NHS
Lancashire and South Cumbria
Integrated Care Board

Approved at the meeting held on 6 August 2025

Minutes of the ICB Quality and Outcomes Committee held on Wednesday 2 July 2025 via MS Teams

Members		
Jane O'Brien	Non-Executive Member (Chair)	L&SC ICB
Roy Fisher	Non-Executive Member	L&SC ICB
Steve Spill	Associate Non-Executive Member	L&SC ICB
Kathryn Lord	Interim Chief Nursing Officer	L&SC ICB
Asim Patel	Chief Digital Officer	L&SC ICB
Andy Knox (attending from 2.30pm – 3.45pm)	Acting Medical Director	L&SC ICB
Regular participants		
Neil Greaves	Director of Communications and Engagement	L&SC ICB
Claire Moore (deputising for D Atkinson)	Head of Risk, Assurance and Delivery	L&SC ICB
Andrew Bennett (attending from 2.30pm)	Director of Population Health	L&SC ICB
Mark Warren	Nominated Director of Adults/Director of Children's services	Blackburn with Darwen Council
In attendance		
Jo Leeming	Committee and Governance Officer (minutes)	L&SC ICB
Glenn Mather	Associate Director of Performance & Assurance	L&SC ICB
Ann Dunne (items 6a & 6b)	Director, Safeguarding	L&SC ICB
Nicola Baxter (item 7)	Head of Medicines Optimisation	L&SC ICB
Rakhee Jethwa (item 11)	Associate Director All Age Continuing Care (AACC) and Individual Patient Activity (IPA)	L&SC ICB

Item No	Item	Action
42/2526	**Welcome, Introductions and Chair's Remarks** The Chair, Jane O'Brien, welcomed all to the meeting and advised she was chairing the meeting in the absence of Sheena Cumiskey.	
43/2526	**Apologies for Absence/Quoracy of Meeting** Apologies had been received from Sheena Cumiskey, Julie Colclough, Lindsay Graham, Andy White, Joe Hannett, Arif Rajpura, Bridget Lees and Debra Atkinson (Claire Moore deputising). Kathryn Lord was deputising for the Chief Nursing Officer position as Sarah O'Brien had now left the organisation. Special thanks were noted to Sarah for her contribution to the committee. The meeting was quorate.	
44/2526	**Declarations of Interest** 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 and Outcomes Committee Register of Interests.**	

	RESOLVED: That the Quality and Outcomes Committee register of interests was received and noted.	
45/2526	**a) <u>Minutes of the Meeting Held on 4 June 2025 and Matters Arising</u>** The Chair noted the minutes had been shared for any points of accuracy and no amendments had been received. **RESOLVED: That the minutes were approved as a true and accurate record.** **b) <u>Action log</u>** **RESOLVED: That the action log would be updated as discussed.**	
46/2526	**<u>Patient story</u>** This population health case study had been shared to show how population health interventions had the potential to improve the health of people through targeted and practical interventions that meet the needs of the population. Local barbers were trained in cardiovascular disease (CVD), blood pressure testing, and making every contact count (MECC). Men were encouraged to test their blood pressure in the safe, convenient and comfortable environment of their barber's shop. In addition, this was considered to have the potential to reduce the risk of 'white coat syndrome' (i.e. artificially raised blood pressure seen in clinical settings) and removing the need to attend a GP/Pharmacy when they didn't feel unwell. Clients were informed how to record their BP and what the readings meant. They were also provided information about healthy eating, alcohol consumption and other relevant public health information by their barber. Most barber appointments were one-off appointments, so the client was alone with the barber, allowing confidentiality if required. However, the blood pressure monitoring machine was used by many men while waiting for their appointment. If the result of the blood pressure check required further investigation, they were signposted to either the nearest pharmacy, their own GP or urgent care. This was based on the guidance provided to the barbers. Everyone who was tested was provided with a copy of their BP numbers from the test, even if they walked away with no further action required, due to being in the 'healthy blood pressure' range. The Chair felt this was a great story and K Lord noted very positive feedback had been received from committee members. The story targeted men's health as generally, men had worse health outcomes than women. As most men went for a haircut, a barber was approached and trained to undertake the checks. Comments from committee members had shown this was something that should be grown and developed across the region, but we needed to look at how people were supported to have the confidence to take this forward. N Greaves referenced the link to item 8, Integrated Population health outcomes report, on the agenda as this was one of many examples of population health work being done with partners in places and this aligned to priority pieces of work and the agenda. R Fisher noted that this initiative had been funded through Blue Skies, which was a charity at BTH, and questioned how it would be afforded to roll it out further and funded in the future. K Lord advised this would be picked up under item 8 as this was very much about how the shift was made from hospital funding to community to voluntary sector. The Chair noted this was fantastic value for money to train people compared to the cost of treatment in a healthcare setting. N Greaves advised his team produced the video in partnership with Blue Skies; therefore, their logos had been used but other partners had also been involved. A Patel stated this reminded us of what could be done out in the community and considering the ICB blueprint, health economics and strategic commissioning. There were so many examples of projects like this, which had resulted in positive health outcomes, but the difficulty was scaling, and how we strategically commissioned such projects with the certainty of funding. The Chair noted the Board should be advised of this, and it would be good to track some of these initiatives against	

	outcomes and how we evidenced they were making a difference. **RESOLVED: That the committee noted the content of the story.**	
47/2526	**<u>*The agenda was taken out of order *</u>** **a) <u>Performance Assurance report (including development of an Integrated Performance report) / Escalation report</u>** The report provided an update against the latest published performance data on several key metrics and gave an update on the development of an integrated performance report. G Mather advised the paper was split into two parts, the first of which gave an update on the latest position and actions against key performance indicators, and the second gave a brief update on the development of an integrated performance report. The high-level summary showed that the system remained under ongoing pressure and increased demand. Performance related to cancer had deteriorated across all areas during April 2025, although lots of work was being undertaken on improvements. The number of patients waiting for treatment had increased marginally in month to a total of 240,649 at the end of April at ICB level. There continued to be an emphasis and weekly scrutiny on the reductions in 52+ and 65+ week waiters, which were not yet at zero. Gynaecology was an area of particular concern, accounting for 46% of all the 65+ week waiters. The 2025-26 Priorities and Operational Planning Guidance had refocused attention back on the 18-week constitution standard with an intention to improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement. Additional information regarding waiting times for children and young people had also been included in the report, and there were several ongoing work areas to address the long waits. The data showed that LSCFT had fully recovered their long waiters position which was mainly due to speech and language therapy (reduced from 472 over 52 weeks waits in March 24 to 0 in April 2025), which was a good example of where interventions had made an impact. NHS England 45-minute ambulance handover Implementation (Release to Rescue) was expected to commence 1 July 2025, and all providers would be required to have processes to support safe and successful implementation at site levels. The data showed there were only 2 inappropriate out of area placements at the end of May 2025, which was attributed to the work undertaken by LSCFT on their 5-point plan. The estimated dementia diagnosis rate was still above target and the Northwest position but remained below the national figure. With regards to the development of an integrated performance report, G Mather advised one meeting had taken place and another was scheduled for next week with a list of proposed metrics to include going forwards. However, they were still trying to find data sources and determine how the report would be presented. The intention would be to work towards Statistical Process Control (SPC) charts where possible and to include narrative around the metrics. A further update would be provided at the August 2025 meeting and the first full report presented in September 2025 Committee. The Chair noted thanks for the report, which was very clear and explained the ongoing work. R Fisher noted the wait times for diagnostics as this might be the first experience for those patients who came through primary care. LTH was quite poor with 63.2% waiting less than 6 weeks but ELHT was very good with achievement of the 95% standard. A Patel noted that diagnostics had been an ongoing area of discussion with a deep dive previously undertaken. We needed to pose the question to provider colleagues of how diagnostic performance could be improved across the system. LTH was a specialist tertiary centre, therefore was quite different to ELHT. There was a requirement to get something back that could be tracked through as the position remained stagnant and progress was needed. It was noted that with the organisational change, provider performance would be regionally based and not within the remit of the ICB. Conversations	

	regarding waiting lists were being undertaken with individual provider boards, and they needed to look at the causes and variation within services. R Fisher queried the diagnostic figures, and it was confirmed they were for acute only. G Mather advised they had previously suggested the use of mutual aid for diagnostics as there was scope for this, however, patients had a lot of influence in terms of which provider they chose to access. Often, patients would wait longer to go somewhere more local. Whilst LTH was a significant outlier, it was on the right track to improvement. K Lord noted, in terms of assurance, the perspective was from the ICB as a commissioner of services, not from a provider element. The report in September 2025 would aim to shift to this focus and this was where the ICB blueprint would be brought in looking at contracting, commissioning and quality coming together. S Spill questioned if the data was available on the number of appropriate out of area placements, and what constituted those. G Mather advised this was where we did not have specialist services for these conditions and could provide the data on this. **RESOLVED: That the committee noted the report.**	
	Safeguarding Adults and Children: **a) ICB Safeguarding Strategy** The report provided a summary of year one progress against the ICB Safeguarding Strategy. The 3-year Safeguarding Strategy and Plan was endorsed by Quality Committee in July 2024 and sets out the strategic approach and priorities to strengthen ICB arrangements for safeguarding across Lancashire and South Cumbria for 2024 to 2027. The Chair welcomed A Dunne to the meeting and noted that the ICB had safeguarding responsibilities as a commissioner and an employer. It was noted that not all delivery objectives had been met and questioned the consequences. A Dunne gave some key highlights from the report and assurance that they were on track to meet the key deliverables for year one. This included: • Advanced designated professional presence and contribution at local place/district level groups. • ICB Safeguarding single access point, well received safeguarding newsletter, training offer and champions models across All Age Continuing Care. • Led the review and devised health provider escalation matrix to assist timely reporting of PiPoT concerns (Person in Position of Trust concerns). Delivering safeguarding effectiveness • Facilitated x3 safeguarding network sessions with senior leads from Trust, meeting with legal teams to talk through current case law. This supports the community of practice response to complex children/YP, application of MCA in complexity and PiPOT. Meets duty to collaborate and apply best practice. • Agreed health multi agency partnership training offer into partnership Boards. Meeting partnership statutory duties. • Reviewed, reset and provided safeguarding supervision to all designated professionals. Supporting delivery of ICB statutory duties K Lord noted thanks to the team for all the work undertaken but questioned whether there was a strategy that was future-proofed as we moved forward. A Dunne advised that as the direction of travel remained unknown, they would need to see if any legislation was changed. It was likely the strategy would change if the ICB duties in primary care legislation were stripped. K Lord advised the committee would need to keep a focus on this as whilst the future responsibilities were unknown, the duty would remain with the	

	ICB during this period of transition. The Chair noted that in the blueprint this had been flagged as an area not necessarily sitting with the ICB and it was agreed that K Lord would work closely with the directors and escalate to the Chair if some direction was required. **RESOLVED: That the committee**: - • **Noted progress in year one of the 3-year strategy** • **Agreed that it would receive progress updates as required** **b) <u>ICB Safeguarding Annual Report for 2024-2025</u>** This was the third Safeguarding Annual Report of the ICB, and it described activity between 1 April 2024 and 31 March 2025. It set out a range of activities to maintain robust safeguarding arrangements for the ICB in its role as a commissioner of health services, Safeguarding Partner and as an employer. It provided examples of how the ICB engaged the voice of the child and young person and adult, and how we do all we can to make safeguarding personal. It also outlined the ICB's focused priorities, progress made and the next steps. Above all the report aimed to transparently demonstrate and assure the delivery of ICB statutory accountabilities. M Warren noted thanks for the good work on the report in the difficult circumstances. It was suggested that it might be useful, including the making safeguarding personal element in section 12, Safeguarding Adults, to bring the link from an ICB point of view. However, it was positive to see the commitment to place based multi agency policies in the report. With regard to section 13, Mental Capacity Act, it was suggested that the waiting time for Deprivation of Liberty Safeguards (DOLS) should be included. A Dunne agreed to check this. Local authorities had significant waiting lists for DOLS, which were looked at by the CQC and it would be good to see these from a systematic regional perspective, not just the ICB. M Warren advised that he could provide this information for the 3 local authorities to assist in providing a complete picture. It was agreed that once provided, this information be included in the final annual report before publishing on the website. A Dunne recognised that some of the priorities had not been achieved or progressed, but these were reliant on several interdependencies. Progress was being made but very slowly, but this was about trying to move forwards together with partners. The Chair noted thanks to A Dunne who left the meeting at 2.27pm. **RESOLVED: That the committee**: - • **Approved the Safeguarding Annual Report April 2024- March 2025 and report the position formally into the ICB Board.** • **Once approved, agreed publication of the Safeguarding Annual Report on the ICB website subject to information on DOLS waiting times to be included.**	
48/2526	**<u>Medicines Optimisation and Safety report</u>** The Medicines Optimisation team developed a workplan that was in line with the objectives of Lancashire and South Cumbria Integrated Care System (LSCICS) and objectives of the Medicines optimisation Strategy. The workplan, which covers medicine safety, quality and value was supported by the Medicines Optimisation Local Enhanced Service (LES). The LES was structured to support the implementation of our medicine's safety priorities, quality work and to support financial balance. The main challenges included: - • Growth in NHS prescribing of weight management drugs. • Implementing the Pregnancy prevention programme. NatPSA Valproate. • Challenging Value/QIPP target.	

A Bennett joined at 2.28pm.

N Baxter advised she would take the paper as read but gave some key highlights and updates. Valproate continued to be high risk due to the high chance of birth defects if taken during pregnancy. Whilst pathways had been agreed for mental health and learning disability patients to have their annual review, risk assessment, appropriate counselling and be prescribed a highly effective form of contraception, in line with the pregnancy prevent programme, the same agreement was not in place for neurology patients, due to a lack of capacity in the neurology department at LTH. The team could not be assured that patient coding on the GP patient medication record was accurate or consistent, therefore the ICB could not be assured that the pregnancy prevent programme had been applied to all women taking Valproate who were less than 55 years old. The Local Enhanced Services (LES) had been designed to ensure accurate and standardised coding was used, which would give assurance that patients who were not prescribed highly effective contraception could be identified and given the appropriate counselling and contraception. Funding for training primary care colleagues to deliver aspects of the MHRA alert for Valproate had been rejected by the discretionary spend panel, however, there was a plan to upskill in primary care. Since the paper was written, A Knox had been appointed as the executive sponsor to support the work and a meeting was planned with Steve Canty, Divisional Medical Director at LTH.

The team had an extremely challenging QIPP target of £32m, which had been agreed but there had been a stretch applied to make this target £42 million. The medicines optimisation team had highlighted this extra £10 million as high risk as they did not think that this was achievable and had not been identified in the plans. A second stretch had been applied to this, to make the target £48 million, however the medicines optimisation team had only agreed to the £32 million through horizon scanning and planning, which had put a significant amount of pressure on the team. They had recently recruited new staff; however, this was not as many as was agreed due to the most recent vacancy freeze, which would inevitably have a negative effect on the expected rate of return.

The biggest issue with cost growth was related to weight management drugs and a new drug Tirzepatide had recently been approved by NICE to be prescribed from June 2025. Based on data up to and including April 2025, at current growth levels, £10 million would be spent on Tirzepatide this year. Lancashire and South Cumbria Medicines Management Group (LSCMMG) formulary currently has position statements of “Do Not Prescribe” GLP-1s and tirzepatide in primary care. GLP-1s were only recommended as a treatment option for patients under a tier 3 weight management service with limited services across Lancashire and South Cumbria. The commissioning of Tirzepatide from specialist weight management services was currently being reviewed alongside the commissioning of these services. The ICB was reviewing options for local roll out of specialist weight management services. A holding statement had been released to primary care and a paper would go to the next public Board meeting in July 2025 to discuss potential options of the ICB achieving financial balance and compliance with NICE technology appraisals. Without careful planning for the roll out of weight management services and prescribing of weight management drugs, the ICB could come under further significant financial pressure, which could lead to cuts in other patient facing services.

The Chair noted the positive updates and assurance given in the meeting compared to information provided in paper, particularly around Valproate as we needed to manage these patients or would be at risk of litigation. The Chair queried whether the risk regarding the QIPP target was more of a financial matter but N Baxter advised whilst it was, the team would not compromise on safety and quality. It was agreed this would be an alert to Board and a referral to Finance and Contracting Committee.

	A Knox joined the meeting at 2.37pm. R Fisher noted that the report stated that 'the QIPP/Value target of up to £46 million is not very high risk and is placing immense pressure on the team,' which should be corrected to state that it was very high risk. A Knox noted this issue had been discussed in the Improvement Assurance Group (IAG) meetings earlier today and the request from PwC and NHSE was for work to be undertaken on looking at how well the QIPP was delivered month on month working with Business Intelligence and finance teams. K Lord advised there had been a number of enquiries around weight loss injections, and they were working with the Patient Experience , Medicines and Communication teams to respond to these. Several members of the public had gone to their GP asking for these injections, and it was anticipated there would be more of this. There had been communication to GPs and pharmacies advising the injections could not be prescribed solely for weight loss. There would be very specific criteria, which would depend on the outcome of the paper presented to public Board in July 2025. A Knox advised the ICB was under pressure from region to prescribe and there was a budget attached. However, the criteria for this to be prescribed on the NHS would be extremely tight, although people could still purchase it privately. This drug was not completely free of risk, but the outcomes appeared to be significant. Mitigations were in place to manage this for this year, and there would be a plan for the following year. S Spill noted the contradiction between surgeons not operating on people until they lost weight but then the drug would not be prescribed to help those lose weight. N Baxter advised that the intention was to take a paper to Commissioning Resource Group (CRG) as the request for funding for CPPE Valproate training programme was rejected by the discretionary spend panel. The Chair noted that, in principle, the committee was supportive of staff being trained but we needed to ensure there was a value for money assessment. N Baxter advised the contract valuation assessment would be discussed today with Steve Canty at LTH to agree a way forward and could report back to the committee. *N Baxter left the meeting at 2.46pm.* **RESOLVED: That the committee: -** • **Noted the report.** • **Approved the recommendations in the report**	**NB / AW**
49/2 526	**a) Integrated Population health outcomes report** The Chair welcomed A Knox and A Bennett to the meeting. A Knox shared a presentation on Population Health Outcomes and highlighted some key points: - Progress against delivery – case studies illustrating change - The change we need to deliver – short term, medium term and long-term impact with examples - National healthy life expectancy rates - Population health intervention triangle - Questions to ask ourselves - The ICB Board has agreed three unifying goals - Initial view of 2024/25 metrics – mortality rates - Key messages for 25/26 - Role of the Prevention & Health Inequalities Steering Group The Chair noted thanks for the comprehensive presentation, and it was very positive that this was being embedded into the work of the committee and would be included in reporting going forwards.	

R Fisher noted thanks for the excellent presentation and referenced the positive work undertaken in Claremont ward in Blackpool on improving outcomes in this super deprived area, which had been done in conjunction with residents. A Knox noted that there were many organisations working with us, and this was also about working with residents first to better use our skills and resources for individual communities. It was about the humility of spirit and working differently with communities. A Bennett advised that we needed to look at how the learning from these approaches would be embedded into the commissioning model, and how this work was proceeding. The Chair agreed as the qualitative data was as important as the quantitative data. Reference was made to the patient story discussed earlier as when something works, it was about how we get better at spreading that best practice. A Patel noted that, looking at the data on healthy life expectancy, some were going in the right direction but lots were going in the wrong direction. However, it was not that simple to compare areas as each population was different, but it was about looking at what could be done in other areas to achieve the same outcomes.

R Jethwa joined the meeting at 3.15pm.

M Warren noted importance of public health departments being able to support population health with data is key. Committee to look at some approaches across the entire region and what it means in each area, and health and wellbeing boards being held accountable, and to deliver on that would be key.

RESOLVED: That the committee approved the recommendations for reporting into Quality and Outcomes Committee.

b) Triple A report - Prevention and Health Inequalities Steering Group
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: -

1. The 25/26 plans for the Population Health Academy
2. The review of the Personalised Care Training and the Flourish Patient Activation Measure tool.
3. ICB priorities, the role of PHISG and the updated Terms of Reference including the appointment Vice Chair.
4. The Health Inequalities and Prevention quarterly report for January-March 2025
5. Review of risks identified across the ICB regarding health inequalities
6. Update on action plan resulting from the Health Inequalities Internal Audit undertaken by MIAA in 2024.

A Bennett advised they had first report brought this report to the last committee meeting in June but ran out of time, therefore it was agreed it would be brought back following the context setting conversation from A Knox. Consideration was being given to the expenditure position of the ICB, and programmes needed to be timed appropriately to ensure we were building the future organisation in the right way at the right time.

The Chair noted that the ICB-024 Maternity Services Risk was not being sufficiently mitigated and A Bennett advised the group had been keeping a view on this but colleagues in the teams much closer to this were managing this. As the risk related to the lack of a dashboard and system wide BI, some of this was within the ICB's control but some was part of a broader regional issue therefore required a level of advanced monitoring. C Moore advised that monthly risks were reported to executives for

	oversight, and was currently preparing a risk update report which could highlight that there had been a discussion around this risk at Quality and Outcomes Committee. The current risk score was 16 on the Operational Risk Register, and there were inter-dependencies around the data but this could be shared with A Patel to be included in the update going to executives. A Patel advised this risk has been discussed frequently, and the score had been questioned. There was a single maternity system across all providers, and this was a national issue being able to obtain the right data from this. It was about having the ability to have an overarching set of data across the system. A Patel noted caution about escalating this to Board as it was more of a reporting risk not an immediate risk to quality or clinical practice. K Lord agreed and referenced item 15, the letter from Jim Mackey and Duncan Burton on maternity and neonatal care, as this might be related to this. **RESOLVED: That the committee noted the report and approved the terms of reference.**	
	<u>All Age Continuing Care (AACC) and Individual Patient Activity (IPA) – monthly update</u> This report updated and provided assurance on progress already made and the plans in place to: improve the quality of the AACC & IPA service alongside improved performance and mitigation against financial risk. Issues and areas requiring review and improvement were identified through the report with updates on actions completed and outstanding actions remaining with target dates. The report focused on areas of work that the AACC & IPA Service were prioritising to achieve quality and financial stability for the future, acknowledging the turn around direction and plan in place to support achievement. The Chair welcomed R Jethwa and advised this committee was particularly interested in the areas of quality and outcomes. *A Knox left the meeting 3.31pm.* R Jethwa advised she would take the paper as read and would take any questions. S Spill noted there was a turnaround director and a team for a period of 6 weeks with extension commenced March 2025. It was confirmed that some members of the PWC team would finish this week, and a smaller team would remain in place. Exit planning would commence shortly before they were due to leave and the AACC and IPA teams would then continue with the work. M Warren noted the importance of the committee being aware of AACC and there were conflicts with the 4 local authorities regarding the review work, escalation process and way applications were being dealt. K Lord advised that she would be leading on this for the ICB following the departure of Sarah O'Brien in the interim period and would deal with any specific points. However, it was unclear where this would land in terms of legislation in the future, but needed to continue as usual in the transition period. Teams were working incredibly hard and the number of panels continued to be large. M Warren advised we needed to work together as a system, but this was not necessarily always happening as there was lots of disagreement around 50/50 cases. It was agreed a meeting needed to be held with the 4 local authority directors of adult social services, K Lord and C Harris to agree on funding and decision making as patients should not be stuck in the middle of financial discussions. A Patel questioned if the dispute process would have any bearing and R Jethwa advised this was used but was in the process of being revised, and conversations were being undertaken between executives. The Chair noted thanks to R Jethwa for the report and for working in a challenging area under scrutiny. *R Jethwa left the meeting at 3.40pm*.	

	RESOLVED: That the committee noted information provided as assurance and approved the attached Equality and Health inequalities impact and risk assessment for Nobi 1 project.	
50/2526	**a) Escalation report** K Lord alerted the committee to the three incidents related to BTH, and there would be a round table discussion for all sectors with the provider to have a discussion and collectively bring together the issues. If there was anything to escalate, this would be brought to the committee. **RESOLVED: That the committee noted the report.** **b) <u>Patient Safety Incident Response Framework (PSRIF) Provider Policy & Plan Update</u>** 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 to proceed with full implementation in line with national policy and contractual requirements. K Lord advised that previously the full plans were brought but as they are very lengthy, they were listed for approval. *A Bennett left the meeting at 3.27pm.* **RESOLVED: That the committee:** • **Noted the contents of the report.** • **Considered and supported approval of the provider PSIRF Policies and Plans recommended in section 2.2.**	
51/2526	**<u>LSCICB self-assessment against National Quality Board guidance and NHS England statutory quality requirements - update</u>** The paper outlined the statutory duties, accountabilities, core responsibilities and compliance which the Integrated Care Board (ICB) holds for quality, under the NHS England Operating Model for Quality and aligned to the National Quality Board's guidance for systems, as articulated in the *NHS England's Quality Functions: Responsibilities of Providers, Integrated Care Boards and NHS England - April 2024* document. The functions covered: • Strategic management of quality • Operational management of quality • Patient safety • Experience of care • Clinical effectiveness • Safeguarding • LeDeR, STOMP and STAMP, SEND, mental health The National Quality Board (NQB) had issued guidance, and NHS England had outlined the statutory compliance that an ICB must be able to demonstrate. The aim was to offer assurance to the ICB Quality and Outcomes Committee and Board that the ICB had robust quality processes in place and plans to address where gaps in compliance were identified. The ICB Quality Team had completed a third self-assessment exercise on behalf of the organisation, which allowed for triangulation against requirements and alignment to other ICB functions, as well as collation of supporting evidence. Where gaps had been identified, there were clear lines of escalation to the relevant ICB function highlighting areas of risk, to ensure mitigating actions were identified to address these. K Lord advised she would take the paper as read and noted this was the third review since the ICB formed. It was flagged there were areas with very high-risk scores, and whilst mitigations and actions were in place, assurance could not be provided on the	

	quality element of the service that was being delivered. However, some improvements had been made over the course of the reviews. It was discussed and agreed that this report be brought back to the committee every 6 months as anything across the risk agenda would come via the risk report. **RESOLVED: That the committee:** • **Noted the report content, identified gaps and mitigations;** • **Noted next steps and actions to address identified gaps.** • **Provided any comments/feedback;** • **Confirmed frequency of NQB guidance review and ICB self-assessment reporting activity for 2025/26.**	
53/2526	**Triple A report – Primary Care Quality Group** This 3 As report from the chair of the Primary Care Quality Group identified the key issues to be escalated to Quality and Outcomes Committee. K Lord referenced the alert of a dental patient safety incident currently under review regarding the implications of waiting times noted actions around dental. However, no harm was identified because of undergoing 2 general anaesthetics within 2 months. A further update would be provided to the group on any improvements and assurances that had happened because of the investigation. The Local Dental Committee and ICB dental clinical advisor would meet to discuss improving pathways for raising concerns. **RESOLVED: That the committee noted the report.**	
54/2526	**Committee Escalation and Assurance Report to the Board** 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.**	
55/2526	**Items referred to other committees** Referrals to Finance and Contracting Committee: • The extremely challenging QIPP target stretched to £48m for the medicines optimisation team. • The conflict between local authorities and the ICB regarding financial matters for AACC cases. **RESOLVED: That the items above be referred.**	
56/2526	**New directives/regulations/reviews that have been published** K Lord advised a letter had been issued from Jim Mackey and Duncan Burton on maternity and neonatal care. Between now and December 2025 there would be urgent reviews of up to 10 trusts where there were specific issues, which might involve BTH. As soon as any further information was provided, this would be brought to the committee. It was also noted that the NHS 10-year plan would be published tomorrow and N Greaves had shared a schedule for reporting with executives. **RESOLVED: That the committee noted the letter.**	
57/2526	**Any Other Business** **RESOLVED: That there was no other business.**	
58/2526	**Items for the Risk Register** **RESOLVED: That there were no new items for the risk register.**	
59/2526	**Reflections from the Meeting** The Chair reflected that she had a much more in-depth understanding of the issues by chairing the meeting today.	

	RESOLVED: That the committee note the reflections.	
60/2526	**Date, Time and Venue of Next Meeting** The Quality and Outcomes Committee would be held on Wednesday 6 August 2025, 1.30pm – 4.00pm via MS Teams.	