NHS
Lancashire and South Cumbria
Integrated Care Board

Approved – 17 April 2024

Minutes of the ICB Quality Committee Held on
Wednesday, 20 March 2024, 1.30pm-3.30pm
in Lune Meeting Room 1, ICB Offices, Level 3 Christ Church Precinct, County Hall, Preston, PR1 8XB

Name	Job Title	Organisation
Members		
Sheena Cumiskey	Chair/Non-Executive Member	L&SC ICB
Roy Fisher	Non-Executive Member	L&SC ICB
Professor Sarah O'Brien	Chief Nursing Officer	L&SC ICB
Kathryn Lord	Director, Quality Assurance and Safety	L&SC ICB
David Blacklock	Chief Executive, Healthwatch Cumberland	Healthwatch Together
Dr Geoff Jolliffe	Primary Care Partner - GP, Barrow-in-Furness	L&SC ICB
Mark Warren	Local Authority Representative (LCC)	Lancashire County Council
Attendees		
Dr Arif Rajpura	Director of Public Health	Blackpool Council
Andrew White	Chief Pharmacist	L&SC ICB
Claire Lewis	Associate Director, Quality Assurance	L&SC ICB
Bridget Lees, via Teams	Chief Nurse	Blackpool Teaching Hospitals
Davina Upson	Business Manager	L&SC ICB
Lauren Jackson	Head of Children's Services (SEND and Complexities)	L&SC ICB
Tara Gallagher	Lead Pharmacist	L&SC ICB
Vanessa Webster	Director of Children, Young People and Maternity	L&SC ICB
Debbie Wardleworth	Associate Director of Learning Disability and Autism	L&SC ICB
Caroline Waldron (Item 10)	Designated Nurse for Safeguarding and Looked After Children	L&SC ICB
Clair Martin (Item 12)	Designated Clinical Officer	Blackpool Teaching Hospitals

Item No	Item	Action

1.	**Welcome, Introductions and Chair's Remarks** Members were welcomed to the March 2024 ICB Quality Committee by the chair, and it was noted that Bridget Lees had joined the meeting via Teams on this occasion due to an extra-ordinary board meeting having been called at the trust. The welcome was extended to colleagues who had joined the meeting to present their items and it was agreed that if it would be helpful and informative that they could remain in attendance for the full meeting. The chair drew reference to several agenda items which related to the patient story on SEND and requested that members consider throughout the discussion as to how a difference can be made by challenging what can be altered to make that difference.	
2.	**Apologies for Absence/Quoracy of Meeting** Apologies were received and noted from Dr David Levy, David Eva, Joe Hannett, Caroline Marshall, Debra Atkinson and standing apologies from Debbie Corcoran. The chair and committee members expressed congratulations to Roy Fisher who has taken up the Acting ICB Chair position whilst recruitment of a permanent chair commences. As such members were advised that Roy will be stepping back from the quality committee for an expected 6-month period, and it was noted that an associate director would join the committee for the 6 months.	
3.	**Declarations of Interest** The declarations of interest were noted from the papers relating to: - Item 7: Risk and Escalation and the conflict was noted as being Bridget Lees, Chief Nurse, Blackpool Teaching Hospitals, it was agreed that Bridget would remain in the meeting for the discussions. **RESOLVED: That the above declarations of interest relating to the items on the agenda were noted with no action required.** **(a) Quality Committee Register of Interests.** **RESOLVED: That the register of interests was received and noted.**	
4.	**(a) Minutes of the Meeting Held on 21 February 2024, Matters Arising and Action Log** The minutes from the 21 February 2024 were approved as an accurate record of discussions. **RESOLVED: That the minutes of the meeting held on 21 February 2024 were approved as a correct record.** **(b) Action Log** The following actions were closed from the action log: **Ref No 13.3- Risk regarding long waits for ASD and ADHD**: on March agenda. **Ref No 28 – LD/A Report**: on March agenda. **Ref No 32: Committee cover sheets-** Sarah advised that feedback had been provided to the team so that the cover sheet focuses on the key points.	

	Ref No 33: Learning from Patient Experience – Sarah advised that she and Sheena had discussed with Debbie the links between quality committee and PIEAC and agreed in moving forward that an insight report which summaries activity will come to QC for information to ensure committee advised and share each other's Triple A. David Blacklock commented that he doesn't feel that insight is received correctly at present and requested the need to consider how bring to life and bring this more in line with decision making. Further providing an example that a 150 hour wait in A&E was referenced at board, but this was not discussed in any detail. David would discuss further with Debbie Corcoran to ensure this connection. Geoff noted that there is no register to bring together key issues from board and key areas from committees in relation to patient experience as to how this is tracked. Sheena suggested that when a discussion takes place at committee, we need to routinely reference whether the experience of people has been included as part of the cover sheet template so there is an oversight of any gaps to assist in prioritising areas and align with the work of PIEAC. **Ref No 34: Staffing Capacity relating to primary care concerns –** agreed to close further to the update on the agenda but with an alert through to board. **Ref No 44: BTH Action Plan – Neonatal Mortality:** The report had been received but due to the sensitively of the content is has been agreed that this will be discussed at a Part 2 of the Quality committee in April 2024. **Ref No 45: Serious Incidents** – An update from the learning at the workshop had been circulated with the papers and members agreed to close the action. **Ref No 48: Patient Safety Incident Response Framework** – An update relating to why providers who have high reporting was not included in the flow chart had been circulated with the papers and members agreed to close the action. <u>Action log Updates</u> **Ref No 42: Vaccination Update:** An update was circulated with the papers to members relating to flu vaccination uptake. Discussion ensued as to how as a system the decline in uptake is addressed. Noting that there are groups and forums in place to raise the level of uptake in staff and patients and understand what has changed, suggesting that this could be access to locations, and suggesting training staff in care homes to provide the vaccines. It was agreed that as we have a duty of care to protect ourselves to protect patients that a referral be made to People Board with a request as to how ensure consistent approach across LSC with a generic communication and possibly part of a professional appraisal approach. **RESOLVED: That the action log is updated as detailed.** *The agenda was taken out of order.*	**DB**
10.	**<u>Safeguarding children with disabilities and complex health needs in residential setting</u>** Debbie Wardleworth and Caroline Waldron advised members of the background to this report noting that in December 2023, the Department for Education (DfE) published their response to the recommendations set out in the National Safeguarding Review Panel Safeguarding children with disabilities and complex health needs in residential settings	

	phase 1 & 2 reports. Within their response the DfE had set the steps that government are taking to address the failings and their agreement to most of the recommendations. The purpose of this report was to alert members to the identified gaps in assurance against the national recommendations specifically to safeguard children with disabilities and complex health needs in residential settings. To provide assurance against the recommendation scoping activity was undertaken by ICB safeguarding, children and young people and learning disability teams and an ICB task and finish group established, which identified gaps in the ICB current formal assurance arrangements for monitoring of children in ICB/Children Social Care joint funded residential settings with complex health and special educational needs together with a requirement to establish the local ICB host commissioner role of CQC/Ofsted regulated residential settings for individuals with learning disabilities and autism. The task and finish group have also established that wider considerations are required in relation to the adult learning disability agenda. Members were advised that there are currently twenty-seven children and young people whereby there are joint ICB/Children social care funding arrangements in place. Thirteen of which are placed outside of Lancashire and South Cumbria and fourteen in residential settings within the ICB footprint. With the scoping identifying that there is a lack of consistency and ICB formal assurance and monitoring. It was noted that there are statutory arrangements in place to ensure children and young people are receiving the appropriate care and provision whilst in residential settings, but the ICB does not have a process to be assured that the providers of residential settings have the required quality and safeguarding standards in place to meet health needs and recognise and respond to any safeguarding risks. Caroline outlined the next steps to address the gaps: • Work in conjunction with local authorities who have systems in place to undertake formal quality assurance of providers. • Extend Task and finish group membership to include Local authority. • Establish a directory of all provision and supporting guidance within the ICB footprint. • The risk is held on the local safeguarding team risk register with risk mitigation and controls in place; it will be monitored through the task and finish group and updated accordingly. Sarah welcomed the proposals, but she didn't feel that this went far enough and further discussions are required with children's social care locally to ensure that there is no repetition. Debbie suggested that the learning from adults in residential settings is brought back to a future committee. Geoff commented on the need for integrated working as all partners working together can have more oversight to mitigate the risk. Mark stated that these issues extend beyond Place, as children are placed outside of the ICB footprint and commented that a quality assurance system at Place level is required to stop care homes being opened and have an ICB collective oversight, so Place actions are moved forward as soon as needed. David queried on the responsibility of the Health and Wellbeing Boards to ensure that all homes are registered with the local authority. Mark responded that the local authority would need an evidence base for any objection to be made and re-emphasied	

	the need for joined up working with the ICB to ensure flow of information. It was noted that this is a multi-layered issue which needs to focus on: - What needs to be undertaken now to ensure that children are safe, and it was requested that this detail is included in the future report with mitigations. - There are children in the area which we are not aware of and therefore there is an ask to region to share this detail. Caroline advised that we are aware of children in the area when placed by other areas but we don't necessarily have a current understanding of all the current residential providers. - In moving forward how we change the way we work to have an integrated service and what is needed to change barriers and enablers (Place/ICB/Regional) to have his approach. - Look at how work can be undertaken with continuing care and complex cases in terms of what is working and what could change and be reviewed. Sheena thanked members for the excellent discussion on this very important item with the challenge made as to how this is undertaken differently. A request was made that an update report is brough to committee in 3 months as to what actions must be taken and ensure that all settings are safe. *Caroline Waldron left the meeting.* **RESOLVED: That Quality Committee members noted the update report with a request to have a further update in 3 months' time, with a focus on what needs to be addressed.**	**DW** ✓
5.	**a) <u>Quality and Safety Report:</u>** Claire Lewis spoke to the circulated quarterly quality and safety update in relation to the areas of responsibility and highlighted: <u>Children and Young People</u> • Speech and Language Therapy waiting times continue to remain a significant challenge with 396 children waiting over 52 weeks. • Children with long waits in surgical specialties are being considered within the work done by the Provider Collaborative Elective Recovery Group • Physiotherapy- West Lancashire and Greater Preston are noted to have increasing wait times with 52-week breaches now being identified. • Palliative Care – a commissioning framework has been drafted which incorporates all statutory responsibilities for CYP Palliative Care. • A review of the health input in the youth justice provision across Lancashire and South Cumbria has been drafted. The paper outlines the ICB statutory responsibility, and the report is expected to be shared with the CYP board in April 2024. • For 2024/2025 Referral to Treatment times (RTT) for under 18-year-olds will be a key reporting requirement • Work is ongoing developing a comprehensive measles, mumps and rubella elimination plan/work stream in collaboration with ICBs and Local Authorities. • Additional work is proposed to commence to support children with eating disorders across providers. • The business case for the Neurodevelopmental pathway is expected to be taken to CRG this month with a proposal for the model to be implemented in September 2024. • The ICB has established a SEND Assurance Group to ensure robust oversight of progress in meeting the statutory responsibilities for SEND Quality visits to DGHs. **RESOLVED: That quality committee members noted the content of the report.**	

Mortality

- From April 2024 this report will no longer be a standalone report but feature within the provider reports by exception.
- There has been an increase in SHMI at ELHT since inclusion of data from June 23 onwards and a large reduction in spells due to removal of SDEC from data (June 23)
- LTH reported HSMR of 76.5 and SMR of 78.6 (July/August2023) due to consistently low HSMR values reported and published for the trust, a deep dive, data driven analysis was commissioned around adult data and neonatal death/still born data.
- There continues to be a substantial backlog of deaths that require reviewing which has been escalated to all Heads of Department and Mortality leads. Mortality continues to be monitored via the divisional Clinical Effectiveness & Mortality Committee.
- BTH have commissioned an external review of perinatal mortality.

RESOLVED: That quality committee members noted the content of the report.

Regulated Care

- 79.6% of care homes in LSC are rated 'Good' or 'Outstanding' compared to the northwest regional average of 75.4%, which has enabled the corporate risk relating to the fragility of the care sector to be rescored to a reduced level of risk.
- Greater involvement and clear governance within the ICB is required to progress improvement across essential components of the Enhanced Health in Care Homes framework which are critical to the ageing well/frailty and system resilience agendas
- Legacy arrangements pre-ICB resulted in inconsistency and gaps in systems for quality assurance across the NHS commissioned ASC providers. A system has been established for monitoring commissioned nursing home providers across Lancashire and Blackburn with Darwen (BwD), and work has commenced to include providers in Blackpool and South Cumbria.
- There has been a significant improvement in the number of contracts returned within quarter three, which demonstrates the market being engaged with effectively.
- The Social Care Nursing Advisory Committee (SNAC) has been established with the first meeting taking place 30 November 2023 to engage with social care nurses and agree terms of reference and agenda.
- The CQC has introduced a new inspection framework and implementation is underway across the ICS.

RESOLVED: That quality committee members noted the content of the report.

Learning Disability and Autism

- A business case for an adult neurodevelopment pathway is being prepared, that will dovetail into the CYP model. This will support transitions, provide wraparound support for people waiting and diagnosed.
- LeDeR review has been established and an improved position for KPI performance and number of focused reviews being completed.

RESOLVED: That quality committee members noted the content of the report.

Elective Care

- Noted that the elective care reports will be provided as part of the provider reports to committee from April 2024.

- The 65-week performance will be tracked month on month, but this will be a challenge with the system pressures (continued strike action) to meet the standard of zero by March 2024.
- The 78-week standard will also be closely monitored and reported as necessary.
- The harm's review process undertaken across the system providers is variable, but more regular and robust reports are being received which demonstrate impact and management of patients.
- The dermatology procurement has been completed and rolled out with a single point of access.
- The national outpatients strategy has been delayed which may see an impact.

RESOLVED: That quality committee members noted the content of the report.

Mark commented on 79.6% of care homes in LSC being rated as 'Good' or 'Outstanding' and that it would be useful to understand the variances across the system as Blackburn with Darwen has the lowest rate in the North of England and how quality assurance can be linked to include enhanced health checks and care homes. Sarah acknowledged the challenges in Blackburn with Darwen, noting also that the quality assurance team is a small team but advised that Louise Taylor is linking with Jane Brennan to have an integrated approach.

Mark also referenced the reassuring increase in health action plans for LD/A and queried where the LDA delivery group reports to.

Sarah advised members that further to a recent discussion which she had with Abdul Razaq, Director of Public Health at Blackburn with Darwen Council regarding mortality data it has been agreed that all directors of public health will discuss at the June 2024 clinical assembly as to how as a system we can respond differently.

Debbie advised that she is attending a PCN forum to discuss the variability relating to LD/A health checks and suggested to look at peer support and learning.

Members agreed to escalate to the ICB board the concerns relating to Speech and Language therapy as children would not be school ready; the variability relating to LDA health checks being delivered and mortality relating to the broader issues on health and life expectancy not being moved forward.

b) <u>CYP Autism Assessment</u>

Sarah advised members that the ICB has a duty under Section 3 of the NHS Act and the Autism Act 2009 to provide appropriate services to assess autism in adults and provide support post-diagnosis.

In Lancashire and South Cumbria two pathways exist for adults, in Blackpool a neurodevelopmental pathway approach exists, whereas in the remainder of LSC an autism only pathway exists. In addition, in East Lancashire there is soon to be a non-ICB funded post diagnostic support offer, which represents an inequity of offer. However, the largest inequity exists around right to choose, with only informed and aware adults recognising that this is an option.

Sarah outlined the current provision for children with autism in Lancashire and South Cumbria highlighting that 10,000 children are waiting for an assessment, with some areas having a waiting time of more than 4 years for children and over 12 months for adults. The national demand for autism referrals has increased by 800%.

	The committee did not receive assurance that children or adults are not coming to harm due to the extended waiting times across the footprint. Sarah advised that there are 1907 children with ADHD waiting an assessment which means a waiting time of 140 weeks. There has been a 63% increase in referrals overs the last 4 years and the commissioning is fragmented with pathways having different transition points. There are 7690 adults waiting an ADHD assessment with an expected waiting time of 7 years and members were advised that there are 2 pathways for ADHD similarly to ASD. The risks were highlighted to members noting: • Inequitable offer with barriers to existing support in certain geographies impact upon on some of our most deprived locations • Children and adults on waiting lists remain unsupported and unable to navigate the impact their diagnosis/need may have on their everyday life and how to manage this. The work taken to address the issues was outlined and members noted that there is a task and finish group in place to work with all system partners to have an end-to-end pathway for neurodevelopment for children's and adults with a full business case to be developed by September 2024. Noting that the challenge will surround the recommissioning of the pathway. Members noted the work being taken to address the current challenges in 2024/25 including: • Data cleansing of the waiting list • Consistent use of QB testing across pathways for ADHD • Development of consistent data collection • Waiting list initiative for ASD & ADHD (including access to SALT) • Digital Referral Platform – final testing and implementation • Needs-led support service – commissioning across ICB • Scoping of ASD and ADHD all age Right to Choose providers to prepare consistent messaging for our population and practices. Discussion ensued with David Blacklock querying if GPs can refer a patient elsewhere. Sarah advised that this is possible but there would not be any quality oversight of private providers, and this would only provide a diagnosis and not treatment. A request has been submitted to CRG to provide support to patients whilst they wait assessment. Tara queried as to what number of referrals materialise into a diagnosis that requires intervention and suggested providing support to the referrer to ensure appropriate referrals, so patients are not just added to an ever-growing list. Lauren confirmed that this would be included within the revised proposals. Debbie suggested reviewing the ICBs social media responses and engaging with the population in a different way in terms of alternatives to diagnosis, also suggesting undertaking some quality assurance on a select number of right to choose providers and communicating this to try and ensure the assessment is of good quality. It was acknowledged that certain support can only be accessed once a diagnosis is made and therefore the model needs to be changed to help families to support their children, noting that Healthwatch have been approached to provide support to families. Roy advised of an example that schools are unable to access some funding sources if a diagnosis has not been made. Sarah advised that the proposed end-to-end pathway includes all the discussion and debate from committee but due to the volume there is a level of investment required,	

	which ICB bard needs to be alerted to. In addition, the alert to ICB board should include the extent of waiting times and that the ICB is not achieving the SEND code of practice, which should be a priority. Members agreed that these issues must be addressed through pathway redesign and viewed differently within society which can be influenced though the ICB social media responses. With organization's to be supported to consider reasonable adjustments for services to be accessible and an improved way to support children. **RESOLVED: That quality committee members received the detail and asked for prioritisation to be given to these services through an alert to ICB Board.** **c) Risk regarding long waits for ASD/ADHD** This agenda item was captured through the discussion above.	
6.	**a) <u>Maternity update report</u>** • Maternity Incentive Scheme/Savings Babies Lives • Workforce • Neonatal Operational Delivery Network Update Claire advised that all four maternity services achieved submission of their declaration forms to NHS Resolution (NHSR) by the required deadline of the 1 February 2024. Three of the four services (LTH, ELHT and UHMB) achieved full compliance with all 10-safety actions for MIS. Blackpool Teaching Hospitals achieved 5 out of 10 with action plans in place to support progression and improvement for the year 6 scheme. For the Year 6 scheme the LMNS is underway with confirming assurance visits with each of the services. This will see an increase to 4 visits per trust. The publication of the scheme is due in May 2024. The LMNS Workforce Lead has identified several data quality issues with the current capture and reporting of maternity workforce. This has been escalated at both a Regional and National level which has resulted in the plan to establish a working group to address challenges. Claire noted that Saving Babies Lives, version 3 has seen an increase from 5 care bundles to 6 with the introduction of the diabetes care bundle. The Quarter 3 (2023-2024) report has demonstrated a positive position that no babies less than 27 weeks have been born in the wrong place and no unit is flagging for neonatal mortality. NHS England Specialised Commissioning is underway with stakeholder events for the programme of work to transform neonatal services. A significant risk highlighted was the current lack of engagement with maternity services. Vanessa advised that since the report was written that this risk has been resolved and therefore is no longer an alert. **RESOLVED: That quality committee members noted the content of the report.** **b) <u>Maternity and Neonatal Voices Partnership Guidance - Mapping and recommendations</u>** Sarah advised that the aim of the submitted paper was to provide committee members	

	with a gap analysis and recommendations following a systemwide mapping exercise against the recently published Maternity and Neonatal Voices Partnership Guidance. Members were advised that detail had also been taken to the ICB Public Involvement and Engagement Advisory Committee. Members approved the proposed recommendations include within the report and ongoing oversight and monitoring of action plan by the LMNS. **RESOLVED: That quality committee members approved the recommendations and monitoring of the action plan by the LMNS.** **c) <u>BTH Neonate Action plan</u>** The discussion was captured as part of the action log review. **RESOLVED: That quality committee members noted that this action plan would be discussed at a part 2 meeting in April 2024.**	
7.	**<u>Risk:</u>** - **Risks and Escalations** - **Emerging Provider Risks** Claire Lewis alerted members to the new risks and mitigations contained within the report highlighting: • Two new Never Events reported by Lancashire Teaching Hospitals NHS Foundation Trust (LTHT). Noting that the Trust have identified any learning in the After-Action Reviews and have developed a supporting action plan. • Members were advised that immediate actions were put into place further to being altered to an unexpected death. LTHT continue to follow their monitoring processes for subcontracts and safeguarding. **RESOLVED: That Quality Committee members receive the report, noting the actions being taken to mitigate.**	
8.	**<u>Primary Care Monitoring and reporting Framework Update</u>** Kathryn spoke to the circulated paper noting that this responds to section '2.1 Quality Arrangements – quality surveillance' of the MIAA Audit, previously reported to the Committee. The paper provided an oversight on assurance of monitoring at general practice in relation to the commissioning element of the contract and work which is required surrounding the development of a quality agenda for primary care with contractual oversight in place. The significant pressures being faced by primary care services in Lancashire and South Cumbria were detailed and the need to ensure they are supported to face these challenges and it was noted that this paper has also been reported to Primary Care Commissioning Committee. Members noted that there are governance structures and processes in place to react to issues and undertake some proactive activities. However, as identified at the GP Care Delivery Workshop (31 January 2024), more could be done to triangulate intelligence,	

	preempt issues, take early action and offer support before issues arise. Kathryn advised that the approach will also need to take into consideration the comparably reduced ICB Primary Care and Quality people resource available to provide proactive improvement support which is noted on the risk register. Kathryn advised that currently assurance cannot be provided on quality at pharmacies and reiterated the need to undertake more work to embed processes and triangulation with early interventions to review structures. Geoff commented that after this paper was presented to primary care commissioning committee there had been agreement to hold a time out session to understand the data in more detail and suggested to members that this was done in collaboration with quality committee. Sarah commented that this may be potentially helpful with some members to have the joint discussion. The limited levels of assurance in all areas of primary care quality were agreed to be reported through to ICB Board and ensuring that reference was made to the reactive rather than proactive environment. The workshop which had been suggested was noted to provide recommendations and to be mindful that part of the issues is to have ensure that there is a balance of objective and subjective views. **RESOLVED: That Quality Committee members noted the report with the alerts to be made to ICB Board on the limited levels of assurance.**	
9.	**<u>Special Educational Needs and Disabilities (SEND)</u>** Lauren Jackson spoke to the circulated report which provided members with an overview of progress in meeting the duties for the ICB as set out in the SEND Code of Practice (2015), focusing on several key themes and the significant risks across this agenda. Lauren highlighted: • The newly established ICB SEND Assurance Group which provides oversight of the progress in addressing the current challenges. • The designated clinical officer service provides a point of contact for families and professionals seeking advice, guidance, and action when usual routes have failed and supports the ICB in meeting the statutory responsibilities. • There have been some challenges with the designated service as the function sits within the provider, but the intention is to inhouse from July 2024, which will provide further opportunities to align the role to the national model. • Funding is in place to increase the capacity in service but noted that some challenges remain to meet the 6-week statutory timescales for Education Health and Care Needs Assessments due to increased demand. • The gaps in service from designated clinical officers was outlined including There is inconsistent health representation on some statutory decision-making panels across the footprint and compliance with the annual review process. • In 2021, the Department for Education confirmed that the trial to extend the powers of the SEND tribunal to hear appeals and make non-binding recommendations about health and social care aspects of Education, Health and Care (EHC) plans. It was noted that further work is required, and a process developed for the ICB position in decision making and process on management of tribunals– require further work and process being developed. • A community of practice has been established and will meet for the first time in May	

	2024 to share good practice and learning from around Lancashire and South Cumbria. • Joint commissioning arrangements with local authorities for children and young people with SEND need to be strengthened. • Access to services was noted with a focus on Speech and Language Therapy delays and a system vision for a neurodevelopment pathway. Members thanked Lauren for the helpful and informative paper and requested a regular report to be presented on the SEND agenda with the next update in July 2024. It was also requesting that the report includes what is being learnt from families and children and how the work with the local authorities can be strengthened. Discussion ensued relating to how assurances can be received that the ICB Board are sighted on the whole SEND agenda with a further request being made for a focused session on SEND at board. **RESOLVED: That Quality Committee members noted the risks.**	
13.	**<u>Research and Innovation Collaborative Plan on a Page</u>** Sarah advised members that the plan on a page had been developed with the input from members of the ICB Research and Innovation Collaborative with the aim to set out the priorities within this area. Members noted that Sarah had taken a report on research to the ICB Board in July 2023 with a further update to be tabled in May 2024. Members endorsed the plan on page with a view to this being taken to ICB Board in May 2024. **RESOLVED: That the Quality Committee members endorsed the plan on a page.**	
14.	**<u>Complaints Policy</u>** Kathryn advised the committee of the key amendments to the policy: • To clarify how we will approach handling complaints about NHS providers including those involving more than one organisation. • Amend the scope of the policy to include those complaints about primary care made to the commissioner of services. • Set out the roles and responsibilities within the ICB. • Update references to other legislation and guidance linked to complaints management. • To commit our Patient Experience to provide training in complaint investigation and resolution to appropriate ICB staff. Members were advised that section 6.1 EHIIRAs would be completed once the screening outcome is known relating to what versions of the policy are required, such as braille. **RESOLVED: That the Quality Committee members approved the complaints policy Version 2, May 2024.** *Mark Warren and Bridget Lees left the meeting.*	
11.	**<u>Update on formal response to the national Valporate Alert</u>**	

Tara advised that in November 2023 the Medicines and Healthcare products Regulatory Agency (MHRA) issued a National Patient Safety Alert relating to Valporate advising that Valporate should not be commenced in new patients younger than 55 years, unless two specialists independently consider and document that there is no other effective or tolerated treatment, or there are compelling reasons that the reproductive risks do not apply. Also that at their next annual specialist review, women of childbearing potential and girls should be reviewed using a revised valproate Risk Acknowledgment Form (RAF), which will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialist unless the patient's situation changes.

Members were advised that the alert acknowledged that implementation of the actions outlined were safety critical and complex and that implementation should be co-ordinated at a system level by each Integrated Care Board (ICB).

It was noted that the national alert did not resolve the valproate issues but provided a position for assurance to be met, with Tara advising that of the 11 actions required 5 could be met with immediate effect for Lancashire and South Cumbria.

A L&SC Valproate Steering Group has been established to coordinate a programme of work to develop a patient pathway and clinical guidelines to support the safe use of valproate, reduce the use of valproate in people who can get pregnant and to help prevent unplanned pregnancies in this group of patients. The steering group will work with all local NHS organisations to develop a plan to operationalise the requirements in the MHRA alert however members were advised that until this is complete it is noted that clinicians prescribing valproate for women of childbearing potential, either new initiation or continuation of therapy, may not be able to adhere to the requirement for a second specialist signatory.

A request was made to add this risk to the ICB risk register as full assurance against the regulatory requirements cannot be provided, meaning a risk of harm to any child born to a mother taking valproate during pregnancy. There is also a potential risk to children conceived by fathers taking valproate containing medicines.

Debbie asked whether there had been any involvement from the LD/A board and Tara advised that LD/A are represented on the steering group and will ensure that all communications are appropriate for any patients within this cohort. It was noted that there is a plan to have a LSC pathway document which will include approaches for people with severe learning disabilities. Debbie offered support should this be required.

Geoff queried what the support would be should a patient not have a specialist involved with their care and Tara advised that these patients are being identified and would have targeted action and referenced that the guidance will reiterate the requirement for an annual review which could be via GPs as they have identified responsibilities.

Sheena advised that the progress made to date to implement the national patient safety alert had been noted by the committee and support was given to the steering group to implement the full action plan of the alert.

Members recommended a risk of 16 to be added to the corporate risk register, which could be mitigated to 6 if the full action plan is implemented through involvement with Primary Care and specialist care – neurology in particular.

A further update to committee is requested in July 2024 with Clinical Effectiveness to

	keep this item under review. **RESOLVED: That Quality Committee members recommended a risk of 16 be added to the corporate risk register due to the potential of non-compliance with the national alert and requested an update in July 2024.**	
12.	**<u>Patient Story/Experience</u>** Clair Martin was welcomed to the committee and was advised that this story had been threaded through all discussions. The patient story had been circulated to the committee in advance of the meeting, in order that comments could be provided for themes to be formulated in readiness for the committee meeting. The story this month related to the perspective from a parent, whose journey began when her daughter was 4, where it became apparent that she was starting to struggle with primary school. Some provision was put in place to support her to be able to access her education. Kathryn noted the following comments from members: • This was a very distressing account to read and was a very powerful example of a person's experience of gaps in the service and a childhood lost. • The system failed to support the family and the child. • Where to go next. Claire provided members with further detail from this story: • The NHS services which were commissioned could not offer the level of assessment required for this young person. • There are significant waiting times (up to 5 years for ASD assessments) • NHS services do not routinely make reasonable adjustments. i.e., home visits • Some services commissioned to support the most vulnerable children have rigid criteria, therefore unless you meet the 'exact' criteria, these cannot be accessed. If the case is deemed 'too complex', this is deemed as longitudinal support which is not offered. • Universal, targeted and specialist services could not offer support. • Post diagnostic Autism support is not available. In addition, specialist input for the most complex autistic children needs exploration (sensory support, Psychological, mental health support). • Clinical oversight of children/young people with complex autism does not exist in the system. This is a requirement for Individual Funding Requests. • There are a cohort of hidden children who are not open to any services, and this is not captured or monitored by the partnership. They may have touched multiple services across all agencies and referrals rejected but no way of identifying how many or who. • There is no mechanism for multi-agency services to flag children as in the case study. • There is a system wide workforce gap in knowledge relating to Autism. • This poses an Inspection risk and potential Serious Case Review. Sheena, on behalf of the committee thanked Clair for her care of this young person and their family. Sarah offered for a small task and finish group to be formed outside of the quality	

	committee with support from Clair to look at interim solutions, escalation routes and what mitigations could be established to support vulnerable patients. This discussion could input into the development of the neurodevelopmental pathway to redesign to ensure that the needs of children are met. David Blacklock suggested the involvement of and independent advocacy service for this group. Debbie reinforced that the LDA team can provide support and stated that autism teams in schools are commissioned with Vanessa offering to discuss with Clair should this provision need reviewing. **RESOLVED: That Quality Committee members noted the mitigations being implemented to address some of the issues highlighted through the story.**	**SOB ✓**
15.	**<u>Clinical Effectiveness Minutes</u>** Members received the minutes from the Clinical Effectiveness Group which took place on 23 January 2024. **RESOLVED: That the Quality Committee members received the minutes.**	
16.	**<u>Primary Care Quality Group AAA – 14 February 2024</u>** Members received the triple A from the Primary Care Quality Group which took place on 14 February 2024. **RESOLVED: That the Quality Committee members noted the content of the Triple A.**	
17.	**<u>Feedback from Syetm Quality Group – minutes 29 February 2024</u>** Members received the minutes from the System Quality Group which took place on 29 February 2024 **RESOLVED: That the Quality Committee members received the minutes.**	
18.	**<u>Committee Escalation and Assurance Report to the Board</u>** Members noted the items which would be included on the committee escalation and assurance report to the Board. **RESOLVED: That the Quality Committee note that a report will be taken to ICB board.**	
19.	**<u>Items referred to other committees</u>** **Vaccination update:** It was agreed that as we have a duty of care to protect ourselves to protect patients that a referral be made to People Board with a request as to how ensure consistent approach across LSC with a generic communication and possibly part of a professional appraisal approach.	
20.	**<u>Any Other Business</u>** No further business matters were raised.	
21.	**<u>Items for the Risk Register</u>**	

	- Update on formal response to the national Valporate Alert.	
22.	**<u>Reflections from the Meeting</u>** Was the committee challenged? Making a difference? Members agreed that there was challenging discussion. **RESOLVED: That the Quality Committee note the comments made.**	
23.	**<u>Date, Time and Venue of Next Meeting</u>** The next meeting would be held on Wednesday, 17 April 2024 at 1.30pm, Lune Meeting Room 1, ICB Offices, County Hall, Preston.	