NHS
Lancashire and South Cumbria
Integrated Care Board

Approved at the 2 July 2025 meeting

Minutes of the ICB Quality and Outcomes Committee held on Wednesday 4 June 2025 via MS Teams

Members		
Sheena Cumiskey	Chair/Non-Executive Member (Chair)	L&SC ICB
Julie Colclough	Primary Care Partner Member	L&SC ICB
Jane O'Brien	Non-Executive Member	L&SC ICB
Steve Spill	Associate Non-Executive Member	L&SC ICB
Sarah O'Brien	Chief Nursing Officer	L&SC ICB
Andy White (deputising for Medical Director)	Chief Pharmacist	L&SC ICB
Asim Patel	Chief Digital Officer	L&SC ICB
Roy Fisher	Non-Executive Member	L&SC ICB
Regular participants		
Kathryn Lord	Director, Quality Assurance and Safety	L&SC ICB
Neil Greaves	Director of Communications and Engagement	L&SC ICB
Debra Atkinson	Director of Corporate Governance/Company Secretary	L&SC ICB
Andrew Bennett	Director of Population Health	L&SC ICB
Joe Hannett	VCFSE Representative	VCFSE
Mark Warren	Nominated Director of Adults/Director of Children's services	Blackburn with Darwen Council
Bridget Lees	Nominated Provider Chief Nurse	Acute/MH rep
Arif Rajpura	Public Health Representative, Director of Public Health	Blackpool Council
David Blacklock	Healthwatch Representative	People First/ Healthwatch Cumbria & Lancashire
In attendance		
Jo Leeming	Committee and Governance Officer (minutes)	L&SC ICB
Dr April Brown (observing)	Intensive Improvement Director, National Recovery Support Team	NHS England
Neil Holt	Head of Commissioning Performance	L&SC ICB
David Brewin	Head of Patient Experience	L&SC ICB
Debbie Wardleworth	Associate Director of Learning Disability and Autism	L&SC ICB

Item No	Item	Action
25/2526	**Welcome, Introductions and Chair's Remarks** The Chair welcomed all and requested that the use of chat be limited, that hands should be raised, and everyone should remain muted unless speaking. The Chair acknowledged the difficult time for people working in the ICB, and the need to be cognisant of this when discussing items and that moving forward with the model ICB blueprint, the role of quality and outcomes would be crucial to strategic commissioning. Papers were being shaped in the right way with a focus on assurance, and bringing in the inequalities work, particularly in the integrated performance report. It would also be important to keep thinking about how things could be improved as the committee progressed. The Chair welcomed April Brown, from NHSE observing the meeting and would stay until 3pm, Debbie Wardleworth presenting item 7, Neil Holt presenting items 8a and 8c, and David Brewin presenting item 9.	
26/2526	**Apologies for Absence/Quoracy of Meeting** Apologies had been received from Andy Knox (Andy White deputising). K Lord noted	

	Caroline Marshall was not attending and would be presenting her items. The meeting was quorate.	
27/2526	**<u>Declarations of Interest</u>** The Chair noted that no additional declarations of interest had been made prior to the meeting and asked if at any point during the meeting a conflict arose, to declare at that time. This would be particularly pertinent when discussing specific areas or items relating to specific places of work, e.g. trusts, etc. **RESOLVED: That no declarations of interest were made relating to the items on the agenda.** **(a) Quality Committee Register of Interests.** **RESOLVED: That the Quality Committee register of interests was received and noted.**	
28/2526	**a) <u>Minutes of the Meeting Held on 7 May 2025 and Matters Arising</u>** J Hannett felt that the comment on page 5 regarding undertaking a piece of work on the number of children not brought to appointments got a lot of credence in the meeting but had not been fully reflected in the minutes and this played into the wider point about basic communication. The Chair advised that the role of the committee was around assurance and outcomes, and this was an operational issue. S O'Brien stated it would be providers addressing this issue, however, K Lord agreed information on numbers of appointments not attended could be collated and reported back to the committee. A Brown noted that on page 11 under the item Maternity & Neonatal Services Update, the minutes read as though the paper was accepted but it had been stated the paper could be even better if it discussed some of the specific challenges in Lancashire and South Cumbria. Therefore, the conversation needed to be fully reflected, and the challenge needed to be captured. J Hannett queried the resolution on page 8 for the item on suicide prevention ICB programme as it was asked that the committee supported the ongoing plan, however questions had been asked by voluntary sector alliance partners that hadn't been responded to, therefore the plan had not been fully agreed to. The Chair advised an addendum would be produced to pick up the points raised regarding the minutes, which would be agreed offline. **RESOLVED: That the minutes were approved as a true and accurate record subject to the amendments as discussed.** **b) <u>Action log</u>** D Blacklock noted there had been discussion at the last meeting about bringing back something around what constituted assurance but that had not been captured on the log. D Atkinson advised this was on the log under action 2 to arrange a session with all committees. D Atkinson agreed to take an action to pick up with the corporate governance team to look at better aligning actions with minute references. **RESOLVED: That the action log would be updated as discussed.**	**KL** **DA**
29/2526	**<u>Patient story</u>** K Lord noted there had been some reflections on the patient story prior to the meeting and it was good to see such a positive experience and that social prescribing had helped this individual. However, it was noted that the information had been found in the GP	

	surgery where the lady had been attending because she felt lonely. Therefore, consideration needed to be given as to how this could be shared across the third sector and how the ICB could support with ensuring messages about these services reached people who weren't contacting health practitioners. A Rajpura stated that social isolation was such an important issue in society and the third sector was doing some amazing work in connecting with socially isolated people out in the community. However, this was still an unmet need, and work was needed on engaging with those individuals not in contact with services. Some work involving knocking on doors was being undertaken in the Claremont area of Blackpool, which had uncovered lots of unmet need and there were ways we could try to connect with people, and this was one example where it had worked well. M Warren stated that we needed to be proactive and suggested sharing examples of where we had seen emerging good practice. In Blackburn with Darwen work had been undertaken locally with primary care due to how the funding streams were linked. They were now locating community centres and social prescribers at a single point of contact, and when they became aware of people through whatever route, the first step was to look at how they could connect people into social prescribing and community. J Hannett noted that, whilst it was a good story with a positive outcome for this individual, it felt disconnected from the agenda today and the work plan of the committee. The area where that story had been taken from was one of the only areas in Lancashire and South Cumbria where there was investment into the voluntary sector as a social prescribing link worker had directed that person towards a voluntary sector organisation. The Prescribing Advisory Group had been set up, but it needed a connection into the work of the primary care commissioning group in the ICB to ensure there was equity in social prescribing across Lancashire and South Cumbria. This linked back to the population health approach but there was a lack of it being linked strategically across the entire region. J Colclough felt it was an important piece for this committee as it was about looking forwards and showed how when things were done well this worked well for individuals. However, it was about how these examples were used to empower our places to allow things to grow in communities to match the need. There was a risk with the use of language as lots of different names were used for effectively the same thing, which was about working at grassroots level with people in their communities, not patients as it was about trying to keep people away from the health sector. A Brown encouraged the committee to base conversations within the six strategic priorities of the ICB. This would relate to equalising opportunities, then the committee should capture the impact of any investment and that was where the discussion needed to culminate. The Chair noted it was always helpful to have the patient story at the start of the meeting to think about the whole system and how we operated. This was a piece of good practice, which demonstrated that responding to need and improving outcomes could be done in different ways. The important aspect was around how we started to think about strategic commissioning, looking to improve outcomes and inequalities, and how we might work forward from that as a committee. It was recognised that it was unknown if this example was isolated to Burnley as it was unclear how it was commissioned. It was suggested we needed to understand what we were looking for to be commissioned in the future and how that fit with the strategic priorities. A Rajpura stated that social prescribing was an NHS issue, but work was being done on this at a local level around social isolation using the social prescribing model to engage with people. Social prescribing was just the NHS part of tackling social isolation. The Chair noted that bringing these patient stories was about grounding ourselves around the response to the wider determinants of health. It was requested that S O'Brien's team considered our duties around inequalities and how this related to the work of the committee going forwards. A Patel noted that this told us a story and there was an	**SO/KL**

	intervention that might be specific to Burnley. It was important as isolation and loneliness increased attendance at GPs and A&E, and these people stayed in hospital longer, therefore there was a much wider range of impact including disease and mental health. These stories highlighted this impact, and we needed to then strategically commission services equally across Lancashire and South Cumbria. **RESOLVED: That the committee noted the content of the story.**	
30/2526	**Quarterly risk management update report** Following the review of the ICB's committee structures which was approved by the board at its meeting on 19 March, risks held by the ICB, which received oversight through its assuring committees, had been re-aligned to the new committees' functions and the ICB's risk management reporting cycle for 2025/26. Those risks assessed as having the potential to impact on the achievement of the ICB's strategic objectives were held on the Board Assurance Framework (BAF). There were three risks held on the BAF aligned to the business of the committee and one risk jointly overseen with the Finance and Contracting Committee. Risks assessed as having the potential to significantly impact on the delivery of plans or priorities and rated as "high", were held on the Operational Risk Register (ORR). There were currently 12 risks held on the ORR relating to the business of the Quality & Outcomes Committee which were assessed as meeting the threshold for Corporate Oversight. D Atkinson introduced the paper and advised that, following a facilitated risk management workshop held during the board seminar meeting on 14 May 2025, all risks held on the BAF were currently undergoing a full review; following this, a refreshed BAF would be presented to the board at its meeting in July 2025. This recognised the current operating context and external factors such as the model ICB blueprint and changes to the focus of the ICB, and how risks needed to be managed as an organisation and as a system. There were 3 or 4 themed areas not reflected as strongly as they should on the BAF. Risk appetite was tested and was being reviewed and a refreshed BAF would be brought to Board. The next report may look quite different, but the narrative would explain any changes to risks. It was noted that the paper brought oversight into the committee and the risks should be driving the agenda and the business of the committee. S Spill questioned what levers were in place, both as a committee and as an ICB, to mitigate the two operational risks scored at 20. With regards to risk ID ICB029, Neurodevelopmental pathways across Lancashire and South Cumbria, S O'Brien advised we could mitigate this risk as some of the challenges in those pathways were high because demand had grown nationally but this had not been matched in Lancashire and South Cumbria by increasing commissioning of services and the pathways were disjointed. As some risks were within providers, we had to hold them to account and ensure assurance was provided to the Board. For neurodevelopmental and SEND pathways we had responsibilities as the commissioner and therefore could prioritise these by investing more but in the context of the huge financial challenge, this risk was being held and mitigated as much as possible, and regular updates on those pathways were brought to the committee. R Fisher questioned risk ID ICB012 Clinical Commissioning Policy Backlog and whether the policies had been updated. A White advised that all clinical policies were up to date and approved by the ICB. All policies were being reviewed by public health and other professionals, the vast majority of which were still fit for purpose, but they needed to go through an approvals process. It was felt this risk could be reduced soon and the biggest part of the process was whether the policies changed clinical practice. A White agreed to review the wording of this risk. D Atkinson advised that, from a governance perspective, we did set dates for policies to be reviewed, and it was about risk stratification. An exception report had recently been taken to the executives meeting, where Andy Knox provided assurance, which showed there was governance and oversight on policies.	**AW**

	The Chair summarised that the committee needed to be clear on the mitigations for the risks for which it was responsible, and the impact of to ensure they were having the right impact, and if they weren't what needed to be done further to ensure this. It was important that we ensured we had the right focus as a committee on those risks in line with the business plan. It was agreed there should be an action regarding the meeting agendas and ensuring a focus on risks and the impact of mitigations. The Board had been alerted to the risk about the ADHD pathway and whilst mitigations were in place, there needed to be a continued focus on this. The complaints report to be discussed later showed lots of complaints regarding waiting times for ADHD assessment, it remained an ongoing issue, and it was questioned if more could be done about this around prioritisation as an ICB and use of resources going forward. **RESOLVED: That the committee**: - • **Note the contents of the report.** • **Note the risks currently held on the ICB's BAF and ORR that relate to the business of the committee.** • **Note the significant work underway through the EMT to review all risks currently held on the BAF, and that a fully refreshed BAF will be presented to the board at its meeting on 24 July 2025.**	**DA**
31/2526	**<u>Transfer of specialist learning disability service</u>** The Learning Disability Service at Whalley was transferred from Merseycare Foundation Trust to Lancashire and South Cumbria Foundation Trust (LSCFT) on 01/04/2024. As part of the service transfer, the ICB requested that an external review was completed for assurance that the Mental Health Act was still appropriate following concerns being raised at two care and treatment reviews by the ICB team. The review considered the general service model in place and reviewed the care and treatment in place for all four individuals. Three of the individuals were the responsibility of Lancashire and South Cumbria, one was the responsibility of Greater Manchester. The review was completed between July and September 2024, with recommendations formally received by the ICB in January 2025. The report provided recommendations on a wide spectrum of areas which was detailed within this report with the conclusion of options that needed to be appraised to move forward. Ultimately, the report suggested that care could be delivered within a different model of care that would be less restrictive. The ICB and LSCFT had developed a working group to start reviewing the recommendations and plan actions required. It was anticipated that there would be formal challenge from families to change the current model and there were other risks identified with starting this work which was detailed in the report. This report was requested in line with the Mental Health Act, 1983 alongside NHSE guidance "Getting it right for people with learning disabilities – Going into Hospital because of mental health difficulties or challenging behaviours", 2014 due to lack of clarity on treatment plans and active discharge plans. This paper provided an overview of the recommendations and highlighted the areas that the working group now needed to consider. It was anticipated that due to the complexity of both individuals' needs and family views, this would be an ongoing piece of work that would require sensitivity. D Wardleworth gave a summary of the paper. The Chair noted thanks for the care and attention for these individuals and the comprehensive report. S O'Brien advised that this had been a referral from Audit Committee, which also went to Finance and Contracting Committee regarding concerns about costs. The process to get the external review had taken a while. The role of the committee was to assure itself on the clinical treatment reviews and inpatient treatment of those with learning disabilities and allowing them to live independently. This also linked to oversight of learning disabilities and autism, and the legal responsibilities of the ICB. There was potential for a cost increase if these	

individuals were moved but executives were overseeing this. D Wardleworth had provided a robust update that there had been an independent review, and that the specialist learning disability team was working very closely with the provider and undertaking regular meetings. The review had given clear recommendations, and there was a small group within the ICB working closely with these families and LSCFT. S O'Brien acknowledged D Wardleworth's personal leadership and advocacy for these individuals and for dealing with this very complex, difficult matter.

D Blacklock noted thanks for the focus on this, and it was good to see what was going on in the service, however the report was alarming, particularly around the closed culture with limited access to the individuals. Concern was also raised that it was expected that more progress should have been made with things such as communication and treatment plans when these people had been in hospital care for 20 plus years. It was clear that the families were strongly advocated for what they wanted but the report did not include the voices of the individuals, and their hopes and aspirations. Whilst this might be difficult to ascertain, it was not impossible and questioned whether an independent advocacy commissioned piece of work needed to be undertaken. D Wardleworth recognised these individuals needed their own advocates and confirmed they had already been looking at commissioning independent advocacy with LSCFT.

M Warren recognised the thorough professional and person-centred approach, and it was right to bring this to the committee for scrutiny. These people were individuals, and we needed to engage with them as such, and each case was very complex. Whilst it was appreciated that a home for life had been agreed, things changed and everyone needed to adapt to that, therefore we should not be held to that, and the focus should be to look at what was possible. After 20 years there would be a level of institutionalisation, and it would be difficult for these individuals to know what they wanted and what the opportunities were. It would be extremely challenging and there may be an additional cost as extra support was required. The paper had not identified any needs that could not be met in a wider community environment, and this was about the individuals and our responsibility to work with them. If we were looking at options for the least restrictive options, the local authorities should be included to ensure this was done as a system. D Wardleworth advised it was on the work plan for local authority colleagues to be involved and agreed they did not need to be in a hospital setting. S Spill noted that if the families were objecting to any changes, but clinicians believed it would be better for these individuals then the Court of Protection would be involved to reach a resolution.

The Chair thanked D Wardleworth for the work that had been undertaken and that there was now a way forward to improve things for these individuals. However, there was a need for the committee to be absolutely assured that there weren't any other individuals with care that was no longer appropriate for their needs. D Wardleworth confirmed that these individuals had been treated differently because of perceived agreements that they needed to stay. It was usual practice for care and treatment reviews to be undertaken at regular intervals. With regards to the issue of closed culture, assurance was provided that the provider had referred themselves to CQC and an action plan had been put in place.

The learning disabilities and autism update was due to be presented to the committee in October and it was agreed an update would be provided as part of that report.

RESOLVED: That the committee: -

1. **Note the contents of the report and progress to date.**
2. **Approve the proposed actions to address the identified risk.**
3. **Endorse the proposed plans for updates to be provided via Quality and Outcomes Committee and provide advice on frequency of updates.**

There was a 5-minute break. A Brown left the meeting at 3pm.

32/2526	**Quality performance and health inequalities report** **a) Performance assurance report (month 12) / escalation report** The report provided an update against the latest published performance data on several key metrics. N Holt advised that when Glenn Mather attended last month, he provided a comprehensive report, but the paper presented today had focussed on key areas and this would be an interim way of reporting until item 8c was fully in place. The measures in the paper linked to the BAF and the risks. It was noted that the way in which contractual meetings were undertaken with providers had changed, as much performance was determined by provider performance, and this had been strengthened into a contracting and commissioning assurance type meeting. This would potentially allow for richer and more dynamic feedback on progress against several measures. Some key highlights were presented from the paper, which included the 18-week performance target as there was an emphasis nationally on improvements to get back to the 92% constitutional standard. Part of that plan was for a 5% improvement by March 2026, which would be challenging due to the financial situation This was not just about activity, it was about looking at what could be diverted more appropriately and there was a suite of things across the system to support this. Regarding 18-week performance, there was the ICB position and the position of the four main providers, for which we were the lead commissioner. At ICB level, it was about our registered population, irrespective of which provider they accessed, which was about 20% of all patients waiting. There was some positive news regarding GP appointments as there had been around 341,000 more appointments than originally planned for. However, the rate of appointments per weighted population was below the northwest and national averages. Therefore, although we had been delivering more than planned, we were still unable to offer the same capacity of appointments for our population as was done nationally. This was partly due to the comparatively low numbers of FTE GPs. Urgent and emergency care remained incredibly challenged, and whilst there had been some improvements during April the numbers of people attending A&E continued to be high. It was noted there was some variation in reporting, as the report included some elements on variation of what the sub-level ICB or previous CCG level activity was. Therefore, whilst the high level ICB position was reported on, which tied into the ICB assurance process, there were variations underneath that and we needed to ensure that inequalities were reduced and that standards were brought up across the board. This would be strengthened through the development of the new report to be discussed under item 8c with closer alignment with quality and population health. The Chair noted thanks for the report and looked forward to the new report from September. J Colclough referenced page 5, percentage of incomplete Referral to Treatment (RTT) pathways within 18 weeks and asked if an arrow up or down could be included to indicate which direction this was going. N Holt explained this was about patients referred onto a pathway for treatment but meant they were still waiting for their definitive treatment. It was a dynamic balance and there had been a planning submission for 25/26, which outlined how the waiting list pattern would be shifted to deliver the target of 66.2% of patients who had been waiting less than 18 weeks and monitoring going forward would be against that plan. J Colclough also queried the primary care number of general practice appointments per 10,000 weighted patients and N Holt advised that this was reporting GP appointments by any medical professionals. From a GP workforce we were lower, but higher for nurses and on a par with regional/national averages for other medical professionals. This came down to the presenting need of the patient as to which medical professional they would see. S O'Brien raised concern about children's waiting times. N Holt noted that with the revision	

to the contracts and commissioning assurance meetings there would be an element to pick up aspects of performance relating specifically to children and young people with commissioner representation as well as provider narrative. Each provider had to submit a plan for their 18-week trajectory as a totality and for children and young people, and if this was out of kilter this would be raised at the contract and commissioning assurance meetings. B Lees noted that in every provider, waiting times for children and young people waiting lists were reviewed, although the level of granularity was not always looked at and further work was needed, particularly in community waiting times. A White noted that there were lots of other places where people had appointments other than GPs such as pharmacy first. It was questioned if risk assessments were undertaken to ensure those on long waiting lists were not coming to harm. N Holt advised there was an immense amount of scrutiny from NHSE on the 65-week waiters and providers were required to articulate the reasons why, which was often patient choice to wait or defer as cases were often clinically complex but there had been some massive strides over the last few months in getting this down. Mitigations were in place to avoid harm and there was a national focus on getting waiting times down. The trajectory for pharmacy first contacts had been included in the plans to be monitored against going forwards.

A Patel noted that the focus should be around what was in the NHS oversight framework, and what NHSE asked us to report on, then areas of focus should be monitored via the different committee structures. However, there was lots of duplication in provider conversations and other forums, but the consistent repeating issue was that every month, the demand had been more than the previous month. Therefore, there should be more focus on prevention and the community setting. Where possible, we would need to influence what was being measured at the highest level and any key metrics not there should be included in our local reporting. The Chair agreed this was about the oversight framework, but also noting areas where action was taken and linking that to the wider integrated performance report and inequalities.

RESOLVED: That the committee note the report.

The agenda was taken out of order and item 8c was discussed before 8b.

b) Patient Safety Update

This paper sought formal approval from Lancashire and South Cumbria Integrated Care Board (ICB) for those commissioned providers who had submitted their Patient Safety Incident Response Framework (PSIRF) Policy and Plans in order to proceed with full implementation in line with national policy and contractual requirements.

K Lord gave some key highlights from the paper and noted the never event regarding wrong site surgery at LTH. Since the paper was submitted there had been another never event declared at LTH in Ophthalmologyy but there had been no patient harm. Since January 2024 there had been 4 never events in Ophthalmology at LTH, which had triggered several issues. There would be a review by the Health Services Safety Investigations Body and an independent review by the Royal College of Ophthalmologists, the learning from which would be shared across the system. There was a prevalence of never events in Ophthalmology across the country due to pressures on services and waiting lists. In addition to the Regulation 28 Prevent Future Deaths (PFD) issued to Morecambe Bay for the death of baby Ida Jean Locke, there had been two further PFDs issued by the coroner, one in relation to LTH and the thrombectomy incident reported earlier and issued to LTH, NHSE and Northern Care Alliance. The ICB was working with those providers as the response had to be provided by the end of July. The other PFD was in relation to Cardiology at BTH and would be brought to the committee once further details were available.

S O'Brien noted that there was still not a 24-hour 7 day a week thrombectomy service in

Lancashire, despite multiple alerts to the Board and we now had a formal prevention of future deaths notice and needed to look at what further action could be taken with NHSE. This was a serious patient safety risk and S O'Brien would raise at the LTH Improvement Assurance Group meeting next week.

D Atkinson noted the 4 never events were a concern and questioned what was being done in terms of governance, oversight and assurance to the committee. K Lord explained they had to be formally declared through the committee as part of the never events national guidance, where assurance could be provided about what had happened about the rapid quality reviews. The learning was shared with all providers to ensure system learning, and this issue of never events in Ophthalmology was being seen across the entire country. D Atkinson stated we needed to understand the role of the committee in relation to never events, as it was not enough to just declare them, it was about looking at what could be done to prevent future never events. S O'Brien advised that when there had previously been a cluster of never events, there had been a learning event, and the themes and causes had been brought to the committee. Work had also been undertaken with the patient safety team and providers. The Chair suggested it would be useful to have an update at the next meeting to look at how impactful what happened in the past has been and if there was any further learning.

R Fisher noted that previously some providers had not signed up, but K Lord confirmed that everyone had now signed up although this was still not across primary care as was not in the GP contract.

RESOLVED: That the committee: -

- **Note the contents of the report.**
- **Consider and support approval of the provider PSIRF Policies and Plans recommended in section 2.2.**

c) <u>Development of an integrated performance, quality and health equity report</u>

The report provided an update on the work underway to develop a report that would bring together performance, quality (including outcomes, safety and experience) and health equity. It was intended that the report would include the latest published performance data against key metrics that triangulated with qualitative information and demonstrated any associated impact on outcomes and variation. During the development phase, the committee would still receive a report on key metrics and monthly updates on progress made. The aim was to have the Integrated Performance, Quality and Health Equity Report fully available by September 2025, although it was acknowledged that further refinement may be required.

D Wardleworth left at 3.27pm.

N Holt introduced the paper and advised that the plan was to produce a revised improved integrated report, which linked together the concepts around performance, quality and inequalities. The paper had been co-authored with representatives from each of these areas and they would use a considered opinion to determine what was relevant to be included. A session was scheduled for next week to further refine the thinking, and a proposed layout would be presented to the committee in July and August with September the first proper iteration of the report. The main issue would be metric creep, and measures would need to be aligned and triangulated, with a focus on quality plus the impact and outcomes on populations.

A Bennett noted that they had also been liaising with colleagues in public health teams, and it would not be possible to track the outcomes on everything. Therefore, it would need to focus on areas where the NHS had a primary leadership role and on service intervention where the NHS was responsible. It would be uncomfortable to see some of

	this data as it would show the stark inequalities. J Hannett questioned where had the three goals set by the Board to address health inequalities referenced in section 2.8, health equity, been shared. Also, in relation to the insights report, how the emerging themes would be tracked and what were the priorities. A Bennett advised the three goals were in the paper on Commissioning Intentions presented at the March formal Board meeting and the paper had clearly stated the development work that needed to take place. It was explained that the HCPH Quarterly Oversight Report was the Healthcare Public Health northwest regional public health team who held the ICB to account in an assurance process. N Greaves advised that AI had been used to look at some of the key themes taken from feedback, but this was not as easily relatable to specific performance measures. J O'Brien reflected on the patient story, which was looking at qualitative information then the performance report, which was quantitative data, but we needed both to fully understand what that meant for our population. It was suggested that we could find a way to undertake a 'deep dive' on certain issues and connect the agenda items to ensure the committee was looking at a theme to enrich understanding and what needed to be done about it. N Greaves advised that it was difficult to co-ordinate the patient stories with the committee agendas as the work behind the stories was quite excessive and did not always align but having clear themes throughout the year would allow to look at having the right themes for the right committees. J Colclough noted she attended a recent place meeting about the use of AI being able to extract thematic schemes from qualitative data, which would help to understand peoples' experiences. D Atkinson stated this was about how we get more meaningful focus and discussion, and what are the things we can measure against. Looking at the Prevention and Health Inequalities Steering Group Triple A report, and the work being done through Core20PLUS5 and how some of those risks linked to the risks discussed earlier in the meeting. It was positive that we were starting to have sight of that agenda and the work going on, but we needed to look at how we better framed the issues and what was being done about it, and then how this was triangulated in a meaningful way to provide assurance to the committee. A Patel suggested it was about being more sophisticated by not just looking for the performance item to bring out the triangulation but by picking up on this as we went through the agenda items. As if we were going to reduce the demand on services, we needed to find a way of getting that throughout the entire agenda. The Chair noted that we needed to take that step back, thinking about the objectives we were trying to achieve, the outcomes and the business plan to bring triangulation, and how we get ahead on this to see the impact on managing demand. **RESOLVED: That the committee note the report and agreed to receive a proposed layout committee in July and August, and the first proper iteration of the report in September**.	
33/2526	**<u>Patient insights and patient experience report</u>** This item provided two reports covering patient insights and patient experience. The 'Working with People and Communities' insight report outlined our approach to engagement and involvement, highlighted impact over the last two years, set out activity for the period March to May 2025 and identified priorities for 2025/26. The second element was the 2024/25 annual complaints report for the ICB. All NHS complaint handling bodies were required to complete an annual complaints report. The report showed volumes and types of complaints and correspondence from our constituency MPs. It also provided examples of learning and data on handling times. The numbers of complaints, concerns, enquiries and MP letters for April and May 2025 would be reported verbally at the meeting. For future meetings, the intention was to produce a coordinated report spanning both patient engagement and experience in line with the committee business plan.	

	N Greaves introduced the patient insights section of the paper and advised that this was a version of the report that went to the Board meeting held in public, but it was useful to share here as it gave background around engagement, involvement and communications. There was lots of activity where the ICB was the lead organisation in the priority transformation areas but there was also a significant amount of work across the organisation, which was where it should be embedded in work with providers. Some key highlights were presented to the committee, and it was noted that the report needed further work for future committee meetings, but N Greaves would work with D Brewin on this. D Brewin introduced the annual complaints report and advised it was a requirement under legislation for this to be submitted. Seen further increase and are an outlier volume wise. Gave key highlights. Some key highlights were presented to the committee around incoming volumes of complaints, outcomes of complaints and complaint handling times. A verbal update was provided for the first two months of 2025/26, there had been a further increase in complaints and formal enquiries but there had been a substantial reduction in the overall open caseload. It was suggested whether this report might sit better under the assurance of statutory responsibilities section of the agenda then this could be aligned with the work of N Greaves' team. J Hannett & B Lees left at 4pm. D Blacklock noted there must be a coherent explanation as to why the numbers of complaints were increasing and that would be interesting to hear. Also, for the numbers of MP letters as was this about poorer experience and poorer outcomes for people. Concern was noted about the low number of upheld complaints, and it was questioned why this was lower than the national average. It was key that we used the intelligence from people about their experiences against the overall data carried for each service to enable us to understand the outcomes of each individual service and the experience of individuals as it currently felt quite haphazard. It was not felt that there was assurance that we were gathering enough intelligence from our providers, and we did not seem able to connect that to decision making with the lived experience of people.. Two thematic reports were produced last year, to amplify the patient voice and look at more than just the numbers. In terms of complaint outcomes, often providers decided to uphold or not with an outcome that had been predetermined. The number upheld was much higher when we were not doing primary care complaints. N Greaves understood how this felt haphazard as there was a huge number of our population using services and we had to be targeted with engagement, particularly around engagement and involvement pieces around priorities or reconfiguration. Assurance was given that where there had been procurement or large transformation with decisions, that was where the energy had been focused. There were several examples of service changes and reconfiguration, and all had engagement embedded looking at the patient experience. Sometimes, it took considerable time for a decision and to go through some of those processes, but all the roadmap transformation priorities had public involvement embedded. . D Blacklock noted we needed to look at how we tested learning, as his organization ran the NHS complaints advocacy services, and often received letters about learning from providers. These responses were treated with scepticism as it was not known if the learning had taken place and if any changes had been implemented. The Chair agreed this was about closing the loop and auditing how change happened, but this needed to be built into everything we did. .	

	RESOLVED: That the committee: - • **Note the contents of the 'working with people and communities' insight report.** • **Note the contents of the annual complaints report.** • **Approve the report to be submitted to the Department of Health and Social Care.**	
34/2526	**<u>Triple A report - Prevention and Health Inequalities Steering Group</u>** It has been agreed that the ICB Prevention and Health Inequalities Steering Group (PHISG) will report to the Quality and Outcomes Committee. This report represents the first report to the Committee. Subsequent reports will be on a quarterly basis. The report summarises the items covered in the May 2025 meeting of the PHISG, namely: • The 25/26 plans for the Population Health Academy • The review of the Personalised Care Training and the Flourish Patient Activation Measure tool. • ICB priorities, the role of PHISG and the updated Terms of Reference including the appointment Vice Chair. • The Health Inequalities and Prevention quarterly report for January-March 2025 • Review of risks identified across the ICB regarding health inequalities • Update on action plan resulting from the Health Inequalities Internal Audit undertaken by MIAA in 2024. The Chair noted requested that, as the meeting was overrunning, A Bennett attended the next meeting for this to be given full consideration and discussion. A Bennett agreed and advised this was the first triple A report for this group and requested feedback via email. **RESOLVED: That the committee noted the report and the updated Terms of Reference of the PHISG.**	
35/2526	**<u>Committee Escalation and Assurance Report to the Board</u>** Members noted the items which would be included in the report to the Board. **RESOLVED: That the committee noted that a report would be taken to Board.**	
36/2526	**<u>Items referred to other committees</u>** **RESOLVED: That no items were referred to other committees.**	
37/2526	**<u>New directives/regulations/reviews that have been published</u>** **RESOLVED: That there were no new directives published.**	
38/2526	**<u>Any Other Business</u>** The Chair requested that a member of S O'Brien's team provided an update at a future on Quality Impact Assessments to look at how risks had been mitigated. **RESOLVED: That there was no other business.**	
39/2526	**<u>Items for the Risk Register</u>** **RESOLVED: That there were no new items for the risk register.**	
40/2526	**<u>Reflections from the Meeting</u>** The Chair reflected on how we were starting to move into a different way of working but there was still much to be done. **RESOLVED: That the committee note the reflections.**	

41/2526	**<u>Date, Time and Venue of Next Meeting</u>** The Quality and Outcomes Committee would be held on Wednesday 2 July 2025, 1.30pm – 4.00pm via MS Teams.	