

Approved at the 4 March 2026 meeting

Minutes of the ICB Quality and Outcomes Committee held on Wednesday 7 January 2026 1.30pm - 4.00pm 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
Asim Patel	Chief Digital Officer	L&SC ICB
Andy Knox	Acting Medical Director	L&SC ICB
Julie Colclough	Primary Care Partner Member	L&SC ICB
Regular participants		
Kathryn Lord (deputising for the Interim Chief Nurse)	Director, Quality Assurance and Safety	L&SC ICB
Debra Atkinson	Director of Corporate Governance / Company Secretary	L&SC ICB
Andy White	Chief Pharmacist	L&SC ICB
Mark Warren	Nominated Director of Adults/Director of Children's services	Blackburn with Darwen Council
Arif Rajpura	Public Health representative	Blackpool Council
Sam Westwell	Nominated Provider Chief Nurse	Acute/MH rep
Lindsay Graham	Healthwatch representative	People First/ Healthwatch Cumbria & Lancashire
In attendance		
Jo Leeming	Committee and Governance Officer (minutes)	L&SC ICB
Glenn Mather	Associate Director of Performance & Assurance	L&SC ICB
David Brewin (item 6)	Head of Patient Experience	L&SC ICB
Jane Cass (item 8)	Director of Partnerships & Collaboration	L&SC ICB
Rakhee Jethwa (item 10)	Associate Director All Age Continuing Care (AACC) and Individual Patient Activity (IPA)	L&SC ICB
Bimpe Kuti-Matekenya	Aspirant Non-Executive Director	University of Greater Manchester

Item No	Item	Action
125/ 2526	<p><u>Welcome, Introductions and Chair's Remarks</u></p> <p>The Chair welcomed everyone to the meeting and acknowledged that the organisation was undergoing significant change as it moved towards a new operating model, creating uncertainty for staff both professionally and personally. The committee would need to recognise these challenges and planned to address the new model in future meetings to ensure clarity for everyone. The Chair reminded attendees that this was an assurance committee, and it was noted how hard colleagues had worked on ensuring this focus in the papers presented today.</p>	
126/ 2526	<p><u>Apologies for Absence/Quoracy of Meeting</u></p> <p>Apologies had been received from Jane Scattergood, Kathryn Lord was deputising, and David Blacklock, Lindsay Graham was in attendance and would be representing Healthwatch going forwards. Aaron Cummins was expected to attend but was now unable to and would attend the next meeting on 4 March. The Chair welcomed Sam Westwell, the newly appointed Chief Nurse, AHP and Midwifery Officer at BTH, and Bimpe Kuti-Matekenya who was attending as part of the Aspirant Non-Executive Director Programme. Steve Spill had recently been appointed as Audit Committee Chair</p>	

	<p>and would be a member of Finance and Contracting Committee going forwards, instead of this committee. The Chair requested each person spoke they introduced themselves before they spoke during the meeting.</p> <p>The meeting was quorate.</p>	
127/2526	<p><u>Declarations of Interest</u></p> <p>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.</p> <p>RESOLVED: That no declarations of interest were made relating to the items on the agenda.</p> <p>(a) Quality and Outcomes Committee Register of Interests.</p> <p>RESOLVED: That the Quality and Outcomes Committee register of interests was received and noted. The Chair referenced potential discussions around BTH and requested that S Westwell flag this at the appropriate time if a conflict should arise.</p>	
128/2526	<p>a) <u>Minutes of the Meeting Held on 5 November 2025 and Matters Arising</u></p> <p>The Chair noted the minutes had been shared for any points of accuracy and no amendments had been received.</p> <p>RESOLVED: That the minutes were approved as a true and accurate record.</p> <p>b) <u>Action log</u></p> <p>Action 20 – remained ongoing not as was not due until March. Action 7 – it was agreed could be closed.</p> <p>The Chair proposed that all referrals from or to other committees of the Board could be closed.</p> <p>RESOLVED: That the action log would be updated as discussed.</p>	
129/2526	<p><u>Patient story</u></p> <p>A patient story about increasing awareness and promoting the uptake of cervical screening, especially in Asian communities had been shared with the meeting papers. K Lord thanked those who had provided reflections prior to the meeting. The main themes were about understanding the stigma and difficulties within the South Asian community. It was agreed the story had been well articulated and it was recognised how brave these people were to come forward with this issue. However, one of the key points was how could this be used in a wider context, e.g. for bowel or prostate cancers where people felt too embarrassed to see a doctor, and how this could be taken into the new world of strategic commissioning.</p> <p>A Knox advised that there were dozens of these projects on the population health section of the ICB website around addressing inequalities rooted in stigmatisation, which included work with sex workers in Blackpool around smear tests. Therefore, learning was being taken and spread across the region with an improvement approach to population health. J Colclough questioned N Greaves if there was a way to direct people out in the community to ensure they could find information about these initiatives. R Fisher referenced a recent BBC news report about difficulties of disabled people in</p>	

	<p>accessing cervical screening and whether this was an area of the population that could be targeted as part of the communications exercise. N Greaves explained that the patient story was intended to document ongoing efforts and demonstrate how these initiatives could be integrated into wider cancer campaigns throughout the region. Work was ongoing with communities to ensure engagement and co-production of services to reduce health inequalities. A Patel noted that Asian women had a 32% lower uptake of cervical screening, compared to an 8% difference linked to deprivation in the performance report, and there was a need to regularly update reporting on such disparities, focus on intersectionality, and ensure performance reports captured differences by gender, deprivation, and ethnicity to better inform interventions. The Chair reflected that clarity was needed around what was trying to be achieved in terms of priorities and how that was evidenced in terms of impact and making a difference in communities. Also, how the details of what was being done in individual neighbourhoods could be cascaded across the region on a bigger scale. A Rajpura noted that this all linked with the health inequalities work being undertaken at a local level but tackling health inequalities required considerable time and resources, but this was needed to achieve better outcomes.</p> <p>The Chair noted that patient stories were placed at the start of the agenda to focus members on improving outcomes and connecting with the people they served, and to understand ongoing work, ensuring engagement and co-production of services, and using data to inform and measure the impact of efforts to tackle inequalities.</p> <p>RESOLVED: That the committee noted the content of the story.</p>	
<p>130/ 2526</p>	<p><u>Patient Experience and Complaints report</u></p> <p>D Brewin introduced the report, which summarised volumes and types of contact with the Patient Experience Team in October and November 2025. It also captured performance information and included an update on complaints about the All-Age Continuing Care (AACC) function and analysis of other types of complaints received by the ICB. He highlighted the section on AACC complaints, which had been alerted to committee in November as the volume remained high, handling times had also deteriorated, and the number of open cases had increased. A process review had been undertaken by an external body, and a rapid improvement event would be undertaken on 10 and 11 February. The depleted team remained under increased pressure with concern around wellbeing noted but recruitment had been agreed with interviews taking place next week to ease the position. There was a proposal for a strategic review of complaints handling but it was not yet known how this would be conducted or the timescale.</p> <p>K Lord thanked D Brewin and noted that, whilst the team continued to deliver the service in terms of its statutory duty, the experience of complainants was poor. However, the committee expressed appreciation for the team's efforts. M Warren referenced the rise in AACC complaints and whether this was attributed to the process challenges and disputes between the ICB and local authorities. D Brewin advised that the complaints covered all aspects of AACC but there was a correlation with outcomes of reviews. Many were about communication, which included delays, lack of response and staff attitude. With regards to matters between the NHS and local authorities, this was not an area of complaint as it was dealt separately by the organisations and not generally seen by patients. R Fisher queried a particular complaint about painkilling injections undertaken by a private provider being decommissioned. The Chair advised that whilst this was a pertinent question, it was an operational matter. A White shared a link in the meeting, which provided an explanation on this matter. J O'Brien referenced the breaches against statutory responsibilities and the consequences of such. D Brewin advised that whilst this had been included as a statutory requirement, this was not reported into any national dataset, therefore there was no consequence. L Graham noted that almost two</p>	

	<p>thirds of complaints concerned access and waiting, with dental cases informing improvements in access and equality.</p> <p>The Chair thanked D Brewin and the team, noted capacity challenges and their impact, and highlighted the need to balance patient experience, staff wellbeing, and ongoing improvements in communication and complaint handling. However, concern was noted around AACC and the committee needed to think about the reduction it expected to see once changes had been put in place, but this would be discussed later in the meeting.</p> <p>RESOLVED: That the committee noted the report.</p> <p><i>D Brewin left the meeting.</i></p>	
<p>131/ 2526</p>	<p><u>Quarterly Risk Management Report</u></p> <p>D Atkinson advised this was the quarterly update on risk management activity for those risks relating to the business of the committee. To note, there was a full review of the BAF that went to Board in September, and there were some key revisions that had been built in with quarterly updates that provided a succinct narrative against each risk, and the risk appetite had been embedded and incorporated assurance mapping around the four lines of defence model. There were three main risks on the BAF related to the business of the committee, all of which had been reviewed by the relevant lead executive and the SRO. There were no proposed changes to the risk scores at the end of Q3. Two risks had target scores above the Board's agreed risk appetite, and this was flagged with the Executive Committee and executive risk leads. Further actions and mitigations have been reviewed to determine whether the target risk could be driven down to within the Board's risk appetite. At the time of reporting, 15 risks met the threshold for the corporate risk register, but after closing the risk related to the community tobacco dependency service, 14 remained. Four risks were scored at 20 and were to be reported to the Board, while three exceeded the Board's target risk appetite and were under review for further mitigation.</p> <p>The Chair asked the committee to reflect on whether there was sufficient assurance on the risk description and if the mitigations were adequate and being implemented effectively to have the desired impact. A White advised that as of February, the UK supply of co-codamol would be halved, which would have a very disruptive impact on clinicians as it was one of the highest used painkillers. However, this could pose an opportunity to review patients being prescribed this drug. J Colclough found the paper helpful and considered the risk rating accurate, but assurance had been difficult due to financial pressures, with some quality elements expected to be under strain. She further questioned when the committee should recognise that maintaining service quality might mean accepting longer waiting times. J O'Brien agreed but suggested that where risks exceeded the Board's target risk appetite, more qualitative description be included in the mitigations.</p> <p>RESOLVED: That the committee noted:</p> <ul style="list-style-type: none"> • the contents of the report • the risk management activity undertaken during the reporting period for those risks held on the BAF and ORR relating to the business of the committee (as outlined in sections 2 and 3) and the full risk entries provided in full at Appendices 1 and 2. • the high-level summary dashboard of all risks currently held on the BAF and ORR (Appendix 3). 	<p>DA / CM (email)</p>
<p>133/ 2526</p>	<p><u>ICB Integrated Performance report / risk and escalations report</u> <i>**the agenda was taken out of order**</i></p> <p>G Mather introduced the paper, which provided an update on the latest position against</p>	

key performance indicators (KPIs) together with a view on the quality (including outcomes, safety, and experience) and health equity impact within the system. This was the third iteration of this style of reporting and there was a focus on urgent and emergency care due to the time of year with unprecedented numbers accessing this service. System pressures had led two provider organisations to the highest escalation level (Opal 4), prompting significant support. Referral to treatment times (RTT) and waiting lists remained challenged and off the planned trajectory. NHSE maintained close oversight, especially for long waits, and whilst there had been a huge reduction in 65 week waits, the target of 0 by 21 December was missed by around 20 patients but each patient still waiting had been marked with a date for treatment. Over 20,000 patients risk breaching 52-week waits by the end of March. RTT recovery plans remained ongoing with multiple actions and programmes of care to support managing patients in the most appropriate setting, trying to keep people out of hospital where possible and utilise pre-referral specialist advice. Diversion rates were not yet at the anticipated rate, but several other schemes were being undertaken to aid this. This topic had featured at Finance and Contracting Committee and was expected to be discussed regularly with NHSE. It was noted that if targets were to be met, all opportunities would need to be enacted. Nationally, the aim was to reduce the waiting list to no more than 3 million patients, down from 7.4 million. However, there was no additional funding, and financial constraints meant performance targets would become increasingly challenging, with expectations rising to 92% of patients being seen within 18 weeks by 2028/29. There would be a significant shift in trying to deflect patients to other services or by prevention through primary care services.

A Patel noted there was an expectation from NHSE regarding the appropriate level of assurance and scrutiny around RTT as it was a high national priority and had been discussed at Finance and Contracting Committee earlier today. It was suggested that a supplementary AAA report on acute elective care be brought to the next meeting to discuss this as a separate item in the current climate of increased pressure and challenge around acute elective recovery. The activity management plans would then be brought to Finance and Contracting Committee, recognising the need to balance cost constraints with performance targets as this approach would achieve better alignment. J Colclough questioned where any good ideas were coming from to manage this as the problem would just keep growing. G Mather advised there was some level of support from NHSE around advice and guidance, and how the system could be streamlined, and patients could be redirected into different arenas, but this would take time to develop. More could be done to look around the country to find areas of good practice. K Lord noted part of the committee's role should include gaining assurance around harm reviews and patient safety whilst they waited to be treated.

A Patel advised there was an enquiry at the service delivery meeting around whether there was any correlation between the reduction of inappropriate out of area placements and any increase in waiting times for MH admissions, but it was confirmed that waits for mental health admissions had also reduced. A watching brief would be kept on this to ensure that when improvements were made in one area there was no adverse impact in another area. G Mather confirmed that the percentage of patients with learning disabilities and autism who had been offered a health check was based on the total registered population. J Colclough noted they had seen an interesting link between healthcare reviews and the presence of a hospital passport and questioned if there was any data on this. G Mather advised that this information was available for those in hospital or in the community who were potentially facing hospital discharge but for individuals living in the community without challenges, this information was likely not available.

Business
plan

	<p>K Lord referenced the risk and escalation report and gave a summary of the 3 points of escalation. D Atkinson noted that the paper stated ‘confidential’ but K Lord advised these risks and escalations had to be shared and that should be removed.</p> <p>RESOLVED: That the committee noted the report and that a triple A report on acute elective care be brought to the next meeting.</p>	
<p>132/ 2526</p>	<p><u>Medium term plan – the agenda returned to the original order</u></p> <p>J Cass advised that this agenda item related to the development of the five-year Strategic Commissioning Plan, a requirement of the medium-term planning guidance published the previous August. The ICB was required to submit three-year activity, finance and workforce plans, alongside the five-year plan, which would set out how these commitments would be delivered. The plan was intended to describe the ICB’s vision for improving health outcomes, defining clear outcomes, actions and KPIs. It would draw on the integrated needs assessment, align with Health and Wellbeing Board strategies and the national 10-year health plan, and address key priorities such as reducing inequalities, tackling unwarranted variation, improving equity of access and strengthening patient experience. A steering group from all ICB directorates had been established to draft the plan, supported by a robust population health needs assessment triangulated with performance and quality data. The plan would include detailed Year 1 commissioning intentions for 2026/27, with higher-level intentions for subsequent years, and would align with the refreshed clinical strategy. The plan would set out a clear framework for meeting statutory duties around population health, inequalities and service quality, using insight from community engagement. It would also build on existing population health work, emphasising prevention, partnership working across sectors, and innovation. Commissioning intentions would include defined outcomes, metrics, milestones and governance arrangements across neighbourhood, place and system levels. An outcomes framework would support monitoring of delivery. A public health registrar would review the draft to ensure strong alignment with population health and health inequalities objectives.</p> <p>The Chair noted thanks for the update as it was important for the committee to have oversight and to be assured that the plan would meet the necessary requirements. K Lord questioned if anything was currently required from the committee, but J Cass advised there was nothing at this time as the final draft was not yet ready to be shared. The draft commissioning plan would be shared with Board to provide assurance and would eventually supersede the Joint Forward Plan once legislation changed and would be updated annually. This update simply informed the committee that work was underway, and it was expected that the draft plan would be presented to the committee once it was available.</p> <p>RESOLVED: That the committee noted the update.</p> <p><i>J Cass left the meeting. The committee took a 5-minute break.</i></p>	
<p>134/ 2526</p>	<p><u>All Age Continuing Care and Individual Patient Activity (IPA) – monthly update</u></p> <p>R Jethwa advised the paper provided an update and assurance 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. Key highlights included that the service continued to maintain quality premium performance above 80%, despite significant operational pressures, including 26% sickness absence across the service, which posed risks to service delivery and patient experience. Complaint volumes had risen, linked to high levels of reviews and assessments and a large backlog, mainly in funded nursing care. The Patient Experience and Complaints teams have started to implement improvements following a complaint handling process review undertaken with the recommendation to complete a rapid review.</p>	

M Warren noted it was positive to see some of the work going forwards and the 4 local authorities had been working closely with the ICB AACC team on a Memorandum of Understanding (MOU) to reset the relationship. The MOU had now been signed off by A Cummins and the chief executives of the local authorities with regards to a work programme. He further referenced the waste reduction workstream and where the paper stated there was an agreed s117 policy with local authorities as this had not yet been agreed. R Jethwa agreed this was in development and was a key action to agree, and this error would be amended. R Fisher noted that the eligibility conversion rates had increased but the narrative stated they had since reduced and queried if there was any information around which geographical area this was in. R Jethwa advised she could obtain this and share outside of the meeting, and whilst there were peaks and troughs with eligibility conversion, spot checks were undertaken to ensure consistency in decision making and no areas of concern had been highlighted. There was grip and control around this with dual ratification, which gave assurance that the right decisions were being made. M Warren noted the local authorities had seen the same issue in terms of eligibility as complexity of cases has been increasing. R Jethwa advised work was being undertaken to address gaps in core commissioned services impacted in relation to AACC.

J Colclough referenced the detail regarding audits on discharge to assess and queried if this was related to area, deprivation, was reflective of the community or was due to another matter. R Jethwa confirmed there had been an increase in discharge to assess, some of which was due to gaps in core commissioned services, which was above the statutory responsibilities of local authority colleagues, which resulted in more coming through the discharge to assess pathways. This had been flagged with executives as a matter of concern. M Warren agreed that too many people were being placed through discharge to assess and their chances of returning home were then severely reduced, although this was dependent on the ability of the integrated neighbourhood team to be able to get to a patient quickly. The focus should be on 'home first' with support from primary care even for patients with complex needs. This also linked to the Urgent and Emergency Care Delivery Board, which was meeting tomorrow, and how it could be ensured an intermediate-tier pathway, rather than direct placement into nursing homes, was essential to avoid unnecessary institutionalisation.

With regards to sickness levels, K Lord questioned if this was expected to be long-term or that staff would return. R Jethwa advised there had been high sickness levels for the past 4-6 months, of which a high proportion was long-term sickness, which was concerning. Some of this could be attributed to the model ICB blueprint, organisational change and ongoing pressure on the service to meet financial targets. Support had been provided via the Turnaround Board with the agency worker scheme to deliver the statutory responsibilities along with external supplier support. However, it was anticipated that voluntary redundancy would further compound the issue and could affect statutory duties of the service if recruitment was not possible. The Chair noted that the committee required further understanding of the mitigations in place regarding sickness absence levels given the significant changes affecting staff and when the impact of recent changes to the AACC model might start to be seen, particularly in relation to reducing concerns and complaints. It was agreed this would be reflected in the next report. R Jethwa advised the quality hub was working with D Brewin's team to optimise processes for dealing with complaints more efficiently and K Lord confirmed D Brewin had outlined this work earlier in the meeting.

RJ (email)

RESOLVED: That the committee noted:

- **Progress with the turnaround plan;**
- **Consistency in performance on key performance metrics.**
- **Key audit findings;**

	<ul style="list-style-type: none"> • Operational challenges with 12% sickness and 8% vacancies with impact on service delivery and WRP. • Savings gap within WRP target set; • Large overdue review backlog primarily related to FNC reviews. • Rise in volume of complaints with increased handling times; and • Key risks within service. <p><i>R Jethwa left the meeting.</i></p>	
135/ 2526	<p>a) <u>Patient Safety Incident Response Framework (PSIRF) Provider Policy & Plan update</u></p> <p>K Lord presented the paper, which sought formal approval for those commissioned providers who had submitted their Patient Safety Incident Response Framework (PSIRF) Policy and Plans, or revised Plans, to proceed with full implementation of PSIRF in line with national policy and contractual requirements. Plans had been submitted by two providers, which had been worked through by the team and were ready to be signed off. A revised plan, covering the previous 12–18-month period, had also been updated and under the agreement between ICBs on lead responsibilities, the partner ICB had reviewed the Ramsey Healthcare policy for the same 12–18-month period, and this had also been reviewed and was ready for approval.</p> <p>RESOLVED: That the committee:</p> <ul style="list-style-type: none"> • Noted the contents of the report. • Considered and supported approval of the provider PSIRF Policies and Plans recommended in Section 2. <p>b) <u>LSC ICB Patient Safety Incident Response Framework Policy (PSIRF)</u></p> <p>K Lord advised that the national Patient Safety Incident Response Framework (PSIRF) (August 2022) makes clear the role of Integrated Care Boards in supporting and seeking assurance from providers within their Integrated Care System. An ICB PSIRF policy is a requirement under the national patient safety strategy, and this should outline the ICB's role and function in the management of patient safety events across the system. National guidance has been fully incorporated to inform and align the ICB's policy with current NHS standards and best practice. The policy had been developed to meet requirement from MIAA and updated following stakeholder feedback, including input from Healthwatch. Approval was sought, with the understanding that an early review would be needed around June 2026 due to commissioning changes and responsibilities.</p> <p>D Atkinson noted the document needed to be aligned to the ICB policy template and framework as certain mandated sections might need to be included for staff. The Chair noted it was useful as a reminder of how the governance process worked and where assurance came from the system on quality and outcomes. K Lord advised that the policy aligned to the quality governance framework.</p> <p>RESOLVED: That the committee:</p> <ul style="list-style-type: none"> • Noted the contents of the report. • Reviewed and formally approved the Lancashire and South Cumbria ICB PSIRF Policy as the current framework for patient safety incident response. 	CM / KL (email)
136/ 2526	<p><u>AAA report - Prevention and Health Inequalities Steering Group (including minutes of the last meeting)</u></p> <p>The report provided an update from the Prevention and Health Inequalities Steering Group (PHISG) meeting held on 20 November 2025. A Knox thanked the team for the work on the report and highlighted the good news about funding for the tobacco</p>	

	dependency service. RESOLVED: That the committee noted the report.	
137/ 2526	<u>AAA report - Primary Care Quality Group</u> The report provided an update from the Primary Care Quality Group (PCQG) meeting held on 26 November 2025. K Lord referenced the depth and breadth of the work being undertaken and acknowledged the fragility of the workforce and the volume of work. A White noted that primary care was more than just general practice and questioned whether this should be reflected. However, K Lord advised they did not cover some of the other areas such as pharmacy and dental within the quality team. RESOLVED: That the committee noted the report.	
138/ 2526	<u>Committee escalation and assurance report to the Board</u> Members noted the items which would be included in the report to the Board. RESOLVED: That the committee noted that a report would be taken to Board.	
139/ 2526	<u>Items referred to other committees</u> None. RESOLVED: That the committee	
140/ 2526	<u>New directives/regulations/reviews that have been published:</u> None. RESOLVED: That there were no new directives/regulations/reviews.	
141/ 2526	<u>Any Other Business</u> No other business was raised. RESOLVED: That there was no other business.	
142/ 2526	<u>Items for the Risk Register</u> There were no new items for the risk register RESOLVED: That there were no new items for the risk register.	
143/ 2526	<u>Reflections from the Meeting</u> The Chair reflected that having a smaller agenda allowed time for better consideration of items. J O'Brien thanked report authors that the papers had been more focused and more about assurance. RESOLVED: That the committee note the reflections.	
144/ 2526	<u>Date, Time and Venue of Next Meeting</u> The Quality and Outcomes Committee would be held on Wednesday, 4 March 2026, 1:30pm – 4:00pm, Lune Room, ICB Offices, County Hall, Preston.	