NHS
Lancashire and South Cumbria
Integrated Care Board

Approved – 15 March 2023

Minutes of the ICB Quality Committee Held on Wednesday, 15 February 2023 in Boardroom 1, Chorley House, Leyland

Name	Job Title	Organisation
Members		
Sheena Cumiskey (SC)	Chair/Non-Executive Member	L&SC ICB
Roy Fisher (RF)	Non-Executive Member	L&SC ICB
Dr David Levy (DL)	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
David Eva (DE)	Independent Lay Member	L&SC ICB
Attendees		
Katherine White (KW) (attended on behalf of Mark Warren as his named deputy)	Deputy Director of Adult Social Care	Blackburn with Darwen Council
David Blacklock (DB)	Healthwatch - Chief Executive,	People First/ Healthwatch Cumbria and Lancashire
Angela Allen (AA) - Left after Item 13	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
Andrew White (AW) - Arrived during Item 7	Chief Pharmacist	L&SC ICB
Jane Jones (JJ)	Deputy Director of Safeguarding	L&SC ICB
Louise Talbot (LJT)	Corporate Governance Manager	L&SC ICB

Item No	Item	Action
1.	**Welcome, Introductions and Chair's Remarks** The Chair welcomed everybody to the meeting and introductions. Katherine White attended on behalf of Mark Warren as his named deputy. Jane Jones attended on behalf of Margaret Williams and would be presenting the safeguarding items. The Chair referred to the current pressures in the system recognising the continued support across both health and care to maintain sustainability. The Chair had met with the Non-Executive Members and the Independent Lay Member on the Quality Committee following which, a number of themes were drawn out and would be shared with members of the committee. The Chair advised that the committee agenda had been reorganised with section headings and reflection would be taken at the end of the meeting as to whether any further refinements were required.	**SC/ LJT** ✓

	The Chair referred to the patient story appended with the meeting papers, advising that stories are selected to compliment an item on the agenda – the story for the meeting related to SEND. The Chair had recently attended the System Quality Group which had a particular focus on diabetes. She found the meeting interesting in terms of how it operated which was about continuous improvement and was an important part of the Quality Committee's assurance to the ICB Board.	
2.	**<u>Apologies for Absence</u>** Apologies for absence had been received from Jane O'Brien, Sarah O'Brien, Mark Warren (Katherine White attended as his named deputy), Arif Rajpura, Peter Murphy, Margaret Williams (Jane Jones attended to take the items on the agenda), Joe Hannett and Fleur Carney.	
3.	**<u>Declarations of Interest</u>** **RESOLVED: Debbie Corcoran declared an interest in Item 14 on the agenda relating to the Mental Health, Learning Disabilities and Autism Strategies as she has particular lived experiences. LJT noted for inclusion in the Board and Committee's conflicts of interest log.** **(a) Quality Committee Register of Interests –** Noted.	**LJT** ✓
4.	**<u>Minutes of the Meeting Held on 18 January 2023, Matters Arising and Action Log</u>** **Minutes:** **RESOLVED: That the Quality Committee approve the minutes of the meeting held on 18 January 2023.** **Matters Arising:** Matters were picked up via the Action Log. **Action Log:** **Independent Member on the Quality Committee –** An update would be provided at the next item on the agenda. **Primary Care Training re Mental Capacity –** Bespoke training had been offered to GP practices via the former CCGs. Concerns had been raised about GP training in the Mental Capacity Act and how it is then monitored during the annual appraisal process. GJ had reflected at a recent appraisal that he was only asked about his Life Support training. DL agreed to check with the regional team as to the scope of training covered by the GP appraisal process. ***Post meeting update:*** • Mental Capacity Act updates/training would come under the umbrella of safeguarding. • Safeguarding is not a mandatory requirement for appraisal and revalidation but the advice to appraisers and appraises is to discuss this under the Safety and Quality part of the appraisal meeting. • Intercollegiate guidance on Safeguarding Children and Young Adults recommends a minimum of 8 hours level 3 refresher training in adult safeguarding and 12 hours in child safeguarding over a 3-year period. • Training, education and learning opportunities should be multi-disciplinary with some inter-agency input desirable and delivered internally and externally.	**DL** ✓

	• It should include personal reflection and scenario-based discussion, drawing on case studies, serious case reviews, and lessons from research and audit. This should be appropriate to the specialty and roles of participants. • The same applies to BLS – not mandatory for A&R but if a doctor is not providing any evidence of complying with guidance, then they leave themselves vulnerable should there ever be an issue with a safeguarding case or a resus situation. • Appraisees always make a note of any safeguarding learning or interactions so that they do meet the Intercollegiate Guidance recommendations and the obvious place to capture this is in their appraisal documentation. • Appraisees may also have mandatory requirements depending on their roles and employer's requirements including CQC.	
	Liberty Protection Safeguards – The implementation date was still awaited. Preparation work continued including the development of practice guidance. JJ would check further and advise LJT of a provisional date for inclusion into the committee workplan.	**JJ/ LJT ✓**

	Patient Story/Experience – 16-Year Old in Care – Referred to the Multi-agency Child Exploitation Team - Highlighted variations in commissioning arrangements and recognised that it created challenges in providing timely and appropriate mental health support of children and young people. DL checked with FC outside of the meeting – see the following update:
	
	Post meeting update:
	• Children and Young People's mental health services have been redesigned based on the THRIVE conceptual model of delivering integrated care and are focused on improving the resilience, emotional wellbeing and mental health of children and young people. The model was developed and agreed jointly and aims to ensure consistency of provision by providers across Lancashire and South Cumbria.
	• An additional £10.7million has been invested over 3 years to support this transformation. Once fully implemented it will reduce waiting times, improve experience and quality of care, and make sure young people receive consistent levels of care wherever they live in the region. There will also be a focus on enhancing crisis care and making sure there is support for young people at any time of the day or night, reducing the need for young people to be admitted to hospital.
	• As part of the 'getting more help' offer (crisis care), response and intensive support (RAIS) teams have been commissioned across Lancashire and South Cumbria, to support CYP up to 18 years of age. All urgent referrals are clinically triaged by an experienced mental health practitioner, those requiring urgent response are prioritised and forwarded to the RAIS team for assessment and an initial care plan. Outside of the core offer of 8am – 8pm, an assessment within A&E may be done by an adult mental health practitioner. A multi-agency crisis steering group is being established to take forward the crisis offer, monitor implementation in line with the model and develop communications to stakeholders
	• The risk support model, as part of the THRIVE 'Risk Support Quadrant, introduces a multi-agency framework to support CYP up to 18 years of age (and their families) who:
	  • have emotional well-being needs and/or psychological distress
	  • and are currently unable/unwilling to benefit from evidence-based treatment
	  • and present with a behaviour(s) which, if not supported, are likely to result in harm to self or others and in some cases breakdown in living arrangements
	• The model includes targeted support for looked after children. Risk Support Liaison Workers are now in post to offer multi-agency support and are linking in with children's social care teams to embed the model jointly.
	• Work has also commenced on an approach, as a proof of concept, which will provide lower-level support and interventions to children looked after, who have emotional	

dysregulation. This is being tested in the Pennine area, with a view to inform future commissioning by the ICB and social care partners.

- In addition to our crisis response, the CYP MH transformation programme are also working with NHS and non-NHS providers to ensure that planned care pathways for CYP with a diagnosable mental health condition are consistent across the ICB. This work has commenced and is the focus for the year 3 (2023/24) investment.

Staff Uptake of COVID-19 Boosters and Flu Vaccinations – Thanks were conveyed to KL for the detailed information circulated. LJT advised that SO'B currently had no further update regarding discussions with Directors of Public Health.

Foxton Centre – Reference was made to the Foxton Centre and where synergies lie and what the committee was taking from it and clarification was sought in respect of plans. DC commented that there was a direct synergy with the Public Involvement and Advisory Engagement Committee (PIEAC) advising that the PIEAC has a focus via deep dives through key areas in order that they provide assurance to the ICB Board. She made particular reference between the committees as a dynamic, the connection across continuing healthcare and that the PIEAC could relate this back through patient feedback. It was suggested that informal discussions took place with a view to taking to the ICB Board and if the delivery model was not working effectively, the quality aspects would come back through the Quality Committee. Whilst this approach was welcomed, it was recognised that governance across the ICB was still developing.

Quality Governance Structure – Function and Delivery Map – KL spoke to a circulated visual which was extracted from the ICB Corporate Governance Handbook. She referred to the delivery mechanisms advising that work was taking place via a number of different groups and that some elements were complex. There were also actions being worked through via the committee's workplan that would be brought back to the committee for consideration. It was a maturing and developing model.

RF referred to the Finance and Performance Committee (F&PC) and the inter-relationships with the Quality Committee (QC) and he had recently met with the ICB Chair and the Director of Corporate Governance to review the position of the F&PC highlighting the inter-relationships. The ICB would discuss further with the ICB Chief Executive and it was recognised that work would need to be undertaken with the ICB Board in respect of the integrated performance report. Also, the particular relationship with the QC recognising that it was maturing and ongoing. He would liaise with the Director of Corporate Governance further.

GJ suggested that an issue that has passed through the process be identified with an explanation as to how it worked following which, comments could be made as to whether it was robust enough or whether improvements needed to be made. This was welcomed in terms of the effectiveness of the committee.

DE sought clarification as to how the links with the provider collaborative would work and KL advised that it was a key area that was currently being worked through. She referred to quality improvement programmes across other organisations advising however that they use different methodologies. KL further advised that once the improvement hub started to evolve, it was anticipated that a sub-group would take it forward. It was recognised that it was a complex field at the current time.

DL referred to the improvement hub delivery mechanism, in particular engineering better care which would be rolled across the provider collaborative with an initial focus on frailty. He suggested that it may be useful to see how it fits in with the Quality Committee and for representatives to attend a future meeting to discuss the programme. They had also asked how they could be involved in the ICB.

	DC sought further clarification as to how the function and delivery map worked at system, place and neighbourhood level suggesting that a slide be drawn up that included priorities, structures and focus at different levels. She commented that it would then clarify some of the structures and how it all fit together. KL advised that we were approximately three months away from having a real understanding in terms of place, neighbourhood and system and did not have the synergy between the three at the current time. It was recognised that partnerships needed to be built in. The Chair welcomed the function and delivery map and whilst it continued to evolve, it showed a good representation of the current position recognising that more developmental work needed to be undertaken with a focus on the wider system working at place and neighbourhood. It was suggested that the model be brought back to the committee in approximately four months' time and to better understand the improvement methodology, to invite representatives as suggested by DL. LJT would factor into the committee workplan. DL referred to the PMO for transformation and improvement being set up by the ICB and suggested that Jerry Hawker also attended the committee to provide an update. The Chair stressed the importance of integrating care consistently to make improvement and have the best value possible. Involving the third sector was also important. **RESOLVED: That the Quality Committee receive the update and note the actions being taken forward. It was agreed that the relevant items could be closed on the action log.**	**LJT** ✓
5.	**<u>Review of Quality Committee Terms of Reference</u>** LJT had provided a comprehensive list of the amendments to the Quality Committee Terms of Reference which had been discussed at previous committee meetings and would feed into the Corporate Governance Handbook update to the ICB Board at the end of March. In addition to the proposed amendments, the Chair advised that David Eva would be included in the membership as an Independent Lay Member. **RESOLVED: It was agreed that David Eva was not required to leave the meeting whilst discussion took place regarding the proposal to include him in the membership as an Independent Lay Member.** RF referred to a comment within the report that referring to reviewing his position and time commitment **<u>and how the work of both committees link together</u>** – the latter emboldened wording was not relevant to him specifically which was noted. **RESOLVED: That the Quality Committee recommend the proposed amendments to the Terms of Reference to the ICB Board for approval via the Corporate Governance Handbook.**	**LJT** ✓
6.	**<u>Patient Story/Experience</u>** The Chair referred to the story provided regarding a five-year old who had cerebral palsy, communicated with his eyes and through making noises. His sleep was very disturbed, he was fed via gastrostomy and continued to require numerous meetings with professionals. Prior to the meeting, the Chair had particularly asked if local authority colleagues were able to provide their comments in terms of the context within LSCB. The following comments and observations were made:	

	• Common theme when citizens attempt to liaise with public bodies. Often there are experts on 'one side of the fence' however, there is no expert on 'your side of the fence'. There was no expert support or advocacy and it did not need to be difficult. • In this particular case, the child's mother was articulate however, there are many people who do not have the same voice. It was important that people have the help and are aware of pathways available to them. • When somebody is a victim of crime, they are issued with a crime number. Across health, there is often no support throughout a patient's journey and some are lifetime long. • Advocacy in health and social care is not funded and there are difficulties navigating the system. • There should be learning from patients with lived experience. • There needed to be consistency and training across the system. • The need to reach out to families who have positive outcomes. • Reference was made to workforce development and the need to break down barriers of what is carried out in health and what is undertaken across social care. Reference was also made to multiple and complex needs and linking with discussions about what we want the workforce to look like in going forward. • There needed to be a one stop shop for individuals to go to. • Issue in respect of short-term funding, the committee was advised that Jane Cass was leading on a piece of work for the ICB, working with the voluntary sector about having sustainable activity. • Discussion ensued regarding the need for advocacy which is funded for different types of people and was linked to eligibility criteria and acts of parliament. It was recognised that because of the rigidity, some circumstances may not fit. There needed to be independence support, i.e., an independent person with expertise which may require more than one individual to provide support. It was recognised that there was a real absence of this support. In addition to advocacy supported services, there was also a health equity issue and clarification was sought as to whether information was available that demonstrated reaching out to children from different areas/all areas. • General principles needed to be applied around different ages through to adulthood and making the pathway smoother, more joined up and more systematic. • Reference was made to an initial response service set up by Lancashire and South Cumbria NHS Trust with one contact number made available and consideration could be given in building on this. • It was recognised that there are statutory responsibilities for local authorities having a duty however, they appeared to be at different levels. The Chair thanked colleagues for their comments. It was recognised that the issues related to all parts of health, social care and the voluntary sector along with longitudinal contracts and the work being carried out by Jane Cass. Recognising that whilst important, it was not just about advocacy and there needed to be clear guidance as to what support mechanisms are available. It also feeds into the SEND work. DC recognised the value of advocacy support, while encouraging consideration that services should be constructed and delivered in an accessible way so that the need for advocacy is limited. DC agreed to consider advocacy support through the ICB Public Involvement and Engagement Committee (PIEAC). DB was mindful of the need to review advocacy and noticed the absence of advocacy support in connection with two other reports on the committee agenda. He welcomed the focus on advocacy support. The PIEAC would consider the value added through advocacy in relation to patient involvement/engagement/experience. The Chair also referred to inequalities commenting that consideration would need to be	**DC**

	given as to whether there were any particular groups of people within communities who are also excluded and also recognising the need for all staff to have skills in cultural competencies. Issues go back to the improvement journey. KL would provide feedback on the issues raised. **RESOLVED: That the Quality Committee receive the patient story and note the actions to be taken forward.**	**KL**
7.	**<u>Assurance on Secure and Non-Secure Mental Health Services</u>** Further to the recent BBC Panorama programme which showed patients being abused whilst in the care of an NHS Trust, the National Director Mental Health wrote to each NHSE region and ICB asking that they undertake a number of actions to assist in asking ourselves what more can be done to ensure that those behaviours and actions were not present in the services within L&SC. Following the committee meeting in November 2022, the recommendation to plan site visits was supported. DL spoke to a circulated report which provided feedback. Reviews of two private provider mental health hospitals, with commissioned contracted LSCFT beds were completed: • The aim was to observe the standards of care provision including quality assurances and governance. • Acknowledge the provider evaluation of the systems and organisations surrounding the patient, including referral to discharge and ongoing care. • Understand any barriers that may arise within the wider systems and processes. • Explore means and ways of ensuring our future systems enable aligned, safe, effective and monitored treatment and care pathways. Reviews had been undertaken by LCSFT as a lead provider in six wards with a further nine planned to be completed by the end March 2023. DB stressed the importance of including experts by lived experience when carrying out visits as they can build trust with patients quicker. He also referred to the Walton Hall review and the illusion of advocacy, commenting that it can be very easy not to get it right. DB also described the process as sitting and seeing and it needed to be recognised that some people are unable to communicate. Abuse can happen at night, when individuals are on their own and isolated. Consideration needed to be given in finding a way of developing relationships and undertaking more regular visits. DB also expressed concern about patients being lost in the system and stressed the importance of ensuring they aren't and that repeated visits were needed. The same importance should be applied when comparing to the process of reporting a Never Event. CL advised that a very experienced member of the ICB quality team carried out a visit by way of 'sit and see' and the purpose of the visit related to assurances in respect of safety and quality. She advised that some of the responses relate to how the service is commissioned. It was recognised that there are a lot of complex mental health services. KL referred to peer reviews commenting that a commitment had been made to take this forward which would make a positive difference. Clarification was sought as to how much support there was for families and carers. DC was not assured in terms of quality and safety and the patient experience and this	

	would be considered by the Chair as an alert in the committee highlights report to the ICB Board. Whilst it was recognised that the initial piece of work was undertaken, the outcome of the visits appeared to raise more concerns and there needed to be support in recommending more work in this area and carry out more testing. DC advised that from a public and patient assurance perspective, the ICB's Director of Communications and Engagement could link into the process to look at quality and the patient experience to drive changes and to ensure there is a clear picture and improvements made. It was suggested that in order to have a clearer understanding of where the issues were that a list of secure units across Lancashire and South Cumbria be drawn up. *Andrew White joined the meeting.* CL commented that care and treatment review was not routine for mental health in-patients, as they are now for learning disabilities/autism in-patients. CL and DL to liaise outside of the meeting in relation to the proposal to support further mental health in-patient reviews of quality, safety and experience. The Chair welcomed the comments made and recognised that part of the work undertaken was to gain assurance from organisations and seeking to understand how they were assured. An innovative approach was undertaken and whilst there was partial assurance, further work would be taken forward in order to be fully assured. DL advised that there may be additional resources required if visits were to continue and he would consider a recommendation as to how it could be carried out across the system. He would discuss further with the committee Chair outside of the meeting. By way of reflection, the Chair commented that it would be beneficial if people with lived experience were involved in the visits, peer reviews be encouraged and stressed the importance of ensuring people are not lost in the system. Regular care treatment reviews needed to be undertaken and intelligence should be shared, eg, non-NHS providers that often have people from multiple geographies. **RESOLVED: That the Quality Committee receive the report and note the actions to be taken forward.**	**SC/LJT** **CL/ DL** **DL/ SC**
8.	**<u>Risks and Escalations</u>** CM spoken to a circulated report and highlighted the following: • **Lancashire Teaching Hospitals NHSFT –** Three Never Events declared on 26 January 2023; the detail and actions taken were included in the report. In connection with one of the Never Events, CM highlighted the acknowledgement of the honesty of the member of staff immediately and advised that discussion had been held with the patient the following day. • **Psychiatry UK – The National Online Psychiatry Service –** Serious incident notified on 19 January 2023. This related to three L&SC ICB patients and the detail and actions taken were included in the report. DE referred to online psychiatry and the use of digital and general regulation of the process. He sought clarification in terms of verifications and whether there were any quality gaps. CL advised that as it was a contracted service, there would be a specification with quality indicators which would usually include how providers regulate and manage locums. In addition to the report presented, CM advised of a further Never Event at Morecambe Bay Hospitals NHSFT relating to 'stop before you block' (finger), the national patient safety initiative that aims to reduce the incidence of inadvertent wrong-sided nerve block during regional anaesthesia. Work was taking place to review previous Never Events to	

	ascertain previous actions taken and to reconcile. DL would raise with Medical Directors reminding them of the WHO surgical/medical checklist. AW sought clarification on the follow-up process in respect of timelines and learning from actions. KL advised that once the matter is triggered, immediate action is taken by a team and a checklist is worked through within 72 hours. The Chair suggested that a flowchart be produced in order that the committee is assured of the process and also assured that the loop is then closed. CM advised that the ICB would be declaring the Never Events advising that there would be scrutiny from NHSE and root cause analyses would be fully scrutinised. **RESOLVED: That the Quality Committee receive the report and note the actions being taken to mitigate risks.**	**DL** **CM**
9.	**<u>Special Educational Needs and Disabilities (SEND) Report</u>** The Chair advised that due to unforeseen circumstances, Lesley Anderson-Hadley was unable to attend the meeting, therefore, colleagues were asked to note the report and to direct any comments or questions to Sarah O'Brien via Louise. LJT would review the workplan in respect of the scheduling of a further SEND update to the committee. **RESOLVED: That the Quality Committee receive the report.**	**All** **LJT** ✓
10.	**<u>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: • Infection prevention and control • Safety • Mental health • Cancer • Maternity Alongside the reports was a map which showed the larger providers and high-level information about the status of each across Lancashire and South Cumbria. It was noted that the authors of the reports had not raised any decisions required of the committee. CL advised that authors of the reports would be asked to track any Never Events that occur and incorporate into the quarterly reporting. AA referred to waiting lists, particularly relating to eating disorders and cancer and sought clarification in respect of keeping in contact with patients whilst they were waiting for treatment. She stressed the importance of keeping in contact and made particular reference to the waiting time for patients with eating disorders which was a minimum of two years. AA further advised that the voluntary sector provided some support to patients on long waiting lists. DL advised that the numbers of patients with eating disorders had risen significantly during the pandemic and work was taking place in looking at new models of care. In respect of cancer waiting times, members were advised of a 'Chatbox' which had been developed by East Lancashire Hospitals NHST which provided an opportunity for patients to interact. Work was taking place to roll it out across Lancashire and South Cumbria as good practice.	

	DC welcomed the maps and the high-level detail which then enabled the committee to make informed suggestions for deep dives in particular areas. She referred to CAMHS and eating disorders which had been an issue for a long period of time and did not appear to be improving. DC further commented that there needed to be an understanding in terms of the focus and how the Quality Committee interacts with the Finance and Performance Committee and there needed to be smart sharing of information across. DC referred to quality improvement initiatives and asked whether they were making a difference which would then link back to other committees. AW referred to escalations both in terms of quality and financial aspects, using cancer as an example and not getting people through the system as the capital infrastructure needed to come through. The Chair welcomed the discussion and was mindful of the data presented to the committee and what the Quality Committee and Finance and Performance Committee were reviewing. When reviewing the report, it further emphasised safety, quality and experience and consideration needed to be given as to how the committee was assured that quality improvement had made a difference. KL advised that the report was attempting to capture data/information without going into the performance element. Work continued to further refine the report. Reference was made to the maternity report particularly relating to the Local Maternity and Newborn System (LMNS) and an update would be submitted to the committee in due course in respect of assurance relating to the quality improvement initiative. **RESOLVED: That the Quality Committee receive the report and note the actions being taken forward.**	

11.	**<u>System Quality Group – Update from the meeting held on 9 February 2023</u>**
	
	Due to timings of meetings, KL provided a verbal update and it was agreed that the summary provided to her would be included in the minutes.
	
	Area of Focus: Diabetes Health Improvement – A case for change in diabetes treatment was presented:
	• NICE recommend that all adults with diabetes receive an annual care review. Participation in the review leads to documented agreed treatment targets and an action plan enabling adults to take control and actively manage their diabetes. However, not all people with diabetes receive all of these care processes and wide variation exists. Poor diabetic services/care leads to poor diabetic control which can adversely affect both patients and their families and carers.
	• It is paramount that practices re-engage with diabetic management/best care, including conducting face-to-face diabetic reviews where possible. Face-to-face reviews create opportunities for active listening and open, empathic communication (verbal and non-verbal), which will help re-build rapport and trust with patients.
	• COVID-19 has had a major negative impact on diabetes treatment in the areas of:
	  • workforce reduction resulting in lack of expertise,
	  • skills and capacity,
	  • deterioration of treatment targets,
	  • higher DNAs,
	  • increase in obesity.
	• There is currently much unmet need in the identification of diabetes which needs to be addressed. Furthermore, there are many variances across the LSC footprint where identification, treatment and reviews are concerned; these variances exist in both primary and secondary care. It was also noted that high-cost prescribing does	

	not necessarily deliver good outcomes. **SQG members had commented:** • The impact of lack of routine and ongoing care for diabetes could apply to many long-term conditions and this raises great concern for patients and their families and carers. • There is a need to triangulate care from primary, secondary and community settings in order to improve patient outcomes. Comprehensive services should be developed which would deliver care across the whole diabetes pathway eg, dietary, physical activity pathways, weight management. • There is a need to link with Population Health and Place based teams in terms of improving patient engagement through education sessions in alignment with the broader Prevention agenda. • Best practice must be shared across care providers at all levels and it is essential to work differently so that there is equity of care. It was suggested that hubs could be developed within practices for long term conditions such as diabetes. • A system wide improvement board and oversight group is needed together with oversight at Place level – work is ongoing in this regard. • There was unanimous agreement that listening to the patient and their family and carers is key; a holistic and compassionate approach is of paramount importance. **RESOLVED: That the Quality Committee receive the update.**	
12.	**<u>Safeguarding Update</u>** JJ spoke to a circulated report which provided an overview on areas of activity that required additional monitoring and mitigation: **Advises**: • That safeguarding leadership strives to ensure mitigation is inclusively agreed with wide-ranging discussion, joint planning and actions undertaken. This was a continual cycle of review and rework. • A significant challenge is that our populations 'needs' continue to evolve with service delivery needing to flex and innovate to safeguard children, young people, and vulnerable adults. **Assures:** • The voice of the child and vulnerable adult is the grounding point that drives our collective responsiveness. • That issues of concern were being addressed by the ICB safeguarding leadership, the connections with other directorate teams, partnerships and networks. It was noted that the ICB continued to build and maximise partnership arrangements that could be described mostly to be very strong with strategic and service issues being picked up and responded to. Of particular note was the increase in referrals made in respect of domestic violence. It was noted that multi-disciplinary calls take place either daily or on alternate days. The report provided a number of mitigations including reviewing processes to ensure robust assessments take place, progressing IRIS training, partnership working continued to ensure comprehensive support is offered for victims, children and perpetrators. JJ also referred to emerging items that may require future escalation or may become a significant risk. In particular, she referred to the increase in suicides both in children and adults and audits were currently being undertaken for submission to a future meeting of the committee.	

	RESOLVED: That the Quality Committee receive the safeguarding update.	
13.	**<u>ICB Safeguarding Children and Adults Policy</u>** JJ spoke to a circulated report which was the ICB Safeguarding Children and Adults Policy and incorporated standards for safeguarding and MCA which had been reviewed to include: • Updates in relation to the ICB governance arrangements • Updates in respect to legislation and guidance and the Children in Care section expanded • The revised Safeguarding Assurance Framework Audits for commissioned services are included as appendices • The content is consistent with all the former Lancashire and South Cumbria CCGs with localisation reflective of place based safeguarding arrangements JJ advised that links to threshold documents would need to be included in the policy and a typographical error corrected. It was commented that a one-page summary at the start of the policy would be helpful to readers. **RESOLVED: That subject to the additional information/typographical error being corrected, the Quality Committee approved the policy.** *Angela Allen left the meeting.*	**JJ** ✓
14.	**<u>Mental Health, Learning Disability and Autism Strategies</u>** DL spoke to a circulated report which described and the development of the following system strategies across Lancashire and South Cumbria included with the report in respect of: • Mental Health • Learning Disabilities • Autism Services Prior to the establishment of the ICB in July 2022, the strategies were developed and signed off by the former Strategic Commissioning Committee (SCC) of the CCGs across Lancashire and South Cumbria in 2021 and a lead provider would be identified. DL advised that they were live policies and strategies, and the proposal was that they would form part of the ICB strategy. DC commented that the governance and leadership of the strategies needed to be very clear prior to taking to the ICB Board. She was previously a member of the SCC in connection with the CCGs' responsibilities with patient involvement. Since they were endorsed by the SCC, DC was unsure whether there had been ownership and she questioned the level of ambition; there needed to be more ambition in order to effect the change needed. DC would look to see resourcing around the proposals with a clear recommendation and to carry it out once and consistently across Lancashire and South Cumbria. DC also advised that it linked to the provider collaborative. DB also sought clarification in terms of ownership, how the strategies would be delivered and governance arrangements. He was supportive of the ambition and commended the strategies. GJ was mindful of not having too many strategies commenting that they needed to be	

	embedded into something bigger. He commented that the strategies belonged to all partners in the system, not just the ICB and needed to be applied to all demographics, clinical scenarios, health communities and health inequalities. GJ referred to the health and care partnership which has a strategy developing with four main principles. He suggested that conversations be held with all partners to agree how to apply the strategies to the demographics and then taken through the ICB Board and local authority seeking support. KW commended the strategies, commenting that consideration would need to be given as to whether they sit at place or elsewhere. **RESOLVED: That the Quality Committee welcomed the work that had taken place in developing the strategies and that consideration would need to be given as to how they be delivered.** **That the Quality Committee recommend the adoption of the strategies to the ICB Board noting that consideration would need to be given as to how they are taken forward as part of a wider ICP strategy and the architecture around that.** DL would pick up the actions with Fleur Carney.	**DL/ FC✓**
15.	**<u>Items for the Risk Register</u>** There were no items raised.	
16.	**<u>Committee Highlights Report to the Board</u>** **RESOLVED: The Chair would agree the form of words for the report with LJT outside of the meeting.**	**SC/ LJT ✓**
17.	**<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. • A really good meeting • Discussion around safety, effectiveness and experience **RESOLVED: That the Quality Committee's reflections be noted.**	
18.	**<u>Any Other Business</u>** There were no issues raised.	
19.	**<u>Date, Time and Venue of Next Meeting</u>** The next meeting would be held on Wednesday, 15 March 2023 at 1.30pm-3.30pm in Boardroom 1, Chorley House.	