at an earlier committee meeting, KL spoke to a circulated report which included a number of key actions taken to support the Foxton Centre in delivering	**LJT** ✓ ✓ ✓ ✓ ✓ ✓ ✓

	guidance on how to access services for people with mental health needs and drug/alcohol dependency. Also infection prevention and control assistance in relation to a new build and key contacts were provided for the Changing Futures and Rough Sleepers Group in Blackpool. DC welcomed the work undertaken commenting 'You said, we did' and could see the improvements made, the work taking place with system partners and setting up existing good practice with place. She anticipated this being undertaken systematically with other patient stories. AR advised that they were also looking at undertaking system change to ensure all services meet the needs of people with multiple complex needs and he stressed the importance of all services understanding those complexities. AR also commented that we need to ensure all our services use the trauma informed approach as it is key to making changes. **RESOLVED: That the Quality Committee receive the update and note the actions being taken forward. It was agreed that the item could be closed on the action log.**	**LJT ✓**
5.	**<u>Committee Membership Approval – Independent Member</u>** **RESOLVED: That further discussion was required outside of the committee meeting, therefore, the item was deferred for the current time.**	**SC/ LJT**
6.	**<u>Update on Progress of the Lancashire and South Cumbria Integrated Stroke and Neurodevelopment Network (ISNDN)</u>** The Chair welcomed Hayley Michell and Elaine Day to the meeting who gave a presentation on progress of the L&SC integrated stroke and neurodevelopment network with a specific focus on the service specification and implementation of the acute business case. They also presented the data monitoring approach across the programmes of work and quality and, narrative measures relating to patient participation. *Stephen Sandford joined the meeting.* Thanks were conveyed for the presentation and the following discussion ensued: • Referring to Morecambe Bay, it was pleasing to see the support network had improved. Recognition that length of stay needed to be addressed. It was noted that the Royal Preston Hospital and Royal Lancaster reconfiguration and length of stay will be key. • Consider how services can be transformed and whether a patient needs to be in hospital for all of their rehabilitation. • Reference was made to a case for change which was endorsed by the former Joint Committee of CCGs in 2019 and clarification was sought on progress. It was commented that improvements had been made including improvements in the SSNAP scores. There continued to be concern in respect of staffing levels within speech and language therapy. • Clarification was sought regarding the role of primary care and how strokes	

	were being addressed within primary care and whether there were any blockages in the system. • Pleasing to see psychological support had been built into the pathway and the improvements in quality were welcomed. • Clarification was sought as to how they will measure that the challenge to health inequality is working. It was recognised that stroke has a higher proportional relationship to deprivation and poverty and a question was asked as to whether there was a link back into prevention and the public health approach. • Reference was made to the pressures on emergency systems and risk area that could be tackled was around hypertension. Reference was made to a hypertension project in Blackpool which identified 2,500 hypertensives in the town. The impact of other projects of a similar nature would be beneficial in reducing the number of strokes, death and disability and whilst additional resource would be required, consideration should also be given in investing to save in addition to the human cost. • When reprioritising access, there was also a link to workforce challenges. • It was recognised that there needed to be a push in health check uptake. AR referred to the bus that delivered both COVID-19 and flu vaccines across Blackpool and as it started to wane, consideration was being given to it being used for health checks reaching out to different communities. He further stressed the importance of reaching out rather than 'letting people go'. Consideration could also be given to undertaken it at scale across Lancashire and South Cumbria. • Further consideration would need to be given as to how GPs as providers were performing. The committee was advised that there had been a focus in areas and targets requested by the Cardiac Network in respect of CVD prevention. A number of initiatives were also taking place in respect of AF. *Andrew White joined the meeting.* AR and AA offered their support to be involved in initiatives going forward. The Chair conveyed the committee's thanks to HM and ED for the presentation and the update on progress and they left the meeting. **RESOLVED: That Quality Committee receive the update.**	
The agenda was taken out of order		
8.	**<u>Mental Capacity Act Policy</u>** Ann Dunne was welcomed to the meeting and had recently commenced in post as Director of Safeguarding (job share with Margaret Williams). The Mental Capacity Act (MCA) Policy was presented which provided assurance that the ICB was committed to the application and implementation of the MCA and set out organisational accountability and effective partnership working. It was noted that the Mental Capacity Act 2005 was a law that protects vulnerable	

	people over the age of 16 years of age in respect of decision-making and the MCA policy was designed to protect families, remove distress and prevents cases going to court, allowing health to be able to undertake best practice. DE referred to people's ability in obtaining support in terms of advocacy and sought clarification as to whether there had been changes with the development of the system. MWi advised that the Independent Mental Capacity Advocate (IMCA – an advocate appointed to act on your behalf if you lack capacity to make certain decisions) process was in place and the service was commissioned across Lancashire and South Cumbria. She was unable however, to provide assurance in respect of access. She advised that front line teams would put forward any concerns. GJ made reference to the imbalance in respect of primary care training relating to mental capacity. MWi acknowledged the difficulties in respect of training and in terms of expertise, it was suggested that wrap-around models should be explored. Recognising that it needed to be strengthened, MWi would take training for general practice through the GP safeguarding leads. MWa referred to Deprivation of Liberty Safeguards (DoLS) which supervisory bodies sign off at a local level. He advised the committee that there were a number of DoLS that had either expired or reviews awaited commenting that it would be the responsibility of the local safeguarding adult board to ensure local agencies were complying with DoLS. There was a requirement for local safeguarding adult boards to make reference to the DoLS in their annual reports which should give the committee assurance. MWa also made reference to guidance to be issued in respect of Liberty Protection Safeguards (LPS) and sought clarification as to whether the MCA policy should state that preparations were in train regarding the introduction of LPS. MWi advised that the MCA policy related to the mental capacity element. She referred to the delayed DoLS element and information had been included in the safeguarding report to the committee. In respect of supervisory bodies signing off applications, it was noted that 80% of applications go through the local authority process and it was important to have the whole position of DoLS for local people and not just those going through NHS type routes. The role of the Quality Committee was to share the expectation across the system and then at place. In terms of the governance arrangements, consideration needed to be given in respect of the role of the adult safeguarding sub-groups and that everybody will have training sub-groups as it was more than GPs making decisions. MWa and MWi would work with colleagues in order that place based information was taken through the adult safeguarding boards. An update on LPS would be submitted to the Quality Committee in due course. **RESOLVED: That the Quality Committee approve the Mental Capacity Act Policy noting that further consideration would need to be given in further reviewing the policy in light of the discussion held.**	**MWi** **MWi**

9.	**Safeguarding Update** MWi spoke to a circulated report which provided an update on the areas of activity that required additional monitoring and mitigation. The three main current safeguarding concerns related to: • **Performance** - Children in Care assessments, Court of Protection liberty safeguards delayed applications. • **Vulnerability** - Profile of individuals referred to PREVENT, profile of Domestic Homicide reviews, increasing numbers of regulated care sector quality concerns. • **Workforce** – Managing and maintaining responsive safeguarding function. The committee was advised of the following mitigations: • ICB Safeguarding team has robust partnership across L&SC and through joint discussions and planning there are mitigations agreed to address the risks. This was a continual cycle of review and rework. • A significant challenge was that our population's 'needs' continue to evolve but the team constantly reviews and ensures that service delivery can flex and innovate to safeguard children, young people, and vulnerable adults. • The voice of the child and vulnerable adult was the grounding point that drives collective responsiveness. • The ICB continues to build and maximise partnership arrangements that can be described mostly to be very strong with strategic and service issues being picked up and responded to. MWa referred to the governance changes in respect of accountability to safeguarding and the new place-based accountability panels. MWi would discuss with MWa with a view to submitting an update on the development of the model when available. It was recognised that the panels will bring a real place-based level of scrutiny for adults and children. DC referred to the significant increase in domestic violence rates which were higher than the national figure by comparison and she sought clarification on the drivers around the variation. MWi was mindful of the increase in referrals of very high risk domestic abuse. She advised that there were slightly different multi-agency models of response and delivery in the local place based local authority footprints which were at varying levels of maturity however, colleagues were starting to have an understanding of the activity and complexity of the issues. Conversations were being held with wider systems across the north west to understand how the profiles were changing and work continued with the police and local authority with multi-agency support. AR referred to the review of health assessments for Looked After Children and commented that whilst the service was not commissioned by public health, it was commissioned by the NHS but carried out by health visitors who are employed by the local authority. MWi advised that work was taking place across the system regarding health assessments to ascertain if the key performance indicator was right and to better understand the issues. **RESOLVED: That the Quality Committee receive the report, noting the mitigations and the actions being undertaken.** *Margaret Williams and Ann Dunne left the meeting.*	

7.	**Patient Story/Experience** The Chair referred to the story provided regarding a 16-year-old child in care who was referred to the multi-agency Child Exploitation Team. The story highlighted the variations in commissioning arrangements and recognised that it created challenges in providing timely, and appropriate mental health support of children and young people. By health professionals working together, a consistent clinical view was presented to partners which framed the safeguarding response. There was a shift in thinking from 'what's wrong with you?' to 'what's happened to you?' Agencies were able to work through areas of professional disagreement, avoid further escalation, reduce risk and improve outcomes. The following comments were made: • What is the theoretical or purchased flow of somebody who had this issue and if the service wasn't delivering, why not and how will it improve? • The Quality Committee focus is ensuring that services are commissioned effectively. • The story was an example as to how people care is compromised because of the boundaries in the system. • A repeated theme was coming through that services came together when the person was in crisis. Consideration needed to be given as to how the system can be more joined up and taking more of a preventative approach. • Important to better understand the person and the need we are trying to address rather than a label on a person. • DL would flag with Fleur Carney, ICB Director of Mental Health. • Access to services to be reviewed to ensure pathways were working efficiently. • Clarification as to whether safe and effective services were being provided. **RESOLVED: That the Quality Committee receive the patient story/experience, noting the comments made and actions to be addressed.**	**DL**

	Additional Item – Quality Assurance in the Current Crisis
	
	SO'B provided an update on current pressures and additional supportive oversight and highlighted the following:
	• Region, ICB and Trusts had stepped up the Critical Incident Framework (EPRR)
	• The ICB was maintaining the usual assurance mechanisms, eg, System Improvement Boards, Quality Committee and, quality and safety activity
	• Clinical on-call was established to support pressures and respond to incident(s) – senior clinical support for system decision making
	• Clinical Cell was established:
	  • To understand the Industrial Action (IA) challenges and offer system-wide mitigation
	  • To identify potential and actual harms during exceptional winter pressures and IA and share lessons across L&SC ICB
	  • To review excess deaths in 2022.	

	SO'B also described a number of actions taken which included: • Additional calls with the medical directors and directors of nursing to support, share risks and good practice • Visit by the ICB quality team if required, eg, visit to Blackpool • Review of any incidents, eg, two at Blackpool, NWAS incidents • Trusts – Use of volunteers to support hydration and nutrition, patient leaflets to explain the situation • Close working with social care colleagues regarding discharges • Issuing of guidance for any issues across the system, eg, Oxygen. Thanks were conveyed from the committee to all staff involved for their continued support. The committee was assured of actions being taken to keep oversight of the issues. AR thanked SO'B for the update and recognised the current difficulties. He was also mindful that when placed in difficult situations, there can then often be a detrimental effect on providing compassionate care and empathy which can fall down. He stressed the need for a 10-year plan for the health and care system that has appropriate funding and a workforce strategy that mirrors the plan. It was important that people are kept out of hospital and illness prevented. AR commented that poverty was also a contributing factor and national decisions needed to be made. He hoped as a system that the concerns could be conveyed nationally. The Chair highlighted the role of the Quality Committee who had received oversight and was appraised of the quick learning to ensure actions were undertaken and disseminated as quickly as possible in a safe way. She asked if there were any other observations that needed to be highlighted. AR referred to community work, ie, virtual wards and hospital at home and sought clarification as to whether more could be done in those areas. DL advised that 180 virtual wards were being used currently across L&SC with a trajectory to increase them to 700 by 2024. He advised that similar initiatives were also being taken forward in other parts of the country. AR commented that the uptake of COVID-19 boosters and flu vaccinations amongst health and local authority staff was poor and there needed to be more encouragement to staff to have the vaccinations. SO'B was mindful of the position and would discuss with the matter with other Directors of Public Health. KL would seek vaccination rates and provide the committee with an update outside of the meeting. **RESOLVED: That the Quality Committee receive the update and note the actions being taken.**	**SO'B** **KL ✓**
The agenda reverted back to its order		
10.	**<u>Patient Safety Incident Response Framework – Positional Update</u>** CM spoke to a circulated report which was an update on the progress made in the implementation of the national Patient Safety Incident Response Framework (PSIRF) and outlined the future plans to ensure delivery of the framework within the required timescales.	

	CM took members through the work undertaken to date commenting that there had been good attendance at the working group. Members were reminded that East Lancashire Hospitals Trust (ELHT) had implemented PSIRF in December 2021 as an early adopter organisation with the former East Lancashire CCG and they were currently reviewing the five key local priorities, the impact of actions and agree new priorities for implementation in 2023. North West Ambulance Services Trust (NWAS) was also progressing PSIRF implementation. CM also highlighted the future planned work which was welcomed advising that reports would be submitted to the committee during quarters 1 and 2 of 2023/24 which would outline each Trust's proposed local priorities, policy and plan for formal ICB approval. KL conveyed her thanks to Caroline Marshall and would also be conveyed to Kim Ciraolo who were both leading on this piece of work and welcomed the work undertaken and progress being made in respect of PSIRF. **RESOLVED: That the Quality Committee receive the report and was assured on the progress being made across the L&SC integrated care system on the future work planned along with timescales.**	
11.	**<u>Risks and Escalations</u>** CM spoke to a circulated position report relating to the main providers across L&SC and actions being undertaken in respect of current and emerging escalations/risks/concerns. She advised that whilst it was intended to be a collaborative report to the committee, given the current pressures in the system, the paper to the committee this time had not been written collaboratively with provider Directors of Nursing as it was felt that it was inappropriate to ask them to contribute due to current pressures. The report had been circulated to the committee separately to the agenda and provided the latest escalation updates by exception which identified the following: • Quality/risk concern • Summary • Past harm – Has patient care been safe in the past? • Reliability – Are clinical systems and processes reliable? • Sensitivity to operations – Is care safe today? • Anticipation and preparedness – Will care be safe in the future? • Integration and learning – Are we responding and improving? SO'B reflected on the report and the current system pressures commenting that there was a very strong team in place under KL's leadership. SO'B also commented that the providers had welcomed the supportive approach from the ICB. A number of hospital contracts included quality schedules that are included within internal governance processes and should, therefore, give assurance to the committee which was welcomed. DL referred to the System Oversight Framework (SOF) and sought clarification as to how improvements could be made to achieve SOF2 and the advantages of working at place, health and social care and strong primary care and public	

	health. He stressed the importance of the supportive approach and working together. SA acknowledged the supportive approach across providers and referred to the different types of command calls and mutual aid and welcomed the weekly Directors of Nursing catch up meetings which were very much appreciated. DL had visited Blackpool Teaching Hospitals NHSFT which was very much a supportive mechanism and was helpful to the Trust in respect of their assurance that they were heading in the right direction despite the enormous pressures. **RESOLVED: That the Quality Committee receive the report, noting the actions being taken to mitigate risks.**	
12.	**<u>Patient Safety Partner Involvement in Organisational Safety</u>** CM spoke to a circulated report which informed the committee of the national Framework for Involving Patients in Patient Safety guidance, implications across L&SC and provided recommendations. The report also provided an update on provider progress in implementing Patient Safety Partners (PSPs). CM advised that PSPs would not be employed by ICB as they are required to maintain independence. An options appraisal had been undertaken which outlined three options available to the ICB. *Simone Anderton left the meeting.* When considering the options available to the ICB, it was deemed that Option 1 was the most favourable with a hybrid approach to recruit an individual that would straddle between role 3 (working group member) and role 4 (expert advisor). The position would be reviewed in Autumn 2023. DC supported the proposal and advised that through the ICB's Public Involvement and Engagement Advisory Committee, the central engagement team was looking to work with Healthwatch with a view to working with a group of ambassadors and co-produce key pieces of work. She saw it as being very complimentary in terms of practice. She also commented that recruitment would need to be open and transparent and in terms of having a focus on safety, DC sought clarification as to whether the PSPs would be contributing to any unsafe services only or whether it included all service improvement. *Arif Rajpura and Stephen Sandford left the meeting.* CM advised they would look at individuals who could contribute to health inequalities and would also look at local knowledge. It was recognised that positive disruption would be part of the role and it was important that individuals were supported to achieve this as it would be a learning curve. MWa highlighted a number of areas for consideration in terms of how reactive we wish to be, how we prevent it in the first place, how we embed real and true co-production in the first place.	

	Members were advised that NHSE was working with Directors of Adult Social Services and various service user groups to ascertain what co-production could look like. As we move forward, the concept of co-production and making it real on a day-to-day basis would be where we would look to being. **RESOLVED: That the Quality Committee receive the report and approve Option 1 to recruit a Patient Safety Partner with a hybrid approach to recruit an individual that would straddle between role 3 as a working group member and role 4 as an expert advisor.**	
13.	**<u>Quarterly Quality and Safety Report</u>** CL spoke to a circulated report which provided an overview of the main providers' positions with a focus on five subject areas: • Primary care • Medicines optimisation • Community care • Equality diversity and inclusion • Urgent and emergency care. It was noted that a total of 15 reporting areas were currently in the quarterly reporting cycle. The committee was provided with assurance in respect of the actions being undertaken to apply learning and improve quality in terms of safety, effectiveness and experience. RF referred to community care, specifically care homes and asked if there were any issues arising out of care homes closing due to the current cost of living crisis. CL advised that there was a level of impact and that a report in respect of regulated care would be submitted to the committee in the third month of the quarter (March). MWa also commented that whilst it was a difficult question to answer, the care market sustainability was the responsibility of the Care Act of the local authority. There was provision in terms of the statutory duties and relevant sectors had formally written out setting their rates to operate sustainably. Whilst some care homes were part of a larger organisation so were at scale, some were much smaller, therefore, costs were higher. MWa provided some background information in respect of occupancy advising that the acuity of people moving into care homes was greater. Challenges that were being faced included utility costs, food costs and insurance costs. Each locality authority was working with the ICB to look at what it takes for staff to receive a real living wage and to apply some uplift. He provided some examples of cost pressures locally. It was suggested that an action plan in primary care be drawn up in the event of another pandemic in the future. **RESOLVED: That the declaration of interest made by Dr Geoff Jolliffe as a trustee in a care home be noted. LJT would record in the Board and Committee conflicts of interest log. As no decisions were required, he remained in the meeting and took part in the discussion.**	**LJT ✓**

	GJ asked if there was clear advice and support within care homes in the event that a resident falls, ambulance service strikes and how it should be managed. SO'B advised that there was robust communication with colleagues across the system in respect of each strike including teams across the ICB and within local authorities and any issue would be taken case by case. AW commented that antimicrobial resistance was rising due to the increased use of antibiotics resulting in antibiotics being out of stock. Consideration would need to be given to ensure quality is balanced with finance. He further advised that they were predicting an 11% increase in the primary care prescribing budget in 2023/24 and the prescribing team was looking at ways to reduce this predicted increase. The Chair asked that any further comments on the reports be conveyed to CL. **RESOLVED: That the Quality Committee receive the report and note the issues and escalations to the Board.**	
14.	**<u>System Quality Group (SQG) – Update from the meeting held on 8 December 2022</u>** KL advised that two topics had been discussed at the SQG relating to urgent and emergency care and the learning from the East Kent report. Diabetes would be a focus topic at the next meeting. The SQG had requested that a template be generated to capture key points for taking forward and KL would share the information with the committee in due course. The SQG work programme had also been revised. **RESOLVED: That the Quality Committee receive the update, noting the discussion and key actions being taken forward.** *David Levy left the meeting.*	
15.	**<u>L&SC Medicines Management Group – Commissioning Policy Positions</u>** AW spoke to a circulated report which provided the committee on the work undertaken by the Medicines Management Group to develop commissioning recommendations. The committee noted that an interim ratification process had been established. The recommendations contained with the report been ratified by the Pharmacy and Medicines Policies Sub-group and were presented to the Quality Committee for documenting. AW referred to the possible risks in respect of the implementation of NICE technology appraisals which were a 'must do'. **RESOLVED: That the Quality Committee receive the report and note the positions that had been ratified to date.**	

16.	**<u>Continuing Health Care (CHC) and Individual Patient Activity (IPA) – Performance Report</u>** SO'B spoke to a circulated report which provided committee members with information in respect of current performance within CHC and IPA along with the risks relating to performance and service demands. SO'B advised that the business case was submitted to the ICB Board (Part 2) meeting and agreement was reached for additional investment into a new in-house service model. A detailed report had been well received by the Finance and Performance Committee and they were assured by the additional data they had received. The Quality Committee was advised that as the new service model is implemented (expected to be from July), it was anticipated that the service challenges would be addressed. Bi-monthly reports would be submitted to the Quality Committee focusing on the new model and key performance issues. Six-monthly reports and an annual report would be submitted to the Finance and Performance Committee. **RESOLVED: That the Quality Committee receive the report, agree to bi-monthly reports being produced, note the oversight from the Finance and Performance Committee and note the work being undertaken to bring the new model of service in-house to the ICB.** *Sarah O'Brien left the meeting. At this juncture, the committee was not quorate however, there was no requirement to approve the items remaining on the agenda.*	**LJT ✓ workplan**
17.	**<u>Committee Highlights Report to the Board</u>** The Chair commented that the main theme and thread arising out of the meeting related to urgent and emergency care and consideration would need to be given as to how we move to working in a systematic way. Other matters to be highlighted to the Board included the Mental Capacity Act policy, safeguarding, continuing healthcare and quarterly quality reporting. It was agreed that 'Items for the Risk Register' be included as a standard item for future agendas. **RESOLVED: The Chair would agree the form of words for the report with SO'B and LJT outside of the meeting.**	**LJT ✓** **SC/ SO'B/ LJT ✓**
18.	**<u>Reflections from the Meeting</u>** The Chair reflected on the discussion held and asked whether the Quality Committee had been challenged and whether it had made a difference. Committee members commented that it had been a very well-constructed agenda and meeting. **RESOLVED: That the Quality Committee reflections be noted.**	

19.	**<u>Any Other Business</u>** There were no issues raised.	
20.	**<u>Date, Time and Venue of Next Meeting</u>** The next meeting would be held on Wednesday, 15 February 2023 at 1.30pm-3.30pm in Boardroom 1, Chorley House.	