NHS
Lancashire and South Cumbria
Integrated Care Board

Approved at the 3 September meeting

Minutes of the ICB Quality and Outcomes Committee held on Wednesday 6 August 2025 via MS Teams

Members		
Sheena Cumiskey	Non-Executive Member (Chair)	L&SC ICB
Jane O'Brien	Non-Executive Member	L&SC ICB
Roy Fisher	Non-Executive Member	L&SC ICB
Steve Spill	Associate Non-Executive Member	L&SC ICB
Jane Brennan (deputising for Chief Nurse)	Interim Chief Nursing Officer	L&SC ICB
Andy Curran (deputising for Chief Medical Director)	Associate Medical Director	L&SC ICB
Julie Colclough		L&SC ICB
Regular participants		
Debra Atkinson	Director of Corporate Governance / Company Secretary	L&SC ICB
Mark Warren	Nominated Director of Adults/Director of Children's services	Blackburn with Darwen Council
Andy White	Chief Pharmacist	L&SC ICB
Peter Tinson	Director of Primary and Community Care	L&SC ICB
David Blacklock	Healthwatch representative	People First/ Healthwatch Cumbria & Lancashire
In attendance		
Jo Leeming	Committee and Governance Officer (minutes)	L&SC ICB
Claire Lewis	Associate Director – Quality Assurance	L&SC ICB
Jane Scattergood	Director of Health and Care Integration	L&SC ICB
Neil Holt	Head of Commissioning Performance	L&SC ICB
Ann Dunne (item 7b)	Director, Safeguarding	L&SC ICB
Rakhee Jethwa (item 9)	Associate Director All Age Continuing Care (AACC) and Individual Patient Activity (IPA)	L&SC ICB

Item No	Item	Action
61/2526	**Welcome, Introductions and Chair's Remarks** The Chair welcomed all to the meeting and noted it was a busy agenda therefore it was important to keep to time as other meetings were scheduled at 4pm and 4.30pm. Jane Scattergood was in attendance as she had recently been appointed as the acting Chief Nurse and would take up her new post on 18 August. Neil Holt was also in attendance to present items 6 and 7a, Ann Dunne to present item 6b and Rakhee Jethwa to present item 9. As with all Teams meetings, the raise hand function should be used for questions/comments and the chat function should not be used. All microphones should be muted when not speaking to prevent background noise or feedback. All confirmed agreement that Copilot, an AI tool, could be used to support with production of the minutes.	
62/2526	**Apologies for Absence/Quoracy of Meeting** Apologies had been received from Andy Knox, Andy Curran was deputising, Kathryn Lord, Jane Brennan was deputising, Neil Greaves, Asim Patel, Andrew Bennett, Arif	

	Rajpura and Bridget Lees. Joe Hannett would no longer be participating in the committee. The Chair advised that part of the organisational change work and the ICB becoming a strategic commissioner would involve reviewing membership of subcommittees. The meeting was quorate.	
63/2 526	**<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 and Outcomes Committee Register of Interests.** **RESOLVED: That the Quality and Outcomes Committee register of interests was received and noted.**	
64/2 526	**a) <u>Minutes of the Meeting Held on 2 July 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>** Action 5 – whilst the committee agreed a paper could be brought to the October meeting, it was requested that a verbal update on the psychosis pathway be provided in September. Action 9 – J Scattergood noted the data provided was useful, but this should be categorised as 'children not brought,' not 'did not attend.' There was discussion about the assurance on action taken within Providers seeking to understand this issue and how they were helping to support these children to attend. It was agreed this should be logged as a new action. Action 12 – A White advised 66 policies had to come through the committee and consideration needed to be given as to how this could be managed. D Atkinson advised there was a risk-straited plan going through executives to look at policies. Those with any risks would be reviewed first with a target completion date of the end of December for all policies to either be rolled over as fit for purpose or reviewed and amended. For this committee, Clinical Effectiveness Group (CEG) had a clear role in looking at the details and provide a clinical voice in policy reviews. For any with financial implications, the Commissioning Resource Group would take a view. A Curran advised he chaired CEG, and there were 18 policies that would not require much change. It was agreed that could be delegated from the Quality & Outcomes Committee to CEG. **RESOLVED: That the action log would be updated as discussed.**	
65/2 526	**<u>Patient story</u>** This population health case study was around the need to improve population health and health equity in Lancaster, particularly in the more deprived areas. The focus was on developing an outreach service to engage people who were not accessing healthcare, especially those in deprived areas like the Rylands estate. This was necessary because many residents had high rates of unemployment, mental health problems, and addiction, and were not engaged with healthcare services due to various barriers.	

	The Chair advised no reflections had been submitted prior to the meeting but felt this was a very impactful story. A Curran noted recognition of the power of the person as this initiative was led by a dedicated resident. There were people within the population who were very keen to act, but they needed an organisation such as the ICB behind them. The main challenge was finding these people to enable them to do something like this in their community. J Scattergood agreed, and this linked to the ambition of neighbourhood health, but these people needed support and connections, for us to take this forward as an organisation. The Chair agreed this was at the heart of what we were trying to achieve as a strategic commissioner going forwards. S Spill questioned whether we were still trying to engage with the 100 other people and give them the support we thought they needed. J Scattergood advised the Lancaster City District Health & Care Partnership, along with the District Council, to continue to engage with people and to make the offer accessible, acceptable and welcome. The Chair noted there were several items on the agenda that threaded through this patient story, and we needed to think about the outcomes, and the impact the ICB would have in changing to be more of a strategic commissioner to enable examples like this to be the way of working not just a series of initiatives. This sets the context for the committee to be able to assess the impact of that and consider how this would be taken into the oversight work and give assurance going forwards. **RESOLVED: That the committee noted the content of the story.**	
66/2526	**<u>Presentation on the NHS Performance Assessment Framework</u>** A presentation was shared on NHS Oversight Framework: a new approach to oversight and assessment. N Holt advised that this was originally the performance assessment framework, but it had now gone back to the NHS oversight framework, which looked at how the NHS was judging and scoring NHS organisations. Some key highlights were given, which included that ICBs would not be segmented in 2025/26 due to significant organisational changes in line with the model ICB blueprint. There would be a new objective and transparent approach to segmentation with 6 domains, which would provide an overall score that would give a segmentation but there would be financial override. It was expected more information on scoring would be available during Q2 but until then it wasn't possible to be clear on exactly which segment providers would be in. That would help us to understand through the tools that were due to be made available, the scoring and how it had been done on different domains and how their scores aggregated up. Once this information was available, a further update could be presented to the committee. The Chair thanked N Holt for the presentation as it helped people to understand how the new segmentation would be developed. Also, once it was known where our organisations sat, we would need to consider what this meant for the role of the ICB and the region. M Warren noted that the irony was that if finance and productivity planning were not done in partnership it would affect the other metrics, therefore there was potential for one domain to undermine another unless it was joined up. A Curran advised that the model health system used to be called model hospital, and it now it was clear it was about the whole system, and the ICB will be considering this in the new Operating model. We needed to ensure this framework was not used to berate a provider in a system that was not working well. N Holt advised that currently, it would be reported at provider level, and we would not necessarily get the patient population system perspective. It was mentioned that for NHSE reporting, the four main acute providers were mapped to the ICB but some, particularly West Lancashire patients, did not use any of these and tended to go to Cheshire and Mersey.	

	The Chair acknowledged there was lots more work to do regarding this, and the committee would need to ensure this was placed in the right way, particularly when we understood how things were going to work and operate in the future. **RESOLVED: That the committee noted the presentation.**	
67/2526	**a) Development of an Integrated Performance, Quality and Health Equity Report** 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. The draft report offered an example of the proposed layout using a sample of the latest data. The aim was to have the Integrated report fully available by September 2025. It was acknowledged that further refinement may be required to expand the scope of the report once clarity on ICB verses NHS Regional teams' responsibility was received. The Chair thanked N Holt and colleagues for progressing and developing this report. N Holt gave an overview of the proposed final report and requested feedback as it was important to get this right. There were several meetings with Quality and Health Inequalities colleagues, and the aim was to bring a version to the September meeting that delivered more than at previous meetings. There was a list in the slides of sections/domains that would be reported on, which had been structured around 2025/26 operating measures, links to health inequalities and measures around Core20PLUS5, with some elements on frequency of data, measures and narrative. The intention was to move towards using statistical process control charts and keeping them in domains (themed areas of work). Finance and workforce metrics had not been included as they were currently covered off elsewhere in the organisation, however, this may change depending on what transpired around responsibilities. It was suggested that, going forwards, the report should be provided bimonthly in line with Board reporting. D Blacklock noted thanks for all the work and asked what kind of customer experience information we had access to and would be coming through this report. Patient experience and quality and performance data were very disconnected, and it was how these could be brought together. N Holt advised that Quality colleagues were keen that the friends and family test be included, which covered several NHS service type provisions. However, this would not cover some of the lower-level nuance but it was expected that if the friends and family test outputs were not where they should be then further questions would be raised through quality meetings with providers. There was a balance between covering the higher-level strategic areas and bridging this to the reality on the ground level with patients. D Blacklock suggested he could discuss with N Holt outside of the meeting to collectively look at how they used the breadth of knowledge from customers. P Tinson noted that at different points in the year we received patient surveys and suggested undertaking some deep dives into these. In terms of primary care metrics, there was a lot of focus on urgent dental care and appointments, therefore it was suggested this should be added in. N Holt advised urgent dentals were in the planning submissions, and that they hadn't just focused on the core ones in the operation planning. D Atkinson referenced how this report could be developed wider and how the performance areas could support the Board Assurance Framework (BAF) as it would give the narrative, which linked to key controls in the BAF and provided triangulation. J Scattergood questioned if it was felt that, at a patient level, we would be able to understand, for example, the one person on the waiting list in the same 12-month period who had had 5 unplanned attendances at ED and multiple GP appointments, and whether the system response to their needs was effective. N Holt advised that data was included on frequent attenders at A&E but was not routinely tied in with frequent attenders at GPs, and this may be a deep dive piece to explore that further as it was suspected there would be immense correlation between the cohorts of patients in some of those instances. It was questioned that if the analysis was authored by domain leads, would it be possible to generate read across for context. N Holt advised that if the correct information was	

included in the executive summary and narrative then the read across element should emerge, however, not every single metric would be included. In terms of equity, it was questioned if we could look at waiting lists cut by ethnicity, deprivation, and so on, and include any relevant information from partners as this type of information could help us to feed back to trusts as to how they tailored services to meet the needs of the population. It was advised that ethnicity was not very well coded, therefore this weakened the validity, but deprivation was better coded and that could be shown. Waiting lists were also largely dependent on provider/locality, and that raised the question of whether this was about inequity or whether it was influenced by provider performance. As we were starting to get some of those inequity differentials and markers in there, it would prompt the question and may lead to the work that needed to be done to understand these further.

J Colclough felt that the colours of the symbols made it difficult to interpret and suggested it would be better to use more different colours. It was also suggested it would be good to see more data on community with the increased focus on better community care, for example, how many patients were receiving housebound care. Also, whether some optical input could be added in. N Holt advised the colours related to the RAG ratings but could review this and include more detail on how to interpret the statistical process control charts. The next version of the report would include some community measures, but they would be largely focused on operational matters such as simple contacts and waiting times. There was an optometry line, but this was rounded up and focused on volumes. There was a risk around metric creep and the report becoming unwieldy, and it was questioned whether there was a forum where lower-level details were being picked up. C Lewis confirmed that there were dashboards for primary and community service metrics that fed into groups she and P Tinson were involved with and agreed they could follow up on that.

R Fisher noted that if we continued to add metrics we would lose sight of what was important and the narrative was good as helped with understanding the data, and the executive summary highlighted key issues. However, suggested the inclusion of data on uptake of appointments for extended access provision. C Lewis referenced the escalation report that had been tagged on the end of this paper as this was a legacy piece previously brought to committee. The Chair advised this was about what was the threshold for escalation as the committee would need to remain sighted on some matters. It was suggested there should be a piece of work that clearly sets out what the committee would want to see escalated and the thresholds. It was noted there had been some good discussion and debate with thoughtful contributions, and whilst this was still a work in progress it was moving in the right direction.

RESOLVED: That the committee:

- **Noted the report and commented on the proposal and layout of the integrated report.**
- **Agreed reporting would move to bi-monthly.**

b) LSCICB Safeguarding Dashboard 2025-6, Q1

The quarterly safeguarding dashboard set out a range of activities that supported the ICB to maintain robust safeguarding arrangements in its role as a commissioner of health services, as a safeguarding partner and as an employer.

The Chair commended the team for the work on the report, particularly the cover sheet which set out the AAA, which helped the committee to focus on what it needed to consider in relation to the dashboard. A Dunne advised this was a dynamic document as it was brought at a point in time and noted the longstanding risks, which now had mitigations in place and improvements were being made. Reference was made to section 11, which was a set of statutory safeguarding standards, which all organisations must conform to,

	and it was advised that the ICB was not fully compliant with its section 11 responsibilities. This was in relation to policies, particularly in managing allegations against professionals, which were currently in draft format and would follow the appropriate process for ratification. It was also in relation to training and a training needs analysis had now been completed with an attempt for this to be transferred onto a system. Unfortunately, there had been a glitch in the final phase, but it was hoped that a full report would be provided for Q3. One of the other areas of escalation was the provision of children in care assessment and some progress had been made to an upward trajectory. Some further key highlights were given regarding areas of escalation, additional performance data in contracts, the temporary arrangements for the adoption and fostering medical advisor role, the increasing demand on multi-agency safeguarding hubs and the backlog of cases for the Court of Protection and DOLS team. A Dunne confirmed that the policies on managing allegations against professionals were linked to the local safeguarding boards People in Positions of Trust policies. M Warren suggested that there was the potential for the ICB to work across Blackburn, Blackpool and Lancashire on Court of Protection and DOLS issues, and it was agreed he would link in with Margaret Williams outside of the meeting. R Fisher questioned if there were any metrics on children born into care as some of the most deprived areas within the ICB had some of the highest numbers of children born into care. Reference was made for mothers having to attend court a few days after giving birth and the difficulties faced by these people, which was concerning. The recent CQC inspection of Blackpool Adult Social Care being rated as inadequate was noted but not discussed further as the action plan is being formulated and this will brought back to a future Quality committee meeting. A Dunne advised there was data available, but this was usually collected through the local authority not maternity departments. Blackpool's children born into care service was really working quite well and the safeguarding team had been heavily involved. Whilst no comment could be given about the experience of parents having to go to court within a few days of a child being born. A Dunne agreed to follow up on this to provide further information. **RESOLVED: That the committee reviewed and considered the activity, data, narrative and context presented to gain a level of confidence that the Safeguarding Team was doing all it can to ensure it delivered against:** • **ICB statutory priorities and functions, managing risk and address under performance.** • **Partnership duties, being a strong partner and collaborator across the system** • **Duty to Co-operate, that we are active in supporting doing the right thing for our vulnerable populations in preventing abuse, neglect and harm** • **Focus on populations at Place**	
68/2526	**<u>Provider Annual Quality Accounts 2024/25</u>** The LSC ICB Quality Team had received and reviewed quality accounts relating to 2024/25 for all in-scope providers. Each provider Quality Account provided an open account of the achievements made over the year, including against priority areas which were identified in the 2023/24 accounts for delivery in 2024/25. The 2024/25 accounts also describe the priorities for 2025/26. Improvement priorities had a clear focus on patient safety and experience with a clear drive for culture of improvement and evidence-based learning. The Quality Team would continue to support providers in the delivery of their 2025/26 priorities. J Brennan advised that the annual quality accounts cycle was completed, and providers were compliant with the obligations around uploading quality accounts. The Chair noted that the letters back to all providers were very helpful in understanding the key items in terms of the quality accounts, what providers were working on and what they had been	

	asked to consider further. The account themes were very useful as they gave a sense of the overarching issues. Going forward, as the committee examined the business plan, it would be beneficial to ensure that any tasks had been completed and these were being reported on during the year. J O'Brien was pleased to see the triangulation of this with some of the people work being undertaken around culture and FTSU, and quality improvement linked to workforce issues. This also reminded us of the importance of staff and patient wellbeing. **RESOLVED: That the committee reviewed and approved the actions and recommendations within this report.**	
69/2526	**<u>All Age Continuing Care (AACC) and Individual Patient Activity (IPA) – monthly update</u>** 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 advised there were two sections to this item, the first was regarding assurance around quality and consideration of the information that had been provided, and the second part was around policies. R Jethwa was welcomed to the meeting and thanks were noted for the huge amount of work completed by the team. R Jethwa gave some key highlights from the report, which included a continued focus on quality of the service and the positive outcomes being achieved. Weekly turnaround board meetings were being held and weekly senior leadership team meetings to go through each phase of the workstream. The waste reduction plan (WRP) was being progressed through due diligence and finance and scheme lead meetings. Processes and policies were being reviewed regularly, and quality metrics were progressing well with the quality premium continuing to be above the NHSE benchmarking levels. The eligibility conversion was coming down progressively month by month, as were the numbers of fast-track referrals and activities. Liaison Care were supporting several workstreams including high cost cases, enhanced care and support reviews and overdue CHC reviews. A thematic review on the spike in complaints into the service was due to be completed by the end of August. J Brennan advised that an initial rapid review had been undertaken on the increase in MP complaints, some of which related to individuals, but some were around the controls. S Proffitt had written to our suppliers to remind them of the values of the ICB and the expectation of delivery partners when undertaking work on our behalf. Liaison Care and MIAA had responded to confirm they would work on those values and behaviours and ensure their staff would do the same. Terms of reference have been agreed and shared with the committee Chair as part of the thematic review, which would look at the complaints, soft intelligence from feedback from staff and stakeholders, which would be presented to the committee once completed as a piece of assurance. R Fisher referenced section 7.21, project group work had been paused with one of the two suppliers where the AACC services are completing 1:1 reviews due to an organisational safeguarding investigation taking place.' It was agreed that a summary report would be provided as part of the update in September. D Blacklock queried the conversion rates, and it was confirmed that this meant a change in eligibility criteria, which meant that less people were becoming eligible for AACC. It was questioned what happened to those who were not eligible and who would meet their care needs, and what the lived experience was like for these people. R Jethwa advised that this was about ensuring the right people were eligible for AACC and support could be offered with joint packages of care where health funded a proportion of the needs. If they did not meet the thresholds where local authority colleagues could not provide support, then they would be self-funding their own care needs or local authorities would support	

financially. D Blacklock noted the importance of looking at this from an experiential perspective and for some assurance to be provided around that process. The Chair agreed as this was about how we helped and signposted people appropriately to help people to navigate the system. R Jethwa advised that assessments were constituted with social care colleagues and were completed in a timely manner, and expectations were managed with family members from the start of the process.

M Warren stated that the 4 local authorities were in formal dispute with the ICB regarding AACC as this was all finance driven on the basis there was a £62 million cost saving attached. They received various letters, the last of which was 2 weeks ago from the ICB CEO regarding the model ICB blueprint and set out some of the proposed decisions and position on AACC, which the local authorities had formally rebutted. There had always been challenges around AACC and any form of eligibility criteria but that interpretation of whether there was a primary healthcare need or not was still part of the discussion. Issues remained as it was assumed that once a decision was made, funding would cease immediately rather than after 28 days and in terms of fast-track escalation they had been advised to go straight up to chief executive level. The four local authority CEOs had met with the ICB Acting CEO last week, which had resulted in a further meeting with PwC turnaround directors. Another meeting was scheduled for 4pm today and it was hoped relationships would be reset and moved forwards. Whilst the financial constraints with which the ICB was operating were recognised, it was equally important to know that the local authorities also had financial difficulties. Reference was made to the fact that an independent company had been commissioned to undertake these assessments and processes, but the ICB staff were not able to do their jobs in terms of those assessments. Reference was made to page 9 of the paper, and that 19% of the DSTs completed by the discharge to assess team required re-scheduling, due to the availability of social workers to form the MDT required to complete this process. Part of the dispute was that the team would set a date and time with no consultation, and if no one from the local authority attended then a decision would be made regardless.

J Brennan advised they had been working on a reset around relationships and joint protocols and policies. The ICB had a responsibility to make efficiencies, but patient experience, quality and the workforce were the priority. There were areas to improve on, and the teams were mindful of getting back to the previous ways of working well together.

D Atkinson referenced page 133 of the pack, which showed the number of complaints over the first quarter, but 40 complaints had been carried over from last year, and the average time and response for complaints was 107 days, and an average waiting time of 92 days with an ambition to reduce that to 80 working days in 2025. Therefore, questioned if some of the frustration from families and patients was due to the time taken to respond and should we be aiming for a better response rate. The Chair suggested it would be useful for this to be included in the terms of reference to understand about the handling of complaints and how the response rate could be improved.

S Spill noted that AACC went to Finance and Contracting Committee regularly and had been to Audit Committee last month where it was agreed that the three committee Chairs would meet to discuss responsibilities, assurance and oversight. The Chair advised that a meeting was held where they had agreed to ensure clarity on the respective roles of the three assurance subcommittees, and how this would feed back up to the Board. J Brennan agreed they needed to ensure the reporting was right for each of the committees. With regards to complaints, handling times had been included in the terms of reference but this sat with the patient experience team, but processes were being reviewed to ensure there were smarter, slicker ways of managing the increased volume.

	The Chair acknowledged that this was a work in progress and that further work would be undertaken on the thematic review, which would be brought back to the September meeting to give assurance around the quality aspects. *D Blacklock left 3.45pm.* The Chair noted a series of policies had been brought for consideration. D Atkinson advised these were clinical policies and the normal route for approval would be to CEG then to the committee. However, due to the focus on AACC and as they were new policies, they had been to the Executive Committee. Support had been given on the content and intent but there was further work to be done as they were not in the ICB policy framework and on the correct templates, J Brennan confirmed the team were working on this and they would be taken back to the Executive Committee once this had been done. The executives had requested absolute assurance that there had been engagement with local authorities and stakeholders. It was clarified that the committee had a role in approving the policies, and whether it was confident to support them in principle but that they went back to Executive Committee before being published. J Brennan advised that in the CYPI there was an entire section on engagement with local partners. However, they had not gone out to each of the local authorities and would be adopting a grace period as part of the contract management. They would also ensure that providers had been updated around one to ones and had undertaken several sessions with providers around expectations. ones. It was important the least restrictive practice was taken and reviewed via the legal frameworks that were in place to safeguard individuals, but also working with providers around the expectations around their duties to look after people in receipt of the care. Therefore, there had been engagement with providers from that perspective because it impacted on them around responsibilities and what was expected from one to ones. M Warren stated that it felt premature to sign off these policies as they disagreed with the grace period and PwC would be putting forward suggestions of how to work together. R Jethwa clarified that the grace period policy was around ceasing funding following an individual's death not following a review, and this would be for up to four weeks. J Scattergood agreed with the way forward and suggested there should be discussions offline to get the timing and sequencing right. **RESOLVED: That the committee agreed the policies would be taken back to the Executive Committee as final versions then be brought back to the Quality and Outcomes Committee in September in relation to engagement, formatting and executive committee approval**	
70/2526	**<u>Triple A report – Primary Care Quality Group</u>** 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. P Tinson advised that C Lewis and her team had been supporting several GPs and CQC would also be undertaking further inspections at several GP practices. It had been flagged formally as a risk regarding the concerns around capacity from both quality and primary care teams to respond to some of these. C Lewis noted that the CQC inspection and rapid learning from those findings would be kind of key. Also highlighted was an interface between primary and secondary care that had come up several times around children services, pathology and the potassium bloods assurance, which was on the committee action log. Further reports would come through the AAA to finally close down that issue. Also mentioned was decommissioning of the local enhanced services and the patient experience perspective, which was challenging.	

	RESOLVED: That the committee noted the report.	
71/ 2526	**Triple A report – System Quality Group** This 3 As report from the chair of the System Quality Group identified the key issues to be escalated to Quality and Outcomes Committee. J Brennan referenced the two alerts, one related to Healthwatch in Blackburn and Darwen, and the other around fast track. **RESOLVED: That the committee noted the report.**	
72/2 526	**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.**	
73/2 526	**Items referred to other committees** **RESOLVED: None.**	
74/2 526	**New directives/regulations/reviews that have been published** The NHS Performance Assessment Framework presented today. **RESOLVED: That the committee noted the NHS Performance Assessment Framework.**	
75/2 526	**Any Other Business** **RESOLVED: That there was no other business.**	
76/2 526	**Items for the Risk Register** **RESOLVED: That there were no new items for the risk register.**	
77/2 526	**Reflections from the Meeting** The Chair reflected on the difficult discussions but those challenges had been made respectfully. **RESOLVED: That the committee note the reflections.**	
78/2 526	**Date, Time and Venue of Next Meeting** The Quality and Outcomes Committee would be held on Wednesday 3 September 2025, 1.30pm – 4.00pm via MS Teams.	