UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE QUALITY OUTCOMES COMMITTEE (QOC) MEETING HELD ON THURSDAY 24 JUNE 2021 AT 2:00PM VIRTUAL MEETING VIA MICROSOFT TEAMS

Voting Members Present:
Ms V Bailey - Non-Executive Director (Chair)
Professor P Baker - Non-Executive Director (Deputy Chair)
Ms C Fox - Chief Nurse
Mr A Furlong – Medical Director
Mr B Patel - Non-Executive Director

In Attendance:
Dr D Barnes – Deputy Medical Director (for Minute 55/21/2)
Mrs G Belton – Corporate and Committee Services Officer
Ms E Broughton – Head of Midwifery (for Minutes 49/21 and 55/21/4)
Miss H Busby-Earle – Clinical Director, MSS (for Minute 55/21/1)
Dr A Haynes – Adviser to the Trust Board
Ms S Leak – Director of Operational Improvement (for Minute 55/21/3)
Ms B O'Brien – Director of Quality Governance
Mr I Orrell – Associate Non-Executive Director
Ms J Smith – Patient Partner
Ms C West – CCG Representative

RECOMMENDED ITEMS

49/21 CNST Evidence

Ms E Broughton, Head of Midwifery, attended to present paper F, which detailed the final submission of the NHS Resolution (CNST) 10 Safety Standards for Maternity Services Year 3, including supporting evidence, as part of the Safer Maternity Care agenda; noting that the service was declaring itself compliant with all ten standards.

The report documented maternity service performance against all ten standards and detailed any risks to the submission. It was a requirement that the evidence was thoroughly reviewed by the Trust Board, with a declaration then signed by the Chief Executive and uploaded to NHS Resolution by midday on 15 July 2021. The Chief Nurse noted that over the past three years (including this current year), the CNST evidence submission had been reviewed by the UHL Maternity Safety Board, Executive Quality Board and then the Quality Outcomes Committee in its role as sub-committee of the Trust Board. The Chief Nurse also confirmed that the documentary evidence had also been personally reviewed by herself and Ms Bailey, Non-Executive Director and QOC Chair. Noting that the full documentary evidence had been reviewed by the afore-mentioned groups including the Quality Outcomes Committee in its capacity as a Trust Board sub-committee, it was agreed that a shortened version would be recommended to the public Trust Board for formal approval at its meeting on 1 July 2021 (via attachment to the QOC Summary from today's meeting) with the full documentary evidence available to all Trust Board members. The Committee's thanks were expressed to the Head of Maternity Services, the Clinical Director of Women's and Children's Services and all other Wome's and Children's Clinical Management Group staff involved in this work, which represented a significant undertaking. The Chief Nurse highlighted the need for agreement with the CCG of the most appropriate route for the flow of this information to the ICS to avoid receipt of multiple requests from multiple people and Ms West, CCG representative, agreed that this would be helpful and would be taken forward accordingly outwith the meeting.

Recommended – that (A) an abbreviated version of this report (and supporting evidence) be submitted to the public Trust Board meeting on 1 July 2021 for formal approval ahead of submission to NHS Resolution by 15 July 2021, and **CN/CCSO**

(B) the Chief Nurse be requested to agree with CCG representatives, outwith the meeting, the most appropriate route for the flow of maternity information to the ICS to avoid the receipt of multiple requests from multiple people. **CN**

50/21 Draft Quality Account 2020-21

The Director of Quality Governance presented paper H, which detailed the draft Quality Account 2020-21; an annual report from providers of healthcare about the quality of service delivered. It was noted that the Quality Account would be further updated and submitted to the Trust Board at its meeting on 1 July 2021 for formal approval (paper H on the Trust Board agenda of 1 July 2021 refers). The Committee received and noted the contents of this document, specifically noting that the usual processes were in place for stakeholder review and validation, albeit there would be no opportunity for an external audit review of the document to be undertaken this year. It was also acknowledged that, whilst comprehensive, the document produced was realistic in light of challenges which had arisen due to the Covid-19 pandemic. Given the short timeframe within which production of this document had been required this year, the work commenced last year had not been included, however would be progressed and incorporated into future Quality Accounts accordingly.

Recommended – that (A) the contents of the Draft Quality Account be received and noted, and

(B) the Draft Quality Account be further updated and submitted to the public Trust Board for formal approval at its meeting on 1 July 2021. **DQC**

RESOLVED ITEMS

51/21 APOLOGIES AND WELCOME

Apologies for absence were received from Mr P Aldwinckle, Patient Partner and Miss M Durbridge, Director of Quality Transformation & Efficiency Improvement.

52/21 DECLARATIONS OF INTERESTS

Resolved – that it be noted that no declarations of interest were made at this meeting of the Quality and Outcomes Committee.

53/21 MINUTES

Resolved – that the public Minutes of the Quality Outcomes Committee (QOC) meeting held on 27 May 2021 (paper A1 refers) and the QOC Summary from the same meeting (paper A2 refers) as submitted to the Trust Board on 3 June 2021 be confirmed as a correct record.

54/21 MATTERS ARISING

In discussion on the QOC Matters Arising Log (paper B refers), the QOC Chair noted her hope that items 25/20/1 from 30 July 2020 and 142/19/2 from 19 December 2019 would be available for submission to the QOC meeting in August 2021, as provisionally scheduled. She further noted her intention, as a matter of governance, to flag to the Executive Team any action which took longer than six months to implement.

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

55/21 ITEMS FOR DISCUSSION AND ASSURANCE

55/21/1 Maxillo-Facial Workforce Update

Miss H Busby-Earle, Clinical Director for Musculo-Skeletal Services (MSS), attended to present paper C, which provided an update on the workforce status in the Maxillofacial Department, the challenges currently facing the department around recruitment and retention of staff and plans for mitigation, taking into consideration recovery and restoration. Due to the circumstances described within the report, the difficult decision to temporarily suspend the Head and Neck Cancer Service

had been taken and patients referred on a cancer (two week wait) pathway would therefore be referred to other NHS Trusts, namely Northampton (NGH), Nottingham (NUH), Derby (RDH) and Coventry (UHC).

Section 3 of paper C described, in detail, the actions implemented to mitigate the reduction in staffing levels, particularly with regard to the recovery and restoration of services, including the establishment of honorary contracts and Service Level Agreements (SLAs), the establishment of joint clinics, the appointment to, and advertisements of, vacant posts. Challenges in recruitment to the Maxillofacial Head and Neck post had been placed on the Trust's risk register at a score of 16, which would now need to be increased. The department had a harms review process in place for patients who had breached their 52-week target as a result of the pressures of the Covid-19 pandemic on the Trust, which had been presented at ESB on 1 June 2021 and had an associated risk score of 16.

In discussion on this item, the Medical Director highlighted the good networking arrangements in place and also made reference to the national shortage of Head and Neck Consultants. He noted that management of the relevant issues would necessitate an on-going process and that, ultimately, dependent upon the success of the plans implemented, wider discussions regarding the services long-term viability would potentially be required. Dr A Haynes, Advisor to the Trust Board, noted the need to work with Region to broker long-term support and he requested assurance around the process for harms reviews. In response, the MSS Clinical Director confirmed that 52-week harm reviews were being routinely undertaken and the Medical Director advised that the temporary suspension of the service was unlikely to cause harm as the process would involve directly transferring patients' care to the most appropriate Centre based upon their post code. The Medical Director further confirmed that the implementation of the Integrated Quality Assurance System within the Trust was facilitating the availability of real-time data.

In concluding discussion on this item, Ms V Bailey, QOC Chair, thanked the MSS Clinical Director for all of the work being undertaken by her and her team with regard to this service and the Committee noted the update provided. Specifically noted were the mitigations in place around the care of existing and future patients and, in particular, the ability of patients to continue to access follow-up care. QOC noted the need for discussions around the sustainability of this service over the next few months dependent upon continuing developments. Patient issues had been reviewed and individuals were being dealt with appropriately. The QOC Chair highlighted the potential need to review the governance around patient backlog issues and it was agreed that a further update on progress would be presented to QOC in six months' time (i.e. December 2021).

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

(B) progression in relation to the workforce issues described be continued (including discussions regarding the sustainability of this service in the long-term – dependent upon continuing developments – and the potential need to review the governance around patient backlog issues), with a further update report submitted to the Committee in six months' time (i.e. in December 2021). **CD, MSS**

55/21/2 <u>Thrombosis Committee Report</u>

Dr D Barnes, Deputy Medical Director, attended to present paper D, which detailed an update from the VTE Prevention Task and Finish Group and built upon the outstanding actions highlighted in a previous report in January 2021 and the future Trust direction of VTE prevention and treatment strategy and governance.

The report specifically highlighted the positive performance in 2019/20 and 2020/21 to date against the Quality Schedule for VTE prevention and the continued progress made on electronic reporting against the NICE VTE prevention Quality Standards, particularly with regard to appropriate prescribing of thromboprophylaxis in patients assessed as high risk. The e-meds pilot had proven successful and its use would continue to be actively promoted, since completion of a risk assessment on the Nerve Centre e-Meds module was not currently mandated. The VTE assessment process for long waiters in ED continued to be challenging; despite the fact that ED had appointed a doctor as a champion to oversee the process, there had been no significant improvement in assessment rates. A Trust risk register assessment was being completed based

on data collected on the incidence of VTE in patients who were long waiters in ED versus non-long waiters. Data demonstrated there was a very low risk of VTE overall in either group with no significant increased risk for those patients waiting more than 12 hours for admission. The Deputy Medical Director referenced IT enabling requirements within Nerve Centre, which would help improve VTE RA compliance, as well as thromboprophylaxis and anticoagulation safety in line with current NICE guidelines and quality standards. Particular thanks were expressed to Ms N Baker, Deputy Head of Outcomes and Effectiveness and Mr S Rudge, Nurse Specialist for the particular work they had undertaken. The report documented the specific audit work undertaken and continued work in relation to VTE anticoagulation policies and guidelines with a view to rationalising the number and / or providing clear signposting to related documents. The report concluded that the Trust Thrombosis Committee work programme was advancing well and was in line with expectations.

In response to this report, the Medical Director noted the significant progress made with regard to this work over the last 12-18 months, from which he took significant assurance. Dr Haynes, Advisor to the Trust Board, extended his congratulations for the significant amount of work undertaken and queried how UHL would benchmark on missed doses – in response to the query regarding benchmarking ability, the Deputy Medical Director noted the existence of various regional group and Committees, in which opinions and learning could be shared. It was also hoped that the large-scale audits would make a positive difference in this respect. Ms C West, CCG Representative, highlighted the issue of investigating how Independent Providers were performing on behalf of the Trust, which was acknowledged. In relation to the on-going policy work, the QOC Chair specifically highlighted that two of these guidelines (numbers 18 and 19 on appendix 9 of the report) continued to be RAG-rated 'red' after considerable time had elapsed, which she did not consider to be culturally acceptable and suggested the need for review of the Trust's internal processes in this respect. The contents of this report were received and noted and thanks were expressed to the teams involved for their work which had led to significant continued progress. It was agreed that a further progress report would be presented in 6 months' time (i.e. December 2021).

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

(B) a further progress report be presented in six months' time. **DMD**

55/21/3 Cancer Performance Recovery

Ms S Leak, Director of Operational Improvement, attended to present paper E, which noted that in April 2021, UHL had achieved four standards against the national targets, with the most significant challenges relating to 2 week wait capacity and 31 day surgery waits due to decreased theatre capacity.

In response to a request from the QOC Chair to particularly focus her report in relation to patient harm, the Director of Operational Improvement advised that the quarterly harm review would be reported next month; however, no physical harm had been reported for any patients as of the current time. Whilst the Trust was seeing the tail of the longest waiters decreasing, more patients were being booked. Each of the specialties had an action plan to support their recovery, the trajectory for which was outlined within the report. The CQC had undertaken a virtual visit with eight Trusts, including UHL, and the Trust had received very positive feedback in terms of its response to Covid-19 and cancer. The outcome of this visit would be published nationally and notable good practice would be shared.

In discussion, note was made of the benefit in having the comparative data with the rest of the country, Specific note was made of the positive regional approach to benchmarking with a view to providing equity across the region, which would be of benefit to patients and further updates on this would be provided in future, as available. In conclusion, it was noted that this report provided on-going assurance with regard to cancer performance recovery. Whilst the Trust continued to be in a challenging position, with some specialties more challenged than others, realistic plans had been implemented. Specific note was also made in relation to the CQC review and an acknowledgement of good regional working.

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

55/21/4 Ockenden Update

Ms E Broughton, Head of Midwifery, attended to present paper G, which provided an overview of the progress of submissions to address immediate and essential requirements of the Ockenden Report published in December 2020. The Trust submitted a response to NHSE/I in January 2021, as mandated; this was to be assessed regionally and nationally to bench mark the service against the Ockenden recommendations. UHL received a report back reflecting the outcome of the submission and where further work needed to be completed. The development of a national portal to submit the evidence of compliance with the actions was rolled out and opened to submissions from 18th May 2021. The expectation was that the portal would close in four to six weeks to enable the national team to review the evidence and issue further updates to Trusts. The service had offered a secondment with external funding for four months, for a Senior Project Officer to collate the evidence and make the first submissions and initiate the development of pathways where needed. This was a focused post established to assist in achieving full compliance by December 2021, when the second Ockenden report was published. The information detailed within the report provided assurance that some actions had already been embedded, others required a guideline or Standard Operating Procedure (SOP) to support the pathway and others were completely new, however were not causing any risk to the service currently and an action plan would be developed to achieve these in time. The risks to delivery comprised staffing requirements and outcome of the bid for funding to support achieving Birth rate plus (with note made that even if funding were available, a pool of midwives to employ may not be available given their scarcity), the enhancing Midwifery Leadership criteria and implementation of an external advocate and twice daily MDT ward meetings on delivery suite at the weekends. However, one of the most significant challenges was requesting an external regional clinical specialist to review certain cases relating to Brain injury and/or fetal loss. There were concerns in terms of how this could be supported with time and financial remuneration and support had been requested from the Regional Team in terms of identifying a regional solution. The contents of this report were received and noted, including acknowledgment of the specific risks referenced above.

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

55/21/5 Nursing and Midwifery Safe Staffing and Workforce Report

The Chief Nurse presented paper I, which highlighted a number of key points in relation to nurse staffing, including the fact that Registered Nurse (RN) vacancies for March 2021 were 443 wte (an increase compared to 19/20; 11.5% vacancy rate against a 10% vacancy rate nationally). The Chief Nurse noted that whilst significant progress had been made in terms of recruitment this had been adversely affected by the cessation of overseas recruitment, which could now re-commence. Further challenges had also been brought about due to the Covid-19 pandemic, with a delay in the provision of training for student nurses. Healthcare Assistants (HCA) vacancies for March 2021 were 226 (a reduction compared to quarter 3, with a 12.8% vacancy rate against a 10% vacancy rate nationally). This report was triangulated with information held by the Freedom to Speak Up Guardian and with information arising from patient feedback and there were no particular themes to report. Ms West, CCG representative noted that the staffing challenges faced by UHL were also those faced by LPT and, as such, it would be useful to follow this up at ICS level.

Note was also made that, following changes to the Committee structure and membership, discussions were to be held with regard to which information was submitted to which Committee (e.g. the staffing workforce report was relevant to both the People, Process and Performance Committee and to the Quality Outcomes Committee) and feedback on this issue would be provided in due course (estimated to be within 2-3 months' time). The contents of this report were received and noted. **QOC Chair CN / MD**

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

(B) the QOC Chair, Medical Director and Chief Nurse be requested to report back to the Committee on an outcome of a review as to which information should be submitted to QOC in future, and which should be submitted elsewhere. **QOC Chair CN / MD**

55/21/6 Decontamination of Medical Devices and Cytoscopes

The Chief Nurse presented paper J, for information, and provided assurance to QOC that medical equipment across UHL was decontaminated within a validated process. The contents of this report were received and noted. Mr I Orrell, Associate Non-Executive Director, raised a query in relation to the final sentence of the report, which subsequently led to discussion resulting in agreement regarding the need for an identified process to facilitate consultation with the Decontamination Lead in terms of medical equipment brought into the Trust through the Reconfiguration Programme.

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

(B) the Chief Nurse be requested to progress, outwith the meeting, the issue raised regarding the need for an identified process to facilitate consultation with the Decontamination Lead in terms of medical equipment brought into the Trust through the Reconfiguration Programme. **CN**

55/21/7 Patient Experience End of Year Update 2020-21

The Chief Nurse presented paper K, which highlighted quarter four 2020/21 activity and provided an overview of the work completed within this year and all concluding activity to ensure full delivery of the Patient Feedback Plan 2019-21, prior to a new strategy being formulated and agreed.

Particular points of note highlighted during the presentation of the report included UHL having been awarded in 2020 'Acute Trust of the Year 2019' by the Patient Experience Network National Awards (PENNA) as a result of them having been so impressed by the standard of Award entries from UHL. During 2020/21, approximately 142,000 Friends and Family Test feedback forms had been received, with 135,000 positive responses, 3000 suggestions for improvement and 4000 that were neither negative nor positive. The new Patient Feedback Driving Excellence Priorities for 2021-23 had been developed following a period of extensive engagement with staff, community organisations, carers and members of the public and would provide the direction, structure and pace with regard to how the Trust collected and responded to feedback from patients, families and carers over the next few years within the Trust. Also highlighted was the improvement in the Maternity Department's FFT scores and the fact that SMS texting had now been introduced in ED.

The QOC Chair noted that the information detailed in appendix 1 was very helpful in terms of the analysis of positive FFT score by clinic code by mode of delivery, noting that post pandemic, there would continue to be virtual appointments as well as face to face appointments. The Chief Nurse noted that this data had generated significant discussion at the Executive Quality Board and that the raw data was to be passed to the Head of Strategy and Planning who would build this into the out-patients work being undertaken. The QOC Chair requested that this information was shared across the system given its value to others in terms of lessons learned. Note was also made of related work being undertaken by Professor Dias. The QOC Chair noted the need to view such service developments through the eyes of patients, in terms of the boundaries of 'normal' and the uniformity of expectation. The contents of this report were received and noted, as was the useful information detailed regarding the on-going delivery of services in the future.

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

(B) the Chief Nurse be requested to share the information detailed in appendix 1 across the system given its value to others in terms of lessons learned. **CN**

55/21/8 Support for Carers in Leicester's Hospitals 2013 to date

The Chief Nurse presented paper L, which illustrated the extensive work undertaken in the past and which continued to be undertaken focused upon promoting the needs of family members with a caring responsibility and carers within Leicester's Hospitals. It also provided detailed information about how the Trust had continued to collect feedback from families and carers during the pandemic and the plans to recommence activity to support families and carers with movement into the Trust recovery phase. The contents of this report were received and noted.

The QOC Chair queried whether this report included young carers; whilst it did not include them specifically, the Trust would be participating in the ICS led work around carers and would highlight the issue of young carers within this forum.

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

55/21/9 Quality and Performance Report – Month 2 2021/22

The Medical Director and Chief Nurse presented the Month 2 Quality and Performance report (paper M refers), the contents of which were received and noted. Specific note was made that this report was due to be received in its entirety at the Trust Board meeting due to be held on 1 July 2021 and note was made of work ongoing in relation to mortality and stroke TIA; with the latter discussed recently at EQB. The Chief Nurse highlighted the covid rates (probable and nosocomial), the positive FFT scores and that data relating to single sex accommodation was to feature again within the report once national reporting resumed. In discussion, it was agreed that the Chief Nurse and CCG Representative would discuss the management of falls further outwith the meeting, in terms of the ability to alert or flag, noting that the Quarterly Falls report contained more extensive data than that within the performance report. The QOC Chair noted that use of comparative data would be difficult in the near future given the likely skew of results caused by the pandemic year and subsequent backlog year. **CN/ CCG Rep**

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

(B) the Chief Nurse be requested to discuss the management of falls further outwith the meeting, in terms of the ability to alert or flag, with Ms C West, CCG Representative. CN/ CCG Rep

55/21/10 Patient Safety Highlight Report

The Director of Quality Governance presented paper N, which detailed the latest patient safety data and she specifically highlighted the following information:- (1) the paper included on learning from claims which would form helpful preparation for the Patient Safety Strategy. Key themes arising from this included consent to treatment, anti-coagulation and delay in the diagnosis of fractures (2) Serious Incidents, with two having occurred during May 2021. Note was made that SI figures were likely to increase in the future due to a change in reporting with HSIBs now reported as SIs, how falls were reported and also due to reporting requirements around nosocomial covid deaths and (3) complaints – there had been a decrease in the number of formal complaints and a decrease in the number of re-opened complaints. No new Ombudsman's cases had been opened and one such case had been closed.

The Medical Director note that learning from claims data was tracked through the Adverse Events Group with information, which was quite historical in nature, sent to all of the Clinical Directors and CMG Safety Boards. Dr C Marshall, Deputy Medical Director, had been requested to undertake work on improving the current structure. The Medical Director also made note of the intention to introduce an electronic consent form in the future. The QOC Chair queried the possibility of undertaking a look back exercise, at an appropriate time interval, to determine whether any future increases in SI reporting were due to the criteria for reporting having changed. The Director of Quality Governance noted the robust process in place for investigating any discrepancies and undertook to undertake a look back exercise after a six-month interval. The contents of this report were received and noted.

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

(B) the Director of Quality Governance be requested to undertake a look-back exercise after a six-month interval to determine whether any future increases in SI reporting were due to the criteria for reporting having changed. DQG

55/21/11 Covid-19 Position

The Medical Director and Chief Nurse reported verbally and briefed the Committee on key issues in relation to the COVID-19 pandemic, highlighting the following matters in particular: (a) the number of Covid-19 patients being treated currently within the Trust which remained fairly static;

(b) vaccination and testing update and (c) future planned work in relation to the identification of information required to form a Standard Operating Procedure or policy document within the organisation. The contents of this verbal report were noted. Ms J Smith, Patient Partner, queried how the vaccination 'pop-up' clinics were managed, as she was aware of patients not having received their dates for the second vaccination. UHL staff were not aware of the answer to this question as the Trust was not responsible for running these clinics. The CCG Representative undertook to find out the answer to this question and advise the Patient Partner accordingly. **CCG rep**

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

(B) Ms C West, CCG Representative, be requested to respond to the query raised by the Patient Partner outwith the meeting. **CCG rep**

56/21 ITEMS FOR NOTING

56/21/1 Updated Action Plan relating to Dermatology Referrals

Resolved – that the contents of this report (paper O) be received and noted, with note made of the importance of continued progression against all indicators which were not yet RAG-rated as '5'.

56/21/2 Quarterly Update re the ED Safety Checklist Audit Report

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

56/21/3 Clinical Audit Quarterly Report

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

56/21/4 EQB Action Notes – 11 May 2021

Resolved – that the action notes from the EQB meeting held on 11 May 2021 (paper R) be received and noted.

57/21 ANY OTHER BUSINESS

Resolved – that there were no further items of business.

58/21 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that (A) the following items be recommended onto the 1 July 2021 public Trust Board for formal approval: **QOC Chair**

(1) CNST Evidence (Minute 49/21 above), and
(2) Quality Account 20/21 (Minute 50/21 above), and

(B) the following items be highlighted to the 1 July 2021 public Trust Board via the summary of this Committee meeting for information:
(1) Maxillo-Facial Workforce Update (Minute 55/21/1)
(2) Cancer Performance Recovery (Minute 55/21/3), and
(3) Ockenden Update (Minute 55/21/4).

59/21 DATE OF THE NEXT MEETING

Resolved – that the next meeting of the Quality Outcomes Committee be held on Thursday 29 July 2021 from 2pm via Microsoft Teams.

The meeting closed at 3.50pm

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)	3	3	100	A Furlong	3	3	100
P Baker	3	3	100	B Patel	3	3	100
C Fox	3	3	100				

Non-voting members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
P Aldwinckle (PP)	3	2	67	J Smith	3	2	67
I Orrell	3	3	100	C Trevithick/C West/ H Hutchinson (CCG Representative)	3	3	100