NHS
Lancashire and South Cumbria
Integrated Care Board

Approved at the 8 April 2026 meeting

Minutes of the ICB Quality and Outcomes Committee held on Wednesday 4 March 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
Jane Scattergood	Interim Chief Nurse	L&SC ICB
Julie Colclough	Primary Care Partner Member	L&SC ICB
Regular participants		
Kathryn Lord	Director, Quality Assurance and Safety	L&SC ICB
Neil Greaves	Director of Communications and Engagement	L&SC ICB
Andy White	Chief Pharmacist	L&SC ICB
Peter Tinson	Director of Primary Care	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
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
Ann Dunne (item 7)	Director of Safeguarding	L&SC ICB
Wendy Lewis (items 9 & 10)	Director of System Coordination and Flow	L&SC ICB
Alex Wells (item 12)	Head of Recovery & Transformation PMO	L&SC ICB
Rakhee Jethwa (item 14)	Associate Director All Age Continuing Care (AACC) and Individual Patient Activity (IPA)	L&SC ICB
Suzanne Penrose (item 17)	Transformation Pharmacist, Medicines Optimisation	L&SC ICB
Sarah Mattocks	Head of Governance	L&SC ICB
Bimpe Kuti-Matekenya	Aspirant Non-Executive Director	University of Greater Manchester

Item No	Item	Action
145/ 2526	**Welcome, Introductions and Chair's Remarks** The Chair welcomed all to the meeting.	
146/ 2526	**Apologies for Absence/Quoracy of Meeting** Apologies had been received from Sam Westwell and Debra Atkinson. Arif Rajpura would join from approximately 2:30pm due to an unavoidable conflict. The meeting was quorate.	
147/ 2526	**Declarations of Interest** The Chair noted that no additional declarations of interest had been made prior to the	

	meeting and asked if at any point during the meeting a conflict arose, to declare at that time. **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.**	
148/ 2526	**a) <u>Minutes of the Meeting Held on 7 January 2026 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 20 was on the agenda for the meeting today, but A Patel advised this would be deferred to the next meeting alternate meeting when this report would be due as work remained ongoing. Referral 1 – K Lord advised there would be several different workstreams as this remained ongoing and discussions would be undertaken at the Part 2 meeting today. Referral 2 – remained ongoing. **RESOLVED: That the action log would be updated as discussed.**	
149/ 2526	**<u>Patient story</u>** A patient story relating to perinatal mental health had been circulated with the meeting papers. K Lord provided an overview of feedback received, highlighting the positive impact of autism-informed, person-centred care and the importance of compassion, kindness and active listening. The discussion aligned with the Oliver McGowan Mandatory Training, which supported workforce awareness and understanding. Reference was also made to the Ribblesmere Mother and Baby Unit in Chorley, with eight beds where mothers and families could be alongside their babies, with very positive feedback and outcomes reported. J Colclough noted again the importance of learning disability passports and suggested they be included as part of maternity care. The Chair felt the story had been well articulated and it was good to have a perinatal mental health story as this demonstrated that this was considering the whole person, which applied to lots of elements regarding quality and outcomes for people across the domains of safety, effectiveness and experience. It was also interesting to reflect on the role of the ICB as strategic commissioning going forwards and how services were planned for whole population needs. B Kuti-Matekenya suggested that consideration be given to introducing a more structured approach to involving people in curating and co-designing solutions, to ensure that insights from patient stories translated into commissioning decisions and service redesign, rather than remaining isolated learning points. N Greaves noted that designing services with people was a key principle, with insights from this and similar work informing commissioning intentions, including the five-year commissioning plan. He further emphasised the importance of continuing to embed co-production and co-design at neighbourhood and place level. While supporting mechanisms were in place, it was acknowledged that further work was required and that this focus was	

	central to the development of the organisation's new operating model. **RESOLVED: That the committee noted the content of the story.**	
150/ 2526	**<u>Patient Safety Incident Response Framework (PSIRF) Provider Policy & Plan Update</u>** K Lord advised that approval was being sought from the committee for the policies and plans for Mind in Furness and Rossendale Hospice. These had been reviewed by the Patient Safety Team in line with the agreed PSIRF checklist and reassurance was given to the committee that these met the standards in line with national policy. The Chair questioned if there were any outstanding providers that did not have this in place. K Lord advised that the piece of work for general practice had not yet been enacted due to capacity, but a risk was held for this on the register. **RESOLVED: That the committee:** • **Noted the report.** • **Considered and supported approval of the provider PSIRF Policies and Plans recommended in section 2.**	
151/ 2526	**<u>Clinical Strategy update</u>** ****the agenda was taken out of order**** A Knox advised that the clinical strategy would be a key piece of work in shaping the ICB's direction over the next five to ten years and would be closely aligned with commissioning intentions. Thanks were recorded to Terry Whalley for the work completed to date; however, it was noted that the document now required significant refinement. The strategy had been informed by input from members of the public, clinicians and system partners, but required further development to ensure clarity and deliverability. Sinead Foster and Jess Williams from the PMO team would be involved from 1 April following Terry Whalley's departure. A Knox and J Scattergood would continue as executive sponsors, with Andy Curran continuing to lead from a clinical perspective. Once refined, the strategy would be progressed through the Executive Committee, Private Board and Public Board between now and June. The Chair reflected on the role of the committee in relation to the strategy, noting that while the paper was for noting, it was important for the committee to be assured that the developing strategy adequately reflected current quality challenges and the delivery of positive outcomes for the population. Also, clarity was needed on how the strategy identified and addressed these issues as it was finalised and progressed. A Knox advised that the strategy had been developed in line with the Institute for Healthcare Improvement (IHI) five principles, adopting a population health approach focused on improving access, experience and outcomes, and addressing variation in quality, including health inequalities. He outlined how the strategy would provide a clear 'golden thread' into acute and primary care clinical strategies, ensuring alignment between strategy and commissioning. The importance of effective oversight was highlighted, supported by benchmarking across trusts, places and PCNs, with health equity, finance, culture and the quintuple aim embedded throughout, underpinned by appropriate use of data. J Scattergood agreed that the strategy would act as a clear guiding principle for commissioning intentions, with future planning aligned to embed population outcomes and the reduction of unwarranted variation. The strategy was also recognised as offering a consistent framework for neighbourhood-level working, supporting a shift towards prevention and population health outcomes while balancing financial pressures and current demand. Members highlighted the importance of prioritising investment in neighbourhoods and noted that embedding the strategy across commissioning and contracting activity would support consistent decision-making. It was agreed that this approach would provide a platform for ongoing assurance over the next three to five years, enabling the committee to monitor alignment with the strategy and its impact on	

	quality and outcomes. J O'Brien referenced the Strasys work and the clinical strategy development undertaken with acute partners, noting the importance of alignment with the ICB clinical strategy, as strategic commissioning would be informed by provider clinical strategies. A Knox advised that the ICB clinical strategy was the foundational framework guiding commissioning decisions, with commissioning priorities flowing through the Provider Collaborative Board and GP Confederation. Providers would be expected to align their clinical strategies with the ICB's commissioning and clinical strategies to demonstrate delivery of agreed outcomes. It was noted that while the strategy set a five- to ten-year direction, priorities would be reviewed annually in response to data and community insight, allowing for targeted focus on areas of unwarranted variation. This approach would ensure the strategy was consistently applied across the system while remaining responsive to changing needs. It was confirmed that the work undertaken by Strasys and PA Consulting was well regarded and the clinical strategy would support and enable its implementation through aligned commissioning and strategic decision-making. A Knox confirmed the refined strategy would be presented to Board in June and it was suggested it could be brought to committee prior to that date. ***Post committee note:*** At the committee agenda setting meeting on 5 March, it was agreed by J Scattergood and the Chair that timings of meetings would not permit the strategy to be presented to committee prior to going to Board and therefore it would not be brought back to a future meeting. **RESOLVED: That the committee noted the report.**	
152/ 2526	**<u>LSCICB Safeguarding Dashboard 2025-26, Q4</u>** ****the order of the agenda resumed** A Dunne presented the Q3 safeguarding data for the ICB, noting that many issues reflected longer-term safeguarding risks. A new performance framework for children in care and care leavers has improved understanding of system variation. While review health assessments were performing well, initial health assessments remained below standard, with improvement plans in place. Risks were highlighted in relation to the interim medical advisor model for adoption and fostering, MASH provision—particularly in Westmorland and Furness—and ongoing Court of Protection backlogs, with recovery actions underway. Members were also advised of a Multi-Agency Risk Reduction Assessment Co-ordination (MARRAC) backlog of approximately 500 cases and that work was progressing with partners to address this. Two areas of Section 11 compliance remained outstanding, relating to training compliance and the management of allegations policy, which was pending ratification. The Chair noted thanks for the report and clear presentation of the data. M Warren advised that CQC had consulted on new characteristics for adult safeguarding assessments and highlighted the need for boards to evidence safeguarding as everyone's responsibility, supported by clear roles, strong multi-agency partnerships and a shared understanding of Section 42 enquiries. The Chair agreed that a self-assessment would be helpful and asked that A Dunne consider this with partners. M Warren also suggested a multi-agency peer review, noting that the Blackburn with Darwen Safeguarding Adults Board development day on 1 April could inform this work. The Chair noted the risks associated with meeting statutory duties and emphasised the importance of tracking the impact of mitigations. J Colclough queried whether any further action could be taken to escalate or provide additional support in relation to the backlog of cases with the police. A Dunne advised that the ICB was discharging its statutory responsibilities in partnership with the police and that the backlog was primarily due to volume pressures The MARRAC had its own governance arrangements and	**AD / MW (email)**

	issues were also reported through the Domestic Abuse Board and Community Safety Partnerships, all of which the ICB was represented on. J Scattergood emphasised the importance of maintaining effective relationships with local statutory safeguarding partners. It was noted that concerns regarding the ICB's capacity to contribute to NHS England, in the context of reductions to the running cost envelope, should be escalated through the AAA report to Board to inform scrutiny of related proposals. The committee recognised the need to maximise both local partnerships and the ICB's role within the wider NHS system. J O'Brien noted that the People and Culture Committee would be transitioning to an organisational change committee and suggested that a referral be made regarding statutory responsibilities, to ensure that sufficient resource in terms of workforce was maintained during the transition to enable the ICB to continue to meet its statutory obligations. The Chair noted thanks to A Dunne and the team. A Dunne left the meeting. **RESOLVED: That the committee reviewed and considered the activity, data, narrative and context presented to gain a level of confidence that the Safeguarding Team is doing all it can to ensure it delivers 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.**	
153/ 2526	**<u>Urgent & Emergency Care / Winter Plan update</u>** W Lewis joined the meeting. K Lord highlighted that quality visits had been undertaken across all four systems, with a focus on mental health action cards, and noted sustained system pressure over a challenging winter. While positive feedback had been received regarding staff compassion, patient and staff experience remained poor due to overcrowding and prolonged waits. Harm reviews were undertaken consistently, with increasing focus on longer-term impacts and variation in timeliness and approach across systems. Good practice at Furness General Hospital was noted for sharing. The use of corridor care and associated estate variation was discussed, alongside environmental mitigations and ongoing challenges with infection prevention and control. It was reported that staff felt listened to and empowered to influence care delivery. Key risks were highlighted in relation to pediatric emergency departments, including estate constraints and workforce capacity, particularly the availability of senior pediatric nurses and staff with appropriate life-support training. Ongoing pressures within mental health services were noted, with limited inpatient capacity and recognition that emergency departments were not always appropriate environments for people in mental health crisis; however, assurance was provided regarding the effective use of mental health action cards. Challenges were also identified in relation to learning disability and autism services, including delays in identification and implementation of reasonable adjustments, although actions were underway and senior learning disability nurses were working collaboratively across the system. It was acknowledged that sustained system pressure continued to result in harm and care being delivered in non-standard environments, and that while good practice had been identified and shared, ongoing risk remained, and mitigations continued to focus on delivering care as safely and effectively as possible. A Rajpura joined at 2.34pm.	

	W Lewis advised that the system entered winter in a more escalated position than in previous years, although mature UEC recovery plans, stronger cross-system working, and the use of the Shrewd dashboard provided improved oversight and coordination. It was highlighted that BTH continued to experience challenges with 12-hour waits, and that Morecambe Bay was underperforming against the four-hour standard and criteria-to-reside, with mitigations in place. System pressures were monitored through dynamic OPEL scoring, with several periods of OPEL 4 declared, most of which were resolved within 72 hours. A prolonged period of OPEL 4 at BTH was noted, with reviews underway locally and at ICB level. The introduction of the national Handover 45 standard was reported to have contributed to corridor care pressures, and a national programme on corridor care was underway, with local provider involvement. Winter learning was being captured through system-wide reviews, with mitigations for 2026/27 focused on care coordination, intermediate care, corridor care, new ED models, and the implementation of national standards for care in the first 72 hours. Further work was identified to strengthen use of the Shrewd system and improve planning for winter surge, particularly for respiratory demand. J O'Brien acknowledged the challenging circumstances and recognised that staff were doing their best in the context of demand exceeding capacity. J Colclough highlighted the impact of staffing ratios on cost, noting increased reliance on overtime and agency staffing. K Lord advised that efforts were being made to utilise bank staff familiar with the organisation to manage costs; however, it was recognised that sustained additional shifts were contributing to staff exhaustion and sickness. A Rajpura expressed concern regarding the use of corridor care and emphasised the need for a clear exit strategy, noting that hospitals should not function as care homes and that older people should be treated acutely in the community as part of neighbourhood health approaches. W Lewis confirmed that a UEC demand management programme was in place, recognising the need to consider quality, operational delivery and financial impact together. It was highlighted that the system needed a more consistent and shared approach to risk ownership, with clarity on where risk was held and how it was managed collectively, recognising that fragmented views of risk created barriers to effective mitigation and ultimately impacted patients. The Chair noted thanks for the report, but that current quality and outcomes were not at the level desired for the population; however, assurance was given that work was underway to deliver the best possible care for patients and staff. It was acknowledged that mitigations were not ideal but were necessary to respond to demand and environmental pressures. The Chair sought assurance regarding provider compliance with the recently introduced Standards for Care of Acutely Unwell Patients in their First 72 Hours in Hospital. K Lord advised that the reporting deadline had been the end of January and that feedback was awaited, with an update to be brought to a future meeting. The importance of compassionate, community-based care and timely access to high-quality inpatient care when required was noted. **RESOLVED: That the committee noted the report.**	**Business Plan**
154/ 2526	**<u>Rapid Improvement Event – All Age Continuing Care Complaints Process</u>** W Lewis advised that a review of the All Age Continuing Care complaints process had been undertaken to address delays, backlog and quality impact. A three-day rapid improvement event identified significant inefficiencies, reducing the process from 33 steps to 10 and establishing a 60-day response target, supported by strengthened escalation and quality markers. Work was underway to address the backlog through capacity and demand modelling, with a 30-, 60- and 90-day implementation and sustainability plan in place. J Scattergood noted thanks to W Lewis for the work undertaken and whilst there were lots to take forward there was a rigorous plan in place. The Chair queried how the committee could best maintain oversight of the impact of the	

	changes being implemented, including how impact should be measured, at what point progress should be challenged if expected outcomes were not being achieved, and how learning and assurance would be effectively closed-looped. W Lewis advised that reportable measures were in place, including 30-, 60- and 90-day milestones and a sustainability plan. It was noted that reporting would demonstrate reductions in backlog and response times, with a formal review planned after one year and measurable improvement expected within six months. M Warren emphasised that patient experience was paramount and suggested that impact could be measured through delivery of the Continuing Healthcare elements of the Memorandum of Understanding between the ICB and local authorities, with confirmation of progress providing assurance and supporting improved outcomes for individuals. J Scattergood noted that while some All Age Continuing Care complaints would continue to arise from dissatisfaction with eligibility decisions, improvements to the timeliness and quality of the complaints process alongside appeals could significantly reduce complaints linked to protracted processes, while recognising that a residual level of complaints would remain. K Lord thanked the committee for its support in escalating the complaints backlog, noting that this had made a material difference, with recruitment underway to support the improvement work. J Colclough suggested there could there be some shared learning across ICB teams on complaints handling. W Lewis agreed that the process could be shared but clarified that while the complaints process was reviewed in its entirety, escalation and detailed improvement work focused on addressing All Age Continuing Care backlogs and delays. The Chair thanked W Lewis for the work undertaken. W Lewis left the meeting. **RESOLVED: That the committee:** • **Noted the findings of the RIE.** • **Approved the new process and escalation procedure.**	
155/ 2526	**<u>Integrated Performance Report (including update on elective care)</u>** G Mather introduced the report which covered December and January. Several performance indicators were below standard, which was expected for the time of year. While pressures remained, several positive areas were highlighted, including increased Pharmacy First referrals, strong performance in virtual wards and hospital at home occupancy, improving GP appointment activity, and reductions in some community waiting lists. NHS England's increased focus on RTT performance was noted, including the ambition to return to the 92% 18-week standard over the medium term. A Quarter 4 RTT sprint had been implemented to accelerate activity, supported by additional investment across acute and independent sector providers. It was reported that the system was already on a recovery trajectory, with further improvement anticipated by the end of the financial year, subject to ongoing weekly NHS England scrutiny. While delivery at pace carried some risk, providers had provided assurance that planned activity would be delivered, with an estimated improvement of approximately 3% in RTT performance, equating to around 12,000 patients being treated or removed from waiting lists. Further additional funding had recently been confirmed to support independent sector activity. The committee noted the breadth of information contained within the report, including updates on patient safety and health inequalities, and that further work on inequalities within elective care would be brought back to a future meeting. P Tinson noted that the new GP contract would introduce five access-related metrics, including call waiting times and same-day access, and that changes to urgent dental care targets following dental reform would be reflected in future reporting.	

	K Lord noted that there had been a high number of never events reported between 1 September and 1 March, and that significant work was ongoing nationally in response to the increased incidence across the country. A Knox referenced the importance of checklists as when staff are under pressure basic things are forgotten and suggested that absolutely everyone be included in the checklist before procedures are undertaken as these avoided mistakes. The Chair referenced the waiting list deep dive scheduled between April and July, and A Patel advised that the original deep dive was on RTT. Additional work would need to be undertaken regarding community children's waiting lists and if this was not available for the next report, something would be scheduled in the future. The Chair further noted the reduction in healthy life expectancy and highlighted the need for this to be considered as the ICB moved further into strategic commissioning, with clear links to the clinical strategy and the actions required to reverse current trends. It was noted that progress was moving in the opposite direction to that intended, prompting further reflection. **RESOLVED: That the committee noted the report.**	**Business Plan**
156/ 2526	**<u>Quality Impact Assessment update</u>** A Wells introduced the report, which gave assurance that progress continued to be made in response to national guidance on Quality Impact Assessments (QIAs). An update was provided on the implementation of revised QIA principles, with quality elements successfully embedded, supported by improved training, guidance and staff engagement. Work was ongoing to incorporate equality and diversity domains into an integrated impact assessment, with a template under review and implementation on track by the end of the month. It was noted that new functionality, including the use of AI tools, had been developed to support completion and review of assessments. Assurance was provided that current processes were operating effectively, with no issues requiring escalation. The Chair noted thanks for the clear summary and acknowledged the progress made to date. A Wells advised that as part of planning for 2026/27, colleagues across the organisation had embraced the use of Quality Impact Assessments (QIAs), with good progress being made. Reflection was given to the significant improvement from previous years, when QIAs were not consistently embedded or were completed retrospectively, and recognition was given to the organisation for the positive shift in approach. A Wells left the meeting. **RESOLVED: That the committee noted the ongoing assurance and the progress being made to further enhance processes.**	
157/ 2526	**LSCICB Quality Governance Framework** K Lord noted that the Quality Governance Framework, based on National Quality Board guidance and aligned to BAF risk 006, continued to provide assurance that the ICB was adhering to required principles, supported by audit processes including Rapid Quality Reviews. It was proposed that a full review be deferred to Quarter 3, to align with organisational change and forthcoming national guidance. **RESOLVED: That the committee noted the report; agreed to a deferral of administrative updates in respect of committee and group titles and to receive the updated QGF at the end of Q3 2026/27.**	**Business plan**
158/ 2526	**<u>All Age Continuing Care (AACC) and Individual Patient Activity (IPA) – monthly update</u>**	

	B Seddon and R Jethwa joined the meeting to present this item. J Scattergood noted that the paper reflected progress in clearly differentiating reporting between the Finance and Contracting Committee and the Quality and Outcomes Committee. B Seddon reported that the service continued to identify quality improvement themes through complaints, audits and appeals, with learning embedded within a single turnaround plan. Despite workforce pressures, including high sickness and vacancies, quality premium targets continued to be met, providing timely access to Continuing Healthcare assessments and outcomes. Operational challenges were noted, including a 20% increase in overdue fast-track reviews during December and January, with mitigations in place through recruitment, business continuity planning and transitional arrangements ahead of planned voluntary redundancies. Progress was noted in improving patient experience through a revised complaints escalation process, with further work underway to strengthen thematic analysis via the Ulysses system. Safeguarding and incident reporting were identified as areas for further development due to the absence of a fit-for-purpose reporting system. A clinical audit of the Discharge to Assess pathway highlighted a high proportion of individuals discharged to care homes and not returning home, with findings informing ongoing quality improvement work and future programme development. The Chair thanked the team for the significant progress made in improving committee assurance on quality and outcomes in relation to All Age Continuing Care, noting that the report was helpful and that oversight arrangements were continuing to strengthen. R Jethwa added that Northwest regional colleagues had been praising the service on consistent delivery, quality premium, run rate reduction and activity volume reduction. Changes were being made to the service model to ensure business continuity of statutory functions was maintained and ensure fast track referrals were prioritised accordingly. J O'Brien sought assurance regarding safeguarding and incident reporting, noting concerns about the absence of clear mitigations. B Seddon advised that separate reporting routes were in place, with incident reporting available via the Health and Safety Team and intranet, although further work was required to improve reporting and thematic analysis. While safeguarding training compliance was confirmed, assurance could not currently be provided due to the absence of a fit-for-purpose reporting system, with interim reliance on manual tracking. It was noted that Ulysses was being explored as a potential solution, alongside a review of governance arrangements to strengthen oversight of safeguarding learning and actions. J Colclough suggested granting care home providers access to Ulysses as another method for data to be submitted. B Seddon advised that this had been discussed with colleagues from the care sector, including consideration of how the model aligned with independent care providers such as standalone nursing and care homes. It was noted that while work was ongoing to develop a consistent approach, further consideration was required to ensure that the right information was captured to support this. It was agreed that 74% of patients referred to AACC Discharge to Assess team lived in their own home prior to admission with only 7% of patients returning home be an alert to Board. **RESOLVED: the committee noted the report and approved the actions and recommendations.**	
159/ 2526	**<u>East Lancashire Hospitals Trust Histopathology update and assurance</u>** It was agreed this would be kept under scrutiny. **RESOLVED: That the committee:** • **Noted the current position and the improvements made in urgent, 2WW, and long wait performance.**	

	• **Acknowledged the ongoing risks associated with workforce instability, rising demand and reduced external support.** • **Noted the continued use of outsourcing and short-term capacity measures while longer term staffing solutions are progressed.**	
160/ 2526	**Policy for Joint Working with the Pharmaceutical Industry and other Pharmaceutical Commercial Organisations** A White advised only minimal changes have been made to the policy. **RESOLVED: That the committee approved the changes to the policy.**	
161/ 2526	**L&SC ICB Antimicrobial Resistance (AMR) & Infection Prevention and Control (IPC) improvement priority areas** S Penrose joined the meeting. The Chair requested that due to time constraints this item be deferred to the next meeting. **RESOLVED: That the item be deferred to the next committee meeting on 8 April.**	
163/ 2526	**Review of committee effectiveness** It was agreed that this be undertaken via a survey submitted by email and a report be presented back to the committee at the next meeting.	
164/ 2526	**AAA report – Prevention and Health Inequalities Steering Group** A Knox advised the report gave assurance that action was being taken on learning gleaned. G Mather noted that the report referred to a deep dive into inequalities into planned care and that this work was running between April and July therefore an update could be brought to the next meeting as the full report would not be ready at that time. **RESOLVED: That the committee noted the report.**	
165/ 2526	**AAA report – Primary Care Quality Group** K Lord referenced the significant volume of work going through the group and the challenge in capacity to deal with this. **RESOLVED: That the committee noted the report.**	
166/ 2526	**Committee escalation and assurance report to the Board** Members noted the items which would be included in the report to the Board. **RESOLVED: That the committee noted that a report would be taken to Board.**	
167/ 2526	**Items referred to other committees** A referral be made to the committee that would replace People and Culture Committee regarding statutory responsibilities, to ensure that sufficient resource in terms of workforce was maintained during the transition to enable the ICB to continue to meet its statutory obligations. **RESOLVED: That the committee noted the referral to be made.**	
168/ 2526	**New directives/regulations/reviews that have been published:** None. **RESOLVED: That there were no new directives/regulations/reviews.**	
169/ 2526	**Any Other Business**	

	No other business was raised. **RESOLVED: That there was no other business.**	
170/ 2526	**Items for the Risk Register** There were no new items for the risk register **RESOLVED: That there were no new items for the risk register.**	
171/ 2526	**Reflections from the Meeting** **RESOLVED: That the committee note the reflections.**	
172/ 2526	**Date, Time and Venue of Next Meeting** The Quality and Outcomes Committee would be held on Wednesday, 8 April 2026, 1:30pm – 4:00pm, on MS Teams.	