

Approved at the 5 November 2025 meeting

Minutes of the ICB Quality and Outcomes Committee held on Wednesday 3 September 2025 via MS Teams

Members		
Sheena Cumiskey	Non-Executive Member (Chair)	L&SC ICB
Roy Fisher	Non-Executive Member	L&SC ICB
Steve Spill	Associate Non-Executive Member	L&SC ICB
Jane Scattergood	Interim Chief Nursing Officer	L&SC ICB
Andy Knox	Acting Medical Director	L&SC ICB
Julie Colclough	Partner Member (Primary Care)	L&SC ICB
Asim Patel	Chief Digital Officer	L&SC ICB
Regular participants		
Sarah Mattocks (deputising for Debra Atkinson)	Head of Governance	L&SC ICB
Kathryn Lord	Director of Nursing, Quality Assurance and Safety	L&SC ICB
Neil Greaves	Director of Communications and Engagement	L&SC ICB
Andy White	Chief Pharmacist	L&SC ICB
Katherine White (deputising for Mark Warren)	Nominated Director of Adults/Director of Children's services	Blackburn with Darwen Council
Arif Rajpura	Public Health Representative, Director of Public Health	Blackpool Council
Lindsay Graham (deputising for David Blacklock)	Healthwatch representative	People First/ Healthwatch Cumbria & Lancashire
Bridget Lees	Nominated Provider Chief Nurse	Acute/MH rep
In attendance		
Jo Leeming	Committee and Governance Officer (minutes)	L&SC ICB
Louise Coulson	Committee and Governance Officer (observing)	L&SC ICB
Damian Nelson (item 7)	Head of Performance and Assurance	L&SC ICB
Rakhee Jethwa (item 9)	Associate Director All Age Continuing Care (AACC) and Individual Patient Activity (IPA)	L&SC ICB
Alex Wells (item 10)	Head of Recovery & Transformation PMO	L&SC ICB

Item No	Item	Action
79/2 526	Welcome, Introductions and Chair's Remarks The Chair welcomed all to the meeting. All confirmed agreement that Copilot, an AI tool, could be used to support with production of the minutes.	
80/2 526	Apologies for Absence/Quoracy of Meeting Apologies had been received from Jane O'Brien and Debra Atkinson (Sarah Mattocks was deputising). The meeting was quorate.	
81/2 526	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.	
82/2 526	a) <u>Minutes of the Meeting Held on 6 August 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 15 – K Lord advised that learning from recent cases was being shared, especially regarding children not brought to appointments, and that improvements in speech and language therapy access were being shared across the system. D Nelson advised there was a new initiative to analyse the relationship between deprivation and non-attendance rates, with postcode data being collected and quality colleagues tasked with feeding back findings to inform future interventions. The committee agreed to keep this issue under review through the Integrated Quality Performance Report, recognising the area as an outlier in national benchmarking and committing to revisit the topic as more data became available. It was agreed that the quality team would triangulate the information regarding deprivation and Not Being Brought data.	KL (action)
83/2 526	<u>Patient story</u> The case study that had been shared showcased how targeted outreach and partnership working in Burnley has helped bridge gaps in healthcare access for underserved populations. It highlighted the importance of addressing social determinants of health through community-based interventions. The Chair noted this was an interesting perspective of responding in an innovative way to deep inequalities and improving access to services, but we needed to look at how this could be scaled up and sustainability of such initiatives. K Lord thanked those who had sent reflections and questions to her directly, and the view was it was positive to see the multiagency work in communities. Questions were about how this was funded and how we could think about further vulnerable groups? This was being rolled out across the system aligned to the inequality data and the long-term condition LES targeting those PCNs with the biggest health inequalities. The work was ICB funded from the Population Health budget. J Scattergood noted that as we progressed into neighbourhood working and the cohorts of people who received services increased, this would show a return on investment and take pressures away from other wider health services, it would also provide a better quality of life for our population. A Patel advised he had recently spent time at Church on the Street in Burnley and reflected on what made that a success. There was an inspirational leader driving this, a treatment room and mental health practitioners, which addressed several requirements. It was suggested the large estate within the faith sector could be explored further and how this model could be applied in other areas.	

	A Knox advised that before summer he had co-hosted an event titled 'So What' with health colleagues that culminated from 3 years of learning from the population health leadership academy about these types of approaches that had been tried in various small areas in Lancashire and South Cumbria but hadn't been systemised and scaled. The day focussed on how these initiatives could be embedded across the system and resulted in 5 key recommendations that would be shared with the 5 trust boards, the ICB board and potentially the committee. These were: 1. We must listen to our communities and understand what matters to them. 2. We must invest in the neighbourhood model – this is a mindset shift. 3. We must build the right leadership capability and capacity. 4. We need to align commissioning and financial plans with this approach. 5. We need to continue to build community power and organise social movement using a continual improvement approach. The message from the most disadvantaged communities was that they did not feel listened to or included in the process and if we could adopt these principles we could accelerate some of this good work across the system and make it business as usual. A Rajpura referenced Claremont in Blackpool where they had looked at higher than normal non-ambulatory attendance at hospital with a specific focus on respiratory due to high rates of smoking. However, it was realised that a disease focus could not be used as those people attending had numerous issues from fuel poverty to housing, and so on, and the project allowed these wider matters to be resolved by working with partners. They had undertaken outreach within communities by knocking on doors as this is what was needed to have open conversations with people on how we can help. They had received some incredible feedback, and the plan was to extend this into Bloomfield in November/December 2025. The Chair suggested this be included as a positive message in the escalation report to board to ensure this didn't get lost. Also, that the committee should think about how it moved forward with its business and be assured that this was being progressed. RESOLVED: That the committee noted the content of the story.	
84/2 526	<u>Quarterly risk management update</u> The report presented the quarterly risk management update on activity against those risks which relate to the business of the Quality and Outcomes Committee. S Mattocks advised there were three risks relating to the business of the committee which were held on the Board Assurance Framework (BAF) and one risk, which received joint oversight through the Finance and Contracting Committee. In addition, there were 13 risks held on the Organisation Risk Register (ORR) relating to the business of the committee, which included two new risks which were approved for inclusion on the ORR by the Executive Committee in July 2025. Section 5 of the report described the work undertaken during this financial year to refresh the BAF, and an updated version would be taken through board later this month. Therefore, the risks in the quarterly updates would look slightly different as they would be based on the refreshed BAF. The Chair noted it was a comprehensive report that tracked the BAF work, the risks and the impact of the mitigations. K Lord advised that whilst risk ICB-027: neurology service gaps across South Cumbria, had been approved for closure, discussions were ongoing and there may be a new risk in relation to service delivery. The Chair suggested the committee would need to return to the new risk ICB-033: ICB and community pharmacy readiness for NHS commissioned services with prescribing. A White noted that this did not include reference to the organisational change, and it was unclear who would be undertaking independent prescribing in community pharmacies in the future therefore, this was out of the control	

	of the ICB, and mitigations could not be put in place. This was a real risk in terms of workforce development, not just for pharmacy but for the whole system. RESOLVED: That the committee noted: • the contents of the report. • the risk management activity undertaken during the reporting period for risks held on the ICB's BAF and ORR relating to the business of the committee. • the two new risks approved for inclusion on the ORR; the closure of 1 risk, and the extension to the target risk score dates (outlined in sections 4.1 - 4.3). • the progress and the next steps to finalise the revised BAF for review and approval by the board in September 2025.	
85/2 526	<u>ICB Integrated Quality Performance Report / Escalation report</u> The report provided the first iteration of the ICB Integrated Quality Performance Report following the work undertaken to bring together performance, quality (including outcomes, safety and experience) and Population Health. It was acknowledged that over the coming months the report would be refined and developed to reflect any changes in responsibility between the ICB and NHS Regional teams and the commencement of the NHS Performance Assessment Framework. A Patel introduced the report, which had previously been based on national indicators but had now included an approach based on outcomes, which was testimony to all the teams involved. The report would generate a lot of discussion, but we needed to remain focussed and should only add in metrics as necessary. The lens would shift in terms of the narrative becoming more about prevention and community transformation. The report captured what we were required to do in terms of the new national performance assessment framework with the use of Statistical Process Control (SPC) charts. The Chair noted thanks for all the work on the first iteration of this report. D Nelson advised the quality and population health teams had been very engaged in this report, which had enabled the production of a more rounded document and as the reporting matured, interventions could be monitored through SPC charts. Damian gave an overview of some of the key focus areas, noting that the fall in CYP elective waiting lists was a false drop as this was due to the transfer of the paediatric neuro disability service to community. The team had received feedback that more CYP indicators should be included in line with preventative pathways set by the government, which included smoking at time of delivery and MMR at 5 years. There had been some good work in primary care around improving the proportion of resident population of children seen by a dentist, and preventative work was being undertaken in schools and nurseries to reduce the number of children having teeth extracted and the demand on Oral and Maxillofacial Surgery (OMFS). The Chair recognised the importance of drawing together different elements of early intervention and prevention to have an impact and give better life chances. A Patel noted it was good to see the triangulation when looking at breach of waiting times in the cancer pathways it was showing that harm reviews were being undertaken. However, it was suggested this should also include where these reviews were taking place and the discussions being undertaken. K Lord advised that page 60 of the report showed the triangulation of those harm reviews, which would be clarified. There was also learning in relation to mental health and learning disabilities, and 12 hour waits, a Quality team was carrying out visits across some of those pathways to test the learning. S Spill queried which team looked at the variance analysis and it was confirmed the performance team undertook this to identify any outliers. R Fisher noted that the executive summary was very useful as it brought focus to key points but suggested this could include clear page references to some of the metrics within the report. B Lees proposed there might be value in linking between what was in the report and the BAF as the report started to mature.	

	A Rajpura stated there were other evidence-based interventions around oral health, and we should be looking at the data on interventions from an inequalities perspective to ensure that waiting lists were being managed so that people from the most deprived communities were not suffering the biggest amount of harm with delays in treatment. A Patel advised they had presented something previously to Finance & Contracting Committee in relation to deprivation and elective recovery, and it would be useful to have a further discussion where this could be looked at by each discipline. It was agreed this should be presented first to the Population and Health Inequalities Group first then be brought to the committee to provide a public health perspective. A Rajpura queried monitoring of the flu vaccination uptake as each year this resulted in additional pressure on the system during winter months. K Lord advised that whilst we did not have this from a primary care perspective, we received the acute data and could see vaccination rates in terms of staff. Vanessa Morris, Lead Nurse for Infection Prevention & Control had tried several times through NHSE to get more ongoing reporting for vaccinations. J Scattergood confirmed that it was NHSE owned data and there was a delay for the data to be validated. However, there was a plan to transfer commissioning of 7A (of the National Health Service Act 2006) services, to ICBs from March 2026 then we would own the data but until then we had a subset of data on flu and covid and could augment the unvalidated NHSE data with our own intelligence. A White noted that the report had lots of description of input, and outcomes should be reported. J Scattergood suggested recording children's wait times as a percentage of their life, waiting a year when aged only 4 years old is 25% of life for example. D Nelson agreed but this was dependent on the data from the providers. S Spill queried how the focus items were determined, and it was advised this was based on criteria used by the performance team such as whether the SPC was showing a special case variation or that an indicator was failing its target. The team had tried to draw out the key focus areas from a professional perspective as a performance team, which would then be worked through with commissioners. They had also tried to include what action was being taken to provide the quality aspect and how we get assurance around that. Support and involvement from the broader ICB teams had been key in the production of the report. D Nelson welcomed the continued challenge to get the report right and include the metrics to make a difference to the population. The Chair noted this was a brilliant work in progress as it had the focus, the actions and assurance, and would evolve over time. RESOLVED: That the committee noted the report.	AR / AP (action)
86/2 526	<u>East Lancashire Hospitals Trust Histopathology update and assurance</u> K Lord advised that since the agenda was circulated, it had become apparent that this item required a paper. This would be put on the November 2025 agenda. RESOLVED: That the committee agreed that a paper be brought to the November meeting.	
87/2 526	<u>All Age Continuing Care (AACC) and Individual Patient Activity (IPA) – monthly update</u> The report updated and provided assurance to the committee on progress and the plans in place to continuously improve the quality of the AACC & IPA service alongside improved performance and mitigation against financial risk. R Jethwa took the paper as read but advised that currently there was 14% staff sickness within the service and 5% vacancies, which was a risk that could potentially impact the business-as-usual delivery or quality premium potential risks to increased backlogs of	

reviews and delivery of the WRP plan of £60.2 million. The Chair reminded the committee they needed to be focused on the assurance around quality. L Graham noted the positive steps that had been taken around gathering patient feedback and offered support from Healthwatch as a thinking partner to increase engagement or to consider different mechanisms for feedback. It was questioned how the patient experience intelligence had been used to shape the intelligence plan and whether there would be an opportunity to systemise this. R Jethwa welcomed the offer of support to increase patient engagement as they were struggling regarding completion of the patient experience and satisfaction forms. However, they would be including QR codes on outcome letters to try to increase feedback and any feedback received so far would be used to shape service improvement, and ideally to help to shape the turnaround plan going forwards. J Colclough noted that she had learnt more from the committee about continuing healthcare and funding nurse care than from clinical exposure, and if staff in primary care do not properly understand the process, then this was not helping to set expectations. It was suggested the primary care newsletter could be used as a tool for education, which would support the system. R Jethwa advised that within AACC they have a learning and development lead who could undertake targeted training if required. J Colclough this would be effective if delivered at the GP registrar training that was done across the entire ICB. K White acknowledged the ongoing work with local authorities as this was a system piece of work with support from Price Waterhouse Cooper in terms of the Memorandum of Understanding and how this would be progressed. N Greaves referenced the low rate of completion of the patient feedback form, but the paper did not explain this further and suggested it would be good to work with the team on this to look at the points at which they tried to obtain feedback. There was a lot of information about complaints, but we needed to try to capture some of the insights. R Jethwa advised there had been 1-3 participants who had presented feedback to date, and the team requested feedback throughout the whole process but would welcome any support from N Greaves' team. The intention was to form a co-production group of service users who could help with targeted pieces of work with the turnaround plan to help improve the service. N Greaves explained they had several citizen advisors on the citizens panel who had experience of using those services who could support with the co-production group. R Fisher noted that conversion rates were coming down due to joint working with local authorities but requested that a broader explanation be provided on the areas where they were coming down. R Jethwa confirmed this could be included in future reports. The Chair referenced the deep dive discussed previously to further understand the increase in MP letters and complaints. K Lord advised Terry Whalley was leading this piece of work and was seeking a clinical view. The deadline for return was 8 September 2025, with the aim for it to be brought to Executive Committee on 16 September 2025 and to committee in October 2025. J Scattergood noted the earlier iterations of the thematic complaints report were process focussed and needed to include patient experience and a clinical view. This was an important mechanism to further understand the impact of the work undertaken through a quality lens. The Chair raised concern regarding the high sickness absence and vacancies. R Jethwa advised they had a business continuity plan and action cards for staff absence. In the first instance they would look at cover across place-based teams to complete priority work and Liaison Care were also providing support with this. There was also the clinical support	LG / RJ (emailed) RJ (emailed) NG (emailed)
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	team, which was inbuilt within the service model, which worked flexibly across the service to support any gaps and reprioritisation work would be undertaken where required. There had been a recent reduction in the quality premium, which was being tracked and monitored. The current model for assessments and reviews was face to face but they have requested that staff move to a hybrid/virtual model if required to complete more assessments and reviews. K White noted that these were complex assessments and would need to be completed face to face. Any decisions should be made jointly with the local authorities. R Jethwa advised this would be the worst-case scenario and this would need to be agreed by the turnaround board. J Scattergood agreed these were joint pathways and joint decision making was key. Another element of mitigation was some focussed leadership support and discussion with the significant workforce employed in AACC regarding organisational change due to the detrimental impact of wellbeing and resilience. The Chair noted thanks to R Jethwa and the team. RESOLVED: That the committee reviewed and approved the actions and recommendations within the report.	
88/2 526	<u>Quality Impact Assessments (QIA) – process update</u> The paper specifically outlined how processes were evolving to ensure that the management of outcomes from QIA's were owned and monitored in line with commissioning best practise. Additionally, the paper provided insight into revised QIA guidance framework which was published on 25 June 2025. A Wells gave some key highlights from the report. Year to date they had worked on 87 QIAs and the process was now well established and embedded due to the hard work of the teams. The Programme Management Office (PMO) and quality team had undertaken internal reflection under section 4 around some of the improvement opportunities. The new QIA framework launched by NHSE in June 2025 was seen as an opportunity to refresh and improve developments of the process. The PMO tool, Verto was also now fully embedded, and they were also using that for the risk management framework, which could be used as good practice on how we manage risks and mitigations out of the QIA process. S Spill referenced section 6.4.i, which was the first of the key principles to ensure a robust process for undertaking QIAs, 'Board commitment and oversight ensuring any decisions made about service changes have an associated QIA,' and questioned how the board would assure itself that every change of direction was subject to a QIA. A Wells advised this was about how we managed our wider change governance, which now sat within Verto and enabled reporting of all change activity being undertaken with active dashboards viewable to board and executives to give assurance on QIAs that have been undertaken. The commissioning team were clear on the need for undertaking QIAs, and processes related to service change, and there was detailed governance that signposted on the need for and importance of QIAs. The number of QIAs completed indicated that we were addressing and mopping up all change activity. The Chair suggested it might be worthwhile undertaking a stock take during the year to see if anything has been missed. L Graham questioned how we would know in the future that the QIAs had improved patient outcomes and experience and was there an opportunity for some transparency for the public to see how these were driving improvements. A Wells advised that they were at the point of ensuring outcomes from QIAs were monitored and tracked, and the focus had been on adverse outcomes but agreed they could start to look at positive impacts and these should be monitored. It was vital that	

	QIA's demonstrated that the change of commissioning pathway or decommissioned had not compromised patient safety. N Greaves advised that these were complex documents and needed some interpretation to be understood. Within the new QIA policy that was being written there would be information on how/when these documents could be shared externally. This would be based on NHSE guidance. B Lees noted there had been lots of discussion in the meeting around inequalities and wondered how we might draw this out in the QIAs. A Wells advised the new recommendations from NHSE referred to a combined EQIA document but in the ICB we also undertook Equality and Health Inequalities Impact and Risk Assessments (EHIIRA). Going forwards, they would be looking at how this could be incorporated into the process. It was discussed and agreed that the committee was comfortable having a regular update on the EHIIRA outcomes. The Chair noted that we needed to ensure risk mitigation had worked and was monitored. A Wells advised this was being built and proposed this be brought as part of the revised QIA policy to the meeting in November 2025. RESOLVED: That the committee supported the proposed review of existing QIA policy and underpinning processes. In doing so, embracing improvement opportunities from the following areas: • Internal reflections and improvement opportunities • Establishing use of existing risk management processes to ensure that mitigating actions are monitored effectively within existing functions • National quality improvement framework published in June 2025 • Findings and recommendations from MIAA audit of existing QIAs. • Risk mitigation and impact data to be included in future reports. It was recommended and agreed that a revised QIA policy and summary of key changes would be provided to the committee in November 2025.	
89/2 526	<u>Triple A report – Clinical Effectiveness Group (CEG)</u> The report identified the key issues to be escalated to the committee. K Lord flagged the alert in relation to delegation of approval of clinical policies and work remained ongoing with involvement from S Mattocks in terms of governance. A White noted that with regard to weight loss drugs and diabetic monitoring, a paper would be brought to the next board meeting and the outcome would be discussed at the next CEG. RESOLVED: That the committee noted the report. The committee agreed the the delegation of clinical policies by CEG could be approved with support from Corporate Governance.	
90/2 526	<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.	
91/2 526	<u>Items referred to other committees</u> RESOLVED: That there were no items to be referred to other committees.	
92/2 526	<u>New directives/regulations/reviews that have been published</u> The committee acknowledged the new NHSE QIA guidance framework. RESOLVED: That the committee noted the new NHSE QIA guidance framework.	

93/2 526	<u>Any Other Business</u> S Mattocks advised that the refreshed terms of reference were agreed by board in March 2025 but that a full committee effectiveness review would be undertaken at the end of Q3 and there would be an early review of the ToR to determine if any amendments were required. Now that the transition of the ICB operating model was underway to becoming a strategic commissioning organisation, it was recommended that the quoracy be reduced from 5 members to 4 with only one executive required and that the frequency of meetings moved from monthly to bimonthly alternating between face to face and MS Teams. A White questioned whether the delegation to CEG for approval of clinical policies could also be undertaken at the same time to ensure a timely resolution. S Mattocks advised this was a separate piece of work and would be progressed differently. RESOLVED: That the changes to the terms of reference be agreed and would be taken through board for approval in September.	
94/2 526	<u>Items for the Risk Register</u> RESOLVED: That there were no new items for the risk register.	
95/2 526	<u>Reflections from the Meeting</u> The Chair reflected there needed to be more links to the work around population health and that the committee was still adjusting to its new remit. There also needed to be more focus on 'so what,' and improvements around communication. N Greaves advised they had changed some of the board templates to incorporate feedback on public perceptions on agenda items being brought and it was agreed the same should be done for the committee. RESOLVED: That the committee note the reflections.	NG (emailed)
96/2 526	<u>Date, Time and Venue of Next Meeting</u> The Quality and Outcomes Committee would be held on Wednesday 5 November 2025, 1.30pm – 4.00pm in the Lune Meeting Room, ICB Offices, County Hall, Preston.	