NHS
Lancashire and South Cumbria
Integrated Care Board

Subject to approval at the next meeting

Minutes of a Meeting of the Integrated Care Board Held in Public on Thursday, 22 May 2025 at 1.00pm in the Lune Meeting Room, ICB Offices, Level 3 Christ Church Precinct, County Hall, Preston, PR1 8XB

Part 1

	Name	Job Title
Members	Emma Woollett	Chair
	Sheena Cumiskey	Deputy Chair/Non-Executive Member
	Jim Birrell	Non-Executive Member
	Jane O'Brien	Non-Executive Member
	Steve Igoe	Non-Executive Member
	Professor Sarah O'Brien	Chief Nursing Officer
	Sam Proffitt	Acting Chief Executive
	Stephen Downs	Acting Chief Finance Officer
	Dr Andy Knox	Acting Medical Director
	Dr Julie Colclough	Partner Member – Primary Care
	Aaron Cummins	Partner Member – Trust/Foundation Trust – Acute and Community Services
	Chris Oliver	Partner Member – Trust/Foundation Trust – Mental Health
Regular Participants	Debbie Eyitayo	Chief People Officer
	Professor Craig Harris	Chief Operating Officer & Chief Commissioner
	Asim Patel	Chief Digital Officer
	Debra Atkinson	Company Secretary/Director of Corporate Governance
	Neil Greaves	Director of Communications and Engagement
	Dr Sakthi Karunanithi	Director of Public Health, Lancashire County Council
	Tracy Hopkins	Voluntary, Community, Faith & Social Enterprise
	Steve Spill	Associate Non-Executive
In attendance	Sarah James	Integrated Place Leader, Central Lancashire
	Dr Lizzy MacPhie	Clinical and Care Leader
	Jo Leeming	Committee and Governance Officer (minutes)

Ref	Item
56/25	**Welcome and Introductions** The Chair, Emma Woollett, opened the meeting and welcomed everyone, thanking the members of the public who were observing the Board meeting either in person or through the live stream. The Chair also welcomed Sarah James, Integrated Place Leader, Central Lancashire and Dr Lizzy MacPhie, Clinical and Care leader who had joined the meeting for discussion on item 5. The Chair advised of changes to the ICB Board further to the last meeting being held and expressed her thanks to K Lavery, former Chief Executive, who left the ICB at the end of April

	2025, for his significant contribution to the ICB and the system. She advised that S Proffitt, had commenced in role as Acting Chief Executive, with S Downs becoming Acting Chief Finance Officer. The Chair extended a welcome to Dr A Knox, Acting Medical Director; S Igoe, Non-Executive Member, who was the Chair of the ICB Finance and Contracting Committee and Steve Spill, Associate Non-Executive noting this was the first public Board meeting for these colleagues. She recognised the new appointments would bring energy, commitment and significant experience to address the challenges and opportunities faced by the ICB.
57/25	**<u>Apologies for Absence/Quoracy of Meeting</u>** Apologies for absence had been received from R Fisher, Non-Executive member, D Corcoran, Non-Executive member, D Park, Partner Member – Local Authorities, regular participants D Blacklock. It was noted that C Whalley, Director of Adult Services (Westmorland and Furness), had intended to join the meeting, however due to unforeseen circumstances her retrospective apologies were noted. The meeting was quorate. The Chair advised that time should be used mainly for discussions and requested short introductions to papers to ensure the substantive work was undertaken questions and answers.
58/25	**<u>Declarations of Interest</u>** The Chair noted that no declarations of interest had been advised of prior to the meeting but requested that should these arise during discussion that these were advised of. **RESOLVED: That there were no declarations of interest raised which related to the business items on the agenda. The Chair would be advised of any conflicts that arise during the meeting as appropriate.** **Board Register of Interests -** Noted.
59/25	**<u>Minutes of the Board Meeting Held on 19 March 2025, Matters Arising and Action Log</u>** **RESOLVED: That the minutes of the meeting held on 19 March 2025 be approved as a correct record.** **<u>Matters Arising and Action Log</u>** There were three actions recorded on the log with progress updates advised of. Members were content for all three actions to be closed. **RESOLVED: That all actions on the log should be closed.**
60/25	**<u>Patient Experience</u>** S O'Brien introduced the item and explained that the format would differ from what was usually presented to Board. Rather than a video from an individual being shared, S James & Dr MacPhie would share how they had worked with a population group within a community. She commented this was very pertinent as this related to the transformation roadmap, the insights report, and driving better outcomes, all of which would be discussed later in the meeting. S James shared a presentation, which highlighted some key that were key to the role of the ICB:

	➢ A shift from a patient experience story to a population experience story ➢ A shift from "doing to" to "working with" communities, working closely through the Preston Health and Wellbeing Partnership to reach out to have community conversations in two wards in Preston (St Matthews and Ribbleton wards) to identify the issues that matter most to those communities such as crime, food poverty, and child development issues ➢ A shift from reactive management to proactive support, giving the example of the Preston Rough Sleepers Project, which moved primary care services into non-NHS settings alongside the city council and VCFSE organisations to provide a range of services in an accessible setting for this vulnerable population group, who otherwise did not access primary care ➢ A shift from treatment to prevention and hospital to community, giving the example of the Physical Activity and Healthcare Co-location Project. Dr MacPhie expanded on the Physical Activity and Healthcare Co-Location project explaining that this related to moving from treatment to prevention and therefore from hospital to community. One aspect of this project was the 'escape pain programme' which provided encouragement for patients to participate in a core strengthening exercise to motivate those with arthritic pain to be more active and enable them to continue normal activities. She advised the programme had been delivered at three leisure centres, across Chorley and South Ribble, which aimed to both address the lack of hospital estate provision and avoid health inequalities with regard to access. Patient feedback has been excellent, and many people continue to attend the health centre on reduced membership offers. Options are being explored to widen the scope with an ambition to commission services on a larger scale but adapted to different populations (e.g. non-English speaking). The Chair thanked S James and Dr MacPhie for an inspirational start to the Board meeting, which grounded members as to what the ICB was here to deliver. A Patel was mindful that this example encapsulated what the ICB was set up to provide, to plan health and care services around the population. He commented on the hospital avoidances which had been evidenced from this project, noting that should this data be extrapolated for the year this would equate to 120 hospital avoidances for that small group of patients. He referenced the performance report, which would be presented later in the meeting, which highlighted the increasing demand for services, commenting that projects such as this example was a must to deliver to be able to control the demand for services and transfer care closer to home. C Oliver queried how these projects were communicated and captured, thereby ensuring that colleagues understood how to refer into the services and how this could be combined into health, social and neighbourhood care. A Patel responded to advise of the work which had been undertaken around high intensity users who present on numerous occasions to A&E but where data highlighting that no interventions had taken place further to the attendance as it was not related to healthcare reasons. He commented there was not a shortage of data but stressed the importance as to how the data was utilised to make improvements in the provisions and services commissioned to ensure these were related to commissioning population health level interventions. A Knox referenced the challenge of how this example could be scaled and spread across Lancashire and South Cumbria. He provided assurances that similar interventions had commenced in areas across the footprint, which was included in the roadmap and future vision to have high-quality community healthcare by 2035. He referenced the model ICB blueprint, the new sense of strategic commissioning and the move to an approach to commissioning for population health. He noted that the data alone would not address inequalities within communities, but this would be utilised to support engagement with communities and partnership working in neighbourhoods to transform care. He recognised that this work has

	already commenced, but it needed to be upscaled to deliver further community transformation. T Hopkins commended the work which had been undertaken to date which focused on taking services to communities which she felt to be the future of health and care and commented that this example would remove healthcare related stigma for services users regarding access to services which they may have previously not accessed due to how they may have felt. She raised a note of caution that not all services could be replicated in every area as services needed to be commissioned based on the needs of each population. S Karunanithi emphasised the importance of systematic collaboration and the need for a structured approach to commissioning services. He acknowledged the good work being undertaken but recognised that some successful projects might not be reflected in the short-term commissioning plans, with some projects not proceeding as expected and he therefore highlighted the need for a reality check between ambition and actual implementation. He noted that it was essential to embed the successful projects into the commissioning plan, estates plan, and workforce strategy. J Colclough recognised the integrated neighbourhood teams were a great resource for developing their own digital directories which would serve as a resource as to what services were available within communities. A Cummins recognised the challenge for the Board about the tension between centralising strategic intent, local development and local autonomy to make decisions. Therefore, consideration was needed as to how a central function and strategic roadmap could be created which would provide knowledge and training for communities to implement themselves and ensure autonomy is within the communities. S Proffitt advised the operating model for the future would support the ongoing work and acknowledged the presentation to Board covered all the aspirations of the ICB. She recognised the work undertaken through these projects which addressed the needs of the population, and the changes implemented to support those needs. Thanks were expressed to S James and Dr MacPhie for their significant contributions and commitment to driving this work. *S James and Dr MacPhie left the meeting.* **RESOLVED: That the ICB Board noted the presentation.**
61/25	**<u>Chair's Report</u>** The report provided an update on the engagement and work undertaken by the Chair and current and pertinent issues. The Chair advised that since the report was written she had attended, along with S Proffitt and the Chairs and Chief Executives of Blackpool Teaching Hospitals, Lancashire Teaching Hospitals and East Lancashire Hospitals, a recovery and support programme entry meeting with NHSE. She advised this was a formal step as part of the recovery and support programme which the ICB was currently in. She reported the meeting provided an opportunity to reflect on the progress made to date, the work yet to be undertaken to meet the signed undertakings and the clear ambition of the ICB to exit the recovery and support programme as soon as possible. The Chair advised the meeting was positive with good feedback having been received. She commented that there was a strong sense of speaking as a system and ownership of the required actions. She commented that progress has been made, and that this was evident in some of the papers being presented today, noting the run rate improvement in the last quarter of 2024/25 both

	within the ICB and across the system, which allowed a reduction in overspend for 2024/25. The robust plans for the coming year were also noted which provided greater confidence in the ICB's ability to deliver. The Chair referenced the transformation roadmap, which would be presented today, and the insights report, which described what has been learned from listening and engaging to develop the insights that underpin the plans of the ICB. She also advised the terms of reference for the new committees were being embedded and provided greater focus on delivering quality and efficiency improvements, emphasising the importance of the committees providing the Board with robust assurance, which The Chair was monitoring with support from the individual committee chairs. The Chair advised that S Proffitt would provide an update against the restructuring the ICB within her report to Board. Finally, the Chair emphasised the achievement of the desired outcomes could not be delivered in isolation, and recognised the executive team was addressing issues that had hindered the ability to work well with partners across the system by strengthening governance and grip which was key to ensuring the ICB was a good partner to other organisations. She recognised that much work remained to be undertaken however, she reported increasing levels of confidence in the direction of travel, and noted the improvements being made now would enable the ICB to deliver its plans to better serve the needs of the population of Lancashire and South Cumbria. **RESOLVED: That the ICB Board note the report.**
62/25	**<u>Report of the Chief Executive</u>** S Proffitt spoke to the circulated report which provided an update on leadership changes within the ICB and the latest updated position on the recently announced ICB reforms. It also included an update on the recently approved Local Enhanced Service (LES) scheme with General Practice. S Proffitt expressed her thanks for the hard work, which was being undertaken to make a difference, despite the challenging period of change, noting the positive progress which was being delivered. She gave her commitment whilst in the privileged position of acting Chief Executive Officer, to bring leadership and clarity to navigate the next few months. S Proffitt commented on the new operating model, recognising this would bring a period of uncertainty for staff as the ICB had to reduce its running costs by 47%. She advised of a clear set of values which had been developed for the ICB, providing assurance and commitment that the changes required would be undertaken with those values at the heart of it. It was noted the new operating model would present an opportunity to create the correct infrastructure which would require a significant focus on listening to and engaging with staff and partners to ensure the success of the ICB blueprint. She further advised of the work which had commenced to apply the model ICB blueprint, noting that this was not a prescribed structure. The plan was to be submitted to NHSE by the end of May 2025 and arrangements had to be in place by December 2025. Following the submission, a consultation period would commence to engage with all staff and partners, which would build on the vision and provide an opportunity to reset the organisation in line with that vision. The main focus of the ICB moving forward would be as a strategic commissioner, which would mean that through the utilisation of good intelligence and engagement we understood the needs

	of the population, building on neighbourhood models, and commissioning the correct services. It was noted that this approach would vary depending on the locality to meet the needs of each population. S Proffitt advised the focus aligned with the ICB's purpose and would facilitate the necessary changes to focus on community out-of-hospital models, providing services in the right place with a shift to prevention rather than just treatment. She stressed that digital transformation was crucial, as digital enablement was currently a barrier but also presented a significant opportunity. The key changes would be to move away from an oversight role to remove layers of duplication around assurance in the health service and focus on the role of commissioner. As part of entering intervention, some work had already been undertaken on reviewing the operating model for commissioning and the blueprint would now be used to help set out the structures and models going forwards, working with all partners across the wider determinants of health. The roadmap later in the meeting would set out key areas of focus that would then inform the commissioning intentions, which would include end of life, frailty and locally enhanced services for primary care which have been agreed. All these priorities would support in removing pressures and demand on services in the urgent care pathway. There had been some positive movement since entering intervention and it was crucial that the financial deficit was addressed as it was a distraction from what was required. The ICB expected the 10-year plan to be received shortly and would then need to work through implementation. The approach to implementing this plan would be co-produced with partners and would be an opportunity to listen to staff and the public to ensure that feedback informed the plans. S Proffitt reiterated her commitment to ensure that staff were kept appraised of any developments in a timely manner with progression being made to the plans to deliver the aims and ambitions and have better outcomes for the population. She recognised some of the good examples of key initiatives, including the shared care records at Derian House and My Wishes to improve planning in end-of-life care, both of which evidenced the impact of digitalisation. S Karunanithi recognised the level of stress and anxiety for staff, and how unsettling it could be and provided thanks to the leadership team for the support which was being provided to staff and partners and offered any required support throughout this process. S Proffitt noted the talent within the organisation and work was being undertaken around a skills audit to ensure there were opportunities for staff. **RESOLVED: That the ICB Board note the report.**
63/25	**<u>Working with People and Communities - Insight Report</u>** N Greaves introduced the paper, which presented proactive engagement and involvement activity across the ICB, based on the principles and approach set out in the ICB strategy for Working in Partnership with People and Communities. The report also included background information on the national legislation in addition to engagement and involvement approaches which had been developed by the ICB and examples of impact. The report summarised key themes from public outreach and engagement programmes since March 2025 and planned activity for quarter one of 2025/26. N Greaves acknowledged the contributions of partners and those within the ICB for their work with people and communities. He advised the paper had previously been presented to the Public Involvement and Engagement Advisory Committee, which had since been de-established further to the committee review presented to Board in March 2025. Within the report

	he drew attention to: ➢ Sections 2 and 3 of the paper referenced the processes, strategy, and legal duties of the ICB regarding community involvement and engagement. ➢ Section 3 included the approaches to engagement, particularly the collaboration with local Healthwatch and partner organisations to align their workplans with the roadmap and priorities of the organisation, and to reach more diverse communities. ➢ Section 5 outlined the key themes across public engagement and N Greaves recognised the importance of ensuring these are embedded in all commissioning work and ambitions. ➢ Section 4 included a link to a series of 'best practice sessions' produced by the population health team for partners and health professionals, setting out learning and impact for working with communities which responded to a comment made by C Oliver earlier in the meeting as to how the services can be accessed. ➢ The work being undertaken with other partners such as MPs, politicians, scrutiny committees, and health and wellbeing boards, which provided a route to ensure the voices of the communities were heard. A Cummins acknowledged the comprehensive report which provided valuable insights into the breadth of engagement activity. He suggested asking groups if they felt heard, which would close the feedback loop and ensure the feedback was used to shape change. Additionally, he suggested that, following engagement events, whether consideration could be given to providing detail as to how the feedback had been reflected in proposals. N Greaves noted that one of the challenges was demonstrating the 'so what' examples, as the work had been co-produced and was being done directly with the communities, noting the importance of the feedback loop and he advised that section 4 of the report provided some examples to demonstrate how a decision had been influenced by engagement. J O'Brien commented that, in relation to health inequalities, often the most disadvantaged people with the worst health outcomes were the hardest to reach and it should be reflected in the strategy and priorities how we could better understand the issues and barriers to engagement. N Greaves agreed that language barriers and the ability to communicate effectively and engage with some groups highlighted significant issues and advised that segmentation work was already taking place with groups and section 5 of the report provided key themes across engagement and involvement activity regarding access to services. C Oliver raised an important point about engaging with local MPs and ensuring that mental health needs and wellbeing were addressed in a way that aligned with community feedback and how this feedback was triangulated back to providers to ensure cohesion between community engagement and service provision. N Greaves responded by noting that much of this work was undertaken on the ground by teams working with populations. Additionally, collaboration with communications teams across the system had influenced promotional campaigns, such as those around mental health messages during the winter period. T Hopkins welcomed the insights report which provided an indication of creative ways of engaging with communities and with the voluntary sector. There had been a shift away from only looking at patient engagement and involvement, to looking at how we could work with communities and people who weren't patients and who struggled to access services to getting better at serving the needs of the population. A Knox praised N Greaves for his exemplary leadership within the system and the strong partnerships which he had established. He highlighted that the Guardian newspaper was running a series of articles highlighting the good work being undertaken in the community in Lancashire and South Cumbria. He emphasised the importance of listening to communities to understand their needs, noting that service provision often needed to be adapted to suit communities, providing several examples of successful community work, and requested that no strategy or commissioned service would be implemented without first ensuring that the

	services provided met the needs of the communities. S Proffitt acknowledged the excellent work being undertaken and emphasised the importance of capturing what was being done well to ensure this was built into the operating model. She advised the executive team were working on engagement with a focus on collaboration to ensure the model was designed correctly. The Chair noted the commitment to bring this item to each Board meeting held in public and supported the importance of building every strategy on insights from public engagenebt, noting that further detail would be submitted on the operating model to the next Board meeting in July 2025. **RESOLVED: That the ICB Board:** • **Note the contents of the report and the insight captured from engagement and involvement activities** • **Note the priorities for engagement for 2025/26 and that a report be submitted to each ICB Board meeting held in public.**
64/25	**<u>People and Culture Committee: Escalation and Assurance Report:</u>** The Board received a summary of key matters, issues and risks discussed from the first meeting held of the People and Culture Committee under the new governance arrangements, which took place on the back of the announcement of the 47% reduction in ICB running costs and therefore noted there was significant discussion of the impact on staff from this announcement and the most appropriate way to manage this. J O'Brien highlighted: • **Advise:** The ICB Culture, Values and Behaviours framework and toolkit had been launched, setting out how we collectively create the culture to achieve the ICB's vision and purpose. • **Advise:** The committee had received a presentation from Spring North, a 3-year programme offering tailored support and aiming to develop a volunteering infrastructure across Lancashire and South Cumbria. • **Advise:** Recognised the impact of overall workforce reduction in some of the providers and in particular opportunities for nursing placements, which would be monitored through the Strategic Education Group. • **Assure:** Approval was given to the committee business plans for 2025/26 and the 12-month people plan • **Assure:** Actions being seen from the Staff Survey Providers and Pulse Survey were being addressed. • **Assure:** The Memorandum of Understanding for mandatory training had been signed by all Lancashire and South Cumbria trusts to facilitate the movement of staff between NHS organisations. • **Assure:** Further work to be undertaken in relation to workforce and finance figures to ensure alignment with detailed narrative to explain differences. S O'Brien commented on the risk of the impact of overall workforce reduction in some of the providers and in particular opportunities for nursing placements, and the lack of job opportunities for newly qualified staff. She advised of a recent concern related to one of the university cohorts recently and noted the primary care training hub had been connected with regional colleagues to explore some opportunities. It was noted that when people undertake undergraduate training, placements needed to be opened across the sector and students needed to be educated that there were alternative options of employment at the end of their training than just within a hospital.

	J Birrell referred to the staff survey and the people plan, commenting on their importance. He asked that the Board was sighted on more detail of these plans including what would be delivered, particularly for 2025/26. D Eyitayo advised that a comprehensive plan had been agreed on the back of the strategy that was approved by the Board in July 2024 and confirmed both the people plan and the work undertaken around cultures, values and behaviours would be presented to Board in July 2025. The Chair noted this would also be incorporated into the development session in June 2025. **Action: D Eyitayo** ***(action log)*** D Eyitayo advised of a system-wide piece of work in addition to the internal ICB regarding the staff survey action plan, which would also be presented to Board in July 2025. **Action: D Eyitayo** ***(action log)*** J Birrell commented that the ICB staff survey results had previously been disappointing and noted the requirement to see an improved position with specific actions for the ICB to achieve this. He also recognised that, given the current uncertainties, delivering improvements would be a challenge in the short term. D Eyitayo reminded the Board that the ICB had opted out of the survey last year, as agreed as a Board, in order to focus on a reset and the journey on values and culture. However there had been participation in the Pulse survey, which the People and Culture Committee had been reviewing with a supported action plan, which was also reviewed by the executive team. She suggested that this could also be presented to the Board. She noted that the response rates to the most recent Pulse survey had been very low, and feedback was not good, which reflected the current position of the organisation. The change plan had been set up to address these issues. S Proffitt agreed this should be brought to Board in July 2025 for transparency and as a benchmark to drive change. The Chair confirmed therefore there would be a substantive item on people for the next meeting in July, where the results of the most recent pulse survey would be brought along with the values and the people plan. **RESOLVED: That the ICB Board:** • **Note the Alert, Advise and Assure People and Culture Committee report and approve any recommendations as listed** • **Note the items referred from another committee to the People and Culture Committee over the reporting period.** • **Note the ratified minutes of the former ICB People committee meeting held on 29 January 2025.** • **Receive the results of the most recent pulse survey, values and the people plan as a substantive item at the July meeting.**
65/25	**<u>2025/26 ICB Final Plan and High-level Budgets</u>** S Downs introduced the paper, which presented the final plan and high-level budgets for 2025/26 based on the latest funding and expenditure plan for all commissioned services and running costs. He advised this set out the planning guidance expectations and the assumptions which had been reflected in the ICB's final plan which had been submitted to NHS England on 30 April 2025. S Downs commented on the statutory duty of the ICB to live within its resources of £5.4 billion and a breakeven plan had been submitted, however there was a consequent requirement to deliver £142.7m savings which equated to broadly 3% of the allocation. He advised that at the time of writing this report, £69.8m of schemes had been fully developed and £72.9m remained either as an opportunity (£14.2m) or unidentified (£58.7m). He advised that work continued with the project management office to ensure all savings schemes had project initiation documents (PIDs) and Quality Impact Assessments (QIAs) completed, and that new opportunities were identified to replace the unidentified value with fully worked up schemes.

	The Chair stressed the importance to note that the system breakeven position reflected the deficit support funding of £164 million and that there would be no further support funding made available and therefore, the delivery of the plan was fundamental. She commented that the plans felt far more robust than previous submissions and they had all had equality impact assessments undertaken. A Cummins recognised the work that had gone into progressing the plan over the last few months had been substantial, both for the ICB and for providers. This meant that the system was in a much stronger position compared to last year, but it was important to recognise he significant risks. He stressed that many of the plans were not mutually exclusive with a reliance on partners within the system to ensure they were delivered without any unintended consequences. He welcomed the planned review to look at respective risks and joint mitigations which would avoid decisions being taken that would put pressure on providers. The Chair paid tribute to the executive team for their continued efforts in producing the plan. **RESOLVED: That the ICB Board:** • **Note the content of this report** • **Approve the high-level budgets for 2025/26** • **Support the work to develop robust QIPP plans** • **Support the process to issue budgets to budget holders who will be accountable for accepting and managing within final budgets** *The meeting paused for a short break.* Prior to re-commencing the formal agenda, the Chair advised of the sad announcement of the death of Dr Waqar-Uddin, a local general practitioner and gave the Boards heartfelt condolences to his family.
66/25	**<u>Transformation Roadmap</u>** A Knox advised that the paper set out the route map to transformation and the road to recovery. He advised the purpose of the item was to offer assurance to the Board about the direction of travel and to welcome some debate and discussion from the Board to sharpen and strengthen the approach. Three key elements of the paper were highlighted: Why? - To drive the sense of purpose and ICB vision to have high quality, community-centred health and care services by 2035. - Aligned with the three big shifts stated by the Secretary of State, the vital need to shift from acute to community, from analogue to digital and from treatment to prevention. - Based on the Lord Darzi report of the current state of the NHS and as a reminder that the vision of the NHS was to ensure the best care for everyone, free at the point of service. - There needed to be transformation to ensure this was a sustainable vision for the future. How? - The first part of the quadruple aim was that we needed to ensure we were improving the health of the population whilst tackling health inequalities; the second was ensuring there was high quality care in terms of access, experience and outcomes. The third part was ensuring we have happy, healthy staff who have a sense of joy and pride in their work and the fourth part was ensuring that resources were used well and were financially sustainable for the future. - The model ICB blueprint showed a big shift in how the organisation should be operating

to ensure the right services were commissioned to have a neighbourhood-led approach to health and care.
- Insights around population health and intelligence should be used to drive some of the changes, and there needed to be an understanding of the needs of our population to strategically commission services that were based on what the population wanted and needed.
- Need to evidence as to whether the outcomes were working and to continually improve.

What?
- In 2025/26 it was recognised that addressing the financial position was critical in order to put the system on a strong footing to transform
- Through 2026/27 and until 2030 onwards there would be a need to recover and then to transform.
- Further to engagement with communities and partners, there were four key areas of focus for effective transformation through the roadmap, specifically end of life and frailty, management of long-term conditions in primary care more effectively, intermediate care and service reconfiguration.
- This would allow a bigger focus on neighbourhoods and places and to work in a more integrated way with teams to ensure the best care for our communities was provided.

The Chair noted this was fundamental to the future direction of the ICB and welcomed discussion from Board members.

S O'Brien welcomed the roadmap as a good example of demonstrating the vision more clearly, commenting it was still quite health focused, and suggested whether this could be strengthened through elements from the system, such as the integrated care strategy being built in**,** which would provide a focus on the wider health and care agenda.

J Birrell expressed concerns about the complexity and the number of actions in the programmes of work. However, he acknowledged that further to the description provided by A Knox, this felt like a joint effort across the system, which was a positive development and that by adding more detail to the roadmap this would help bring it to life.

The Chair noted there needed to be an action plan, but this would need to be agreed across the system and recognised there was work underway across the system with the wider partners.

S Proffitt advised that the work related to the roadmap commenced 6 months ago with the original focus to drive the commissioning intentions, which explained why it was health focused. She advised the roadmap had been through wide engagement with the Provider Collaborative Board and recognised the benefit of inclusion of other groups, such as the voluntary sector. She was mindful that one of the challenges had been ensuring the infrastructure was correct across the system, and provided assurance that conversations were being undertaken with partners to ensure this was executed well. It was agreed that the roadmap should include more than just a health focus.

A Cummins noted that the Provider Collaborative Board was established as a joint committee made up of the five Trusts but now it was more about provider alliance and being connected across the system. He commented this piece of work, when read in isolation left questions on the delivery plan, but when looked at in the context of the commissioning intentions documents and the model ICB blueprint, a shift in the operating model could be seen with the roadmap and delivery vehicle, and this would build a cohesive story for the system. He commented that 'what gets measured gets done,' and suggested the need for some measurable deliverables to be included for service users to 'buy into' the roadmap. Additionally, he suggested having a conversation regarding the model ICB blueprint next steps with NHSE about the performance framework in the operating model, noting the ICB would still be largely held to account on monthly and quarterly performance but some of the roadmap and commissioning intentions

	would need longer and medium-term delivery oversight as time and resources would need to be deployed for this. S Proffitt noted that guidance from the national team related to looking at multi-year planning and recognised the need to review over a longer period than one year. T Hopkins stated this appeared to be a product of a system who was under grip and control, and thereby was health and internally focused. She noted there would be some difficult conversations and decisions ahead as a system, for example, to prevent someone becoming ill with a respiratory illness, much of this related to their living conditions and she queried who would be responsible and what resources were used for ensuring people's needs were met outside of the healthcare setting. Whilst the roadmap was a great piece of work, T Hopkins felt there were other opportunities which could potentially be utilised to support areas which should be included in the roadmap moving forwards. C Harris noted this was a real step change and the right direction of travel. The roadmap was starting from an asset-based approach rather than a deficit model and more could be done to bring that to life in the narrative. This was now dovetailing with the commissioning intentions, and the programmes that had been articulated were those that should be included as part of the transformation. He commmented that the roadmap and commissioning intentions were intrinsically linked as they formed the same plan and recognised the progress which had been made. S Karunanithi commented that health outcomes were going in the wrong direction in Lancashire and South Cumbria, with inequalities widening. To improve health it would take more than just improving healthcare, and this required us to look at how this proposed roadmap linked to a wider roadmap. He suggested the framing of this roadmap could start with the future, particularly children and young people to ensure the best start in life for children, young people, and families and to ensure clarity around the outcomes to have the skills and expertise required. S Karunanithi further noted that the NHS was the main organisation which people looked to for improving health, however he noted other sectors, including housing and education provided support to health services. He also commented on the language used within the roadmap particularly as to what was meant by the 'system' and whether this covered the entire public sector. He was mindful that all public sector services were designed for people to ask for services or help when there was a need, but the focus should now be related to going beyond this through engagement with communities as the needs of the population would increase, and he stressed the importance of ensuring the roadmap was a success. A Knox emphasised the importance of addressing the wider social determinants of health and the need for proactive community engagement, highlighting the success of focused outreach work and the importance of exploring strengthened integrated neighbourhood teams in improving health outcomes and working with partners. He commented as to the change in approach on tackling health inequalities regarding the strategies of the five Trusts and primary care providers and noted that the work had commenced to transform services. A Knox expressed thanks for the comments received which were valued, along with the open challenges presented during the meeting and he committed to incorporating these insights to strengthen the approach to the roadmap. S Proffitt recognised the contributions from Andrew Bennett, Director of Population Health and Terry Whalley, Programme Director, New Models of Care for their efforts in driving this initiative. **RESOLVED: That the ICB Board:** • **Note that the ICB had prioritised work under the LSC 2030 Roadmap for medium to longer-term transformation, ensuring this is coordinated with short-term commissioning intentions and annual plan priorities.**

	• **Note that commissioning teams were working with providers and partners to mobilise actions under the Roadmap.** • **Note that further items for Board decision-making would emerge from work on the Roadmap including plans for service reconfiguration.** • **Note the comments which would be incorporated into the Roadmap.**
67/25	**<u>Committee Escalation and Assurance Reports</u>** The Board received a summary of key matters, issues and risks discussed since the last report to the Board on 19 March 2025 to alert, advise and assure the Board. The summary report also highlighted any issues or items referred or escalated to other committees of the Board. Minutes approved by the committees to date were presented to the Board to provide assurance that the committees had met in accordance with their terms of reference and to advise the Board of business transacted at their meetings. The Chair noted that, further to the paper brought to the last Board meeting regarding changes to the committee structure, this section still contained the final triple A report and approved minutes of the Public Involvement and Engagement Advisory Committee, and the approved minutes of the Primary Care Commissioning Committee. **<u>Primary Care Commissioning Committee – 13 February 2025</u>** D Atkinson advised the approved minutes had been provided from the last meeting of the Primary Care Commissioning Committee held on 13 February 2025 and noted the triple A report from that meeting was received and discussed at the Board meeting om 19 March 2025. It was recognised that under the new committee arrangements, primary care contracting sat within the executive committee portfolio and reporting from the executive committee would be brought into the Board in line with all the other committees. **<u>Quality and Outcomes Committee - 26 March 2025</u>** S Cumiskey noted she had been reflecting on the way the Board was changing, and the opportunities which were available through the Quality and Outcomes Committee to bring greater assurance that we were driving the required impact in changing outcomes for the people we served. She advised the committee would be exploring how this would be measured to bring an integrated report that incorporated all the different strands. S Cumiskey advised the report provided related to business discussed through the previous Quality Committee at the final meeting held on 26 March 2025 and she highlighted: **Alert: Quality Impact Assessments –** The process was not yet fully embedded so the Board could not yet be assured that robust EQIAs are underpinning commissioning and planning decisions. However, she noted that at the recent Quality and Outcomes Committee further progress had been recognised. **Alert: Histopathology –** The committee were keen to seek to understand what action was being taken to sustain improvements and for assurance regarding Duty of Candour with patients. **Advise: South Cumbria Neurology Services –** Committee received an update regarding neurology services in South Cumbria which had previously been an alert to board. An independent provider had been secured to provide the service from 1 April 2025. For the committee to be fully assured will require monitoring of the impact of this new service. An

	update report would be received in 4 months to provide assurance around the service with any issues in the interim to be escalated. **Assure: Alignment of community services for Blackburn with Darwen and East Lancashire** - Committee received a detailed 6-month post-transfer update which was reported to have embedded well and whilst assurance was provided, the performance would continue to be monitored through monthly integrated contracting meetings. The Chair supported the future direction of the committee as the work around assessing the impact of change on our communities would be fundamental. **Finance and Contracting Committee - 15 April 2025** S Igoe gave key the highlights from the first meeting of the Finance and Contracting Committee held on 15 April 2025 noting that significant discussion took place surrounding closure of the 2024/25 financial year. **Assure: Review of Risks** – The Committee discussed the BAF risks of which the committee had oversight and confirmed they were still relevant and scored appropriately. Two further risks were discussed and felt to be worthy of specific discussion on an ongoing basis given their fundamental impact on the ICB and its agreed financial outcomes for 2025/26, specifically: - The achievement of cost reductions related to All Age Continuing Care - Successful achievement of Commissioning outcomes on a timely basis. S Igoe advised the Committee agreed that as a matter of course it would undertake a deep dive into one risk per meeting, the first being those risks associated with All Age Continuing Care (AACC) at the next meeting with a schedule of deep dives being presented to the committee. He noted the significant stretch target for AACC and advised that the end product may vary as a result of requirements to deliver and to be able to demonstrate to NHSE that the ICB was a sustainable organisation, emphasising the necessity to deliver recurrent savings. **Assure: Future ICB Board Assurance** – Agreement that future meetings would focus on future actions and the management of those in so far as they relate to the delivery of the final agreed 2025/26 financial plan. As a result, the committee would provide assurance to the ICB Board as required. **Public Involvement and Engagement Advisory Committee – 26 March 2025** N Greaves advised that the Public Involvement and Engagement Advisory Committee had been disestablished further to the governance review. He recognised that good foundations had been established with regard to engagement and highlighted from the Triple A future reporting to the ICB and work with partners. **Assure: ICB discharging statutory responsibilities and delivering against the Working with People and Communities strategy and principles** – A Summary report was reviewed on engagement and involvement activity and implications (Dec 2024-end Feb 2025) including insight through the quarterly public perceptions survey, pre-consultation engagement in relation to Shaping Care Together and review of activity such as the ICB's male suicide prevention campaign. **Assure: Responsibility in relation to patient experience -** A representative from the ICB's communications and engagement team would attend the Quality and Outcomes Committee to contribute insight from engagement and involvement activity to support the quality and outcomes improvement agenda.

	Northwest Specialised Commissioning Committee – 6 March 2025 and 3 April 2025 J Birrell noted there were two triple A reports for the Northwest Specialised Commissioning Committee and highlighted: **Alert (6 March 2025):** The North West Specialised Commissioning team's capacity remained constrained as NHS England continued to progress an organisational change programme, which had resulted in a freeze on recruitment. There was an increased risk of a potential delay in the TUPE transfer of the specialised commissioning hub team staff to the Lancashire and South Cumbria ICB host. J Birrell noted the triple A from the meeting held on 3 April 2025 advised of a further delay in the TUPE transfer to July 2025. He advised that operationally, this presented an issue for the specialised commissioning team. **Advise: Oversight of Retinopathy of Prematurity Screening in all NW Neonatal Critical Care units** - Agreement to allocate reserved funding from the NW Specialised Commissioning budget to commission the North West wide workforce model of mixed ophthalmologist and nurse screeners and regional co-ordination to ensure sustainability and oversight. The Chair queried the impact on services of TUPE delays and was assured that this was unlikely to be signficant, however J Birrell raised concerns related to the freeze on recruitment as there were already significant vacancies in the staffing structures. C Harris advised regarding the transfer of staff from specialised commissioning from NHSE, noting a formal decision had been taken to pause this transfer, advising the delay was due to NHSE being unable to delegate services as it would no longer exist as an organisation and would have to be transferred to ICBs. A review would be undertaken to determine what would be transferred, noting that it was expected the very specialist national provision would remain centralised and therefore would be transferred to the ICB, which would be different to a delegation agreement. C Harris advised that detail would be submitted to Board once agreement had been reached. **Action: C Harris** ***(held on planner)*** C Harris advised there were operational challenges with the specialised commissioning services due to the recruitment freeze, which meant a reduced number of specialised commissioners were operating within Lancashire and South Cumbria. The ICB was working very closely to provide support and looking at where integrated work could be undertaken. **RESOLVED: That the ICB Board:** • **Note the Alert, Advise and Assure within each committee report and approve the recommendations as listed within the report.** • **Note the summary of items or issues referred to other committees of the Board over the reporting period.** • **Note the ratified minutes of the committee meetings.** • **Update to be submitted to Board related to the TUPE transfer of staff from specialised commissioning.**
68/25	**Integrated Performance Report** A Patel advised the report contained data until the end of March 2025 and drew attention to the increased demand and pressures which had been seen over the last 12 months. He reflected on the efforts from all teams, despite the pressures, to maintain performance and commented that metrics compared favorably within the Northwest and national averages. A Patel highlighted:

Urgent and Emergency Care (UEC)

- Performance against the 4-hour target in March 2025 was 76.9%, an improvement on the previous period but below the 78% target for March 2025.
- The percentage of patients spending more than 12 hours in an emergency department also improved during the most recent period.
- Compared to 2023/24 there had been an increase of 47,000 attendances in 2024/25 (increase of 5.4%).

Primary Care

- Across the year to date (April 24 – February 25) GP practices had delivered 191k (2.07%) more appointments than initially planned.
- L&SC continued to have a lower general practice workforce per head of population than regional and national averages.

Diagnostics

- There has been an improvement at ICB level in diagnostic performance against the 6 weeks diagnostic target (95%) during February 2025, with all of the 4 main providers seeing an improvement.
- The ICB continues to be below the North West and National performance.
- Latest performance for the ICB shows that 79.6% of people waited less than 6 weeks for a diagnostic test, with 78.0% waiting less than 6 weeks at our 4 main providers.
- There are 8 Community Diagnostic Centers (CDC) across Lancashire and South Cumbria which have delivered 200k diagnostic tests (12% of activity) and support the direction of travel in terms of having services closer to the patients home.

Mental Health

- The out of area placement target has been revised to people in beds out of area, rather than bed days.
- The latest data shows that there were 14 inappropriate out of area placements, which is above plan.
- The dementia prevalence target continues to be met within L&SC ICB, above the national position.
- The number of people receiving a health check on a Learning Disability (LD) register for the ICB will be met for the year end.
- The local data flows for NHS Talking Therapies shows that the ICB is just under the reliable improvement target but meeting the reliable recovery target, year to date.

It was noted that at the last Board meeting, C Oliver had made a plea for a continued focus on learning disability health checks and noted that whilst this had been removed from the annual plan there was a commitment that the trajectory would continue to be reported on, specifically due to the importance of delivery which related to the health inequalities in these groups. A Patel advised that work was being undertaken with GP practices to increase awareness to encourage these communities to have health checks, with LSCFT collaborating with the voluntary sector and local mosques.

Overall, it was noted that despite increased demand and pressure on services, performance compared favourably within the region and nationally, however, further work was required, and the transformation plan would provide support to address the increases in demand.

A Patel suggested a review of specific metrics which would provide a focus to Board on the key issues which could be impactful in addressing increases in demand.

A Cummins noted that within the model ICB blueprint, there was an expectation to have highly

	skilled business intelligence and analytics and thanked A Patel for triangulating the data and producing a highly skilled piece of work. However, he recognised the results came at a cost, both financially and in terms of the health and wellbeing impact on staff. He suggested that consideration be given as to what was the priority of the Board and what the ICB could implement to move the metrics to reduce consumption and demand and queried what elements other partners could focus on and deliver, noting that if the analysis could be aligned with the blueprint and the roadmap, this would allow real progress on transformation. S Karunanithi agreed there was a real opportunity to shift the focus from activity to outcomes as the ICB transformed into a strategic commissioner. He referred to the detail contained within the report associated with 'ICB commissioner in month' and noted that many of the key performance indicators that we knew would help people to live longer or reduce admissions were not achieved, querying if this was in spite of these being measured, were they still not being delivered, or were there improvements but not by the targets that had been set. A Patel recognised the degree of variation across the system from a performance perspective and agreed that a narrative was required within the report, which would provide a focus on interventions provided. **Action: A Patel *(emailed)*** C Oliver recognised the significant improvement and work which had been undertaken between LSCFT, local authorities and the ICB related to out of area placements, which had reduced further since the report. However, he commented that two inappropriate out of area placements remained too many. Nationally, there had a been significant discussion about parity of esteem with mental and physical health and despite an important target being dropped surrounding learning disability health checks nationally, the L&SC ICB continuing to maintain a spotlight on this area. This showed a real parity of esteem in action, and he conveyed thanks to A Patel. A Knox raised important points regarding the role of the ICB, the necessary changes, integrated partnership work, and strategic commissioning. He referenced the current quality and variation issues, sighting an example related to the treatment of hypertension where 88% of patients residing in Fleetwood were treated within the agreed target but in Barrow this equated to less than 50%. He advised that the data was reviewed at the Population Health Board, which fed into the Quality and Outcomes Committee, therefore the governance had been strengthened in this area which ensured that the right people and teams were able to take responsibility and action. A Knox strongly emphasised the required focus on what matters to our communities and thinking strategically as partners in places and neighbourhoods about outcomes. He recognised the need for a better integrated strategy for children and young people, working radically differently with schools to ensure children were healthy, both physically and mentally, and thriving academically. He was mindful that the data held everyone accountable for better joint working and outcomes for the populations, as currently, there are too many metrics that show how communities have been let down and the roadmap and blueprint would enable turning plans into action that would make a difference. S Proffitt noted that the budget of £5.4 billion was deemed sufficient for the population and levels of deprivation, but it was not being used in the right way to address the increasing demands and costs, as well as worsening outcomes. This was symptomatic of not having everything in the right place and she recognised the opportunity which was presented through the blueprint to configure things differently. The Chair noted there were several interlinked areas with the model ICB blueprint, transformation roadmap and the performance report, and requested future iterations in an interlinked manner.

	RESOLVED: That the ICB Board note the content of the report.
69/25	**Finance Report – Month 12** The report provided a summarised overview of the year-end position for the system, noting that the figures were subject to an audit taking place. S Downs advised the final 2024/25 position for the ICS was a £129.8m deficit, which was the position after receiving £175m of deficit support funding and £50m of winter surge funding. He noted that excluding these, the system deficit for 2024/25 would be £354.8m, which was £179.8m worse than the £175m control total set by NHS England. S Downs noted the considerable amount of work which had been undertaken in quarter 3 and into quarter 4 to improve the run rates and therefore allowed an exit for 2024/25 in a better position. It was noted there had been a plan to spend £140 million on capital, and providers spent £137.3m, which was a small underspend of £2.4m against the allocation and £2.2m less than plan. **RESOLVED: That the ICB Board note the content of the report.**
70/25	**Audit Committee Escalation report** The Board received a summary of key matters, issues and risks discussed since the last report to the Board on 15 January 2025 to alert, advise and assure the Board. J Birrell highlighted key points from the report: **Alert: External Auditor's Value for Money Risk assessment** - KPMG's interim report to the Committee stated that they currently regard the domains of financial sustainability and governance as having significant risks but improving economy, efficiency and effectiveness is not considered to have any identified significant risks. This position is subject to change as the audit process continues. **Alert: MIAA audit of All Age Continuing Care (AACC**) - MIAA's draft final report would be a Limited Assurance report and contain 19 high priority actions, (a number of which overlap with issues raised by the Financial Recovery Team). This would automatically trigger a more detailed report to the next Committee by the Lead Director. **Alert: Outstanding audit recommendations** - At the end of March 2025, the ICB had 47 outstanding audit recommendations, of which 24 were overdue. **Alert: Freedom of Information (FOI) requests** - Between November 2024 and the end of February 2025 the ICB received 150 FOI requests. However, only 80, (53%), were responded to within the 20-day response period and arrangements were to be reviewed to ensure requests are dealt with in a timely manner. The Chair noted that the items of alert had been brought to the private Board meeting held in April. **RESOLVED: That the ICB Board:** • **Note the Alert, Advise and Assure from the Audit Committee and approve the recommendations as listed within the report.** • **Note the summary of items or issues referred to other committees of the Board over the reporting period (as appropriate).**

	• **Note the ratified minutes of the Audit committee meeting.**
71/25	**<u>Quality Assurance Processes in the ICB including Specialised Commissioning</u>** S O'Brien advised the purpose of the paper was to describe and assure Board of the arrangements, systems and processes in place within the ICB to ensure there was oversight and assurance of the quality of commissioned services in line with national guidance. She highlighted: • The national quality board, which provided several documents to guide the system on undertaking quality surveillance and risk management, and the ICB was compliant with that guidance. • The formal and informal means by which the quality team worked with providers and regulators, and the formal route for reporting surveillance up to Board and escalation of areas of concern was via Quality and Outcomes Committee. • The diagram in the appendices demonstrated how specialised commissioning team undertook their surveillance of quality. The Chair noted the paper was helpful in responding to several matters that had arisen at recent Board meetings. **RESOLVED: That the ICB Board:** • **Note the arrangements for the surveillance of quality in commissioned services and be assured that these are robust and in line with national guidance.** • **Note the arrangements for surveillance of quality in specialised commissioning.**
72/25	**<u>Report concerning matters considered in Private Board meetings held between 19 March and 24 April 2025 (inclusive)</u>** The report was a standing agenda item, for the purposes of transparency and accountability and set out the matters that the Board considered during those private meetings. The Chair noted there were three matters but hoped this report would become shorter as less discussion would be undertaken in private. D Atkinson confirmed the Board had met in private on three occasions and the paper gave a summary of focus from each of those meetings, and a number of those matters had come into discussions today. **RESOLVED: That the ICB Board note the contents of the report which provides a summary of the key matters considered by the board at meetings held in private between 19 March and 24 April 2025.**
73/25	**<u>Any Other Business</u>** There were no issues raised.
74/25	**<u>Items for the Risk Register</u>** The Chair noted the Board had a comprehensive session on the risk register and Board Assurance Framework, which would be brought back to the public meeting in due course. **RESOLVED: That there were no items to be included on the ICB Risk Register.**

75/25	**<u>Closing Remarks</u>** The Chair thanked Board members for some good discussions and for the public attending today. The meeting was closed.
76/25	**<u>Date, Time and Venue of Next Meeting</u>** The next meeting to be held in public would be on Thursday, 24 July 2025, 1.00pm - 4.00pm in the Lune Meeting Room, ICB Offices, Level 3 Christ Church Precinct, County Hall, Preston, PR1 8XB. The meeting closed.

Exclusion of the public:
"To resolve, that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings Act 1960).