NHS
Lancashire and South Cumbria
Integrated Care Board

ANNUAL REPORT

2024 - 2025

www.lancashireandsouthcumbria.icb.nhs.uk

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Contents

Opportunities to learn more or be involved

We hope you find this Annual Report informative.

The Report explains how the ICB discharged its statutory duties during the 2024/25 financial year. It includes information about matters the ICB is required to report on and gives details for people wanting to know more.

The Accountability Report section includes a Governance Report that details the accountability and decision-making framework for the ICB.

There are several ways to find out more about NHS Lancashire and South Cumbria Integrated Care Board and the work it does in planning NHS services.

Our website www.lancashireandsouthcumbria.icb.nhs.uk includes information about our work, the Board and our leadership team.

The website also describes how you can get more involved. For example, the 'have your say' sections lists all open public engagement taking place or there are details about joining a Patient Participation Group.

'Contact us' information is on the website for general enquiries and complaints, compliments and comments.

You can read our chief executive's assessment of the state of the health and care system in the region in a System Report.

The ICB's Commissioning intentions 2025/26 are described on the ICB website.

You can follow the ICB on social media on Facebook, X, Linkedin, Instagram or YouTube channels, just search for LSCICB.

Explanatory note:

Shortly after the end of the 2024/25 financial year, the then ICB chief executive, Kevin Lavery, announced he was leaving his role to spend more time with his family.

Sam Proffitt, previously the ICB's chief finance officer took over as interim chief executive, pending the recruitment of a new chief executive.

Where accountable officer signature is required in the Report the signature will be that of the chief executive at the time of publication – Sam Proffitt.

"Our vision is to have a high quality, community-centred health and care system by 2035"

FOREWORD

I am pleased to present the 2024/25 Annual Report for NHS Lancashire and South Cumbria Integrated Care Board (ICB).

I was delighted to be appointed as chair in September of 2024, having been inspired by some of the great work taking place across Lancashire and South Cumbria to improve health and care for the population. I joined to support collaboration across health and care, and to further the ICB's central ambition of improving the health and wellbeing of people in the region, working closely with partners across health, care, local authorities, and the voluntary, community, faith, and social enterprise sector.

We have a clear vision and strong ambitions to improve quality, transform care in the community, and address the challenges NHS services face across acute, mental health, and primary care. Our core vision is to have a high-quality, community-centred health and care system by 2035. This means focusing on prevention, delivering care in people's homes or as close to home as possible and making the best use of technology. This is very much in line with Lord Darzi's report on the state of the National Health Service in England, published in September 2024, as well as the Government's three 'big shifts' which we expect to be at the forefront of the new NHS 10-Year Plan. Our responsibilities around health inequalities and addressing the unwarranted variation that we see in access and outcomes also remain a priority. The need to focus on addressing these inequalities must run as the golden thread through all the work that we do.

This year has been, again, a very challenging year financially, both for the ICB as an organisation and for the system as a whole. The system has had longstanding financial issues at both provider and commissioner level, and this year we struggled to deliver on the plans we agreed with NHSE at the start of the year. As a result, our ICB, and 3 provider organisations in Lancashire and South Cumbria were subject to national intervention from September 2024, with intensive support from the National Recovery Support Programme, as we worked with partners to address several issues around finance, performance, governance, and leadership.

As the single most financially challenged system in the NHS we must take immediate action to reduce our spending and live within our means. We strongly believe that financial sustainability will result from our commitment to addressing unwarranted variation and inequalities, but we recognise that some of the decisions we will need to make may not always be popular, and for this reason it is imperative that we continue to engage with our populations and our partners to ensure that every decision we take is in line with our core vision.

We also remain positive that there are excellent services, positive examples of collaboration, and passionate and dedicated staff to build upon to improve health and care across the system. You will see examples of excellent work throughout this report.

The pace of change in the environment in which we work has accelerated as the organisation has been in a period of national intervention since September 2024. This has led to important programmes of work to establish the foundations for

delivering our vision in future years. This includes designing our commissioning operating model and a roadmap for transformation which sets a path to 2030.

Looking forward to 2025/26, it is clear we will need to work at pace to redesign the ICB following the announcements regarding the absorption of NHS England by the Department of Health and Social Care and the reforms of ICBs. This will include a significant reduction in running costs and we will need to act in the best interests of our staff to reduce any confusion and distress, whilst delivering the changes we need in a way which helps to make sure we can still deliver our vision.

We will continue to get better at delivering our plans. We will continue to deliver value for money, reduce our deficit and maintain a clear focus on our clinical vision. Quality and finance are two sides of the same coin, not a choice.

We will deliver our plans by working together across NHS organisations, with our partners – local authorities, third sector providers and most of all, those who use NHS services.

I thank our ICB staff, and the many we work in partnership with across our system, who are doing a good job in very difficult circumstances and whose hard work, diligence, and compassion are making, and will continue to make, our vision a reality.

Emma Woollett

Chair

Lancashire and South Cumbria ICB

PERFORMANCE REPORT

Sam Proffitt

Accountable Officer

16 June 2025

Performance Overview

In this section we will look at how we have structured our work over the last year, how we have involved our partners at place, our challenges and our achievements.

Chief officer's statement

As the Acting Chief Executive, I am pleased to present this report, which provides a comprehensive overview of the progress and challenges we faced, and indeed in many cases continue to face, in delivering our strategic objectives and improving the quality of care. I want to acknowledge the hard work and dedication of my colleagues, emphasising the importance of our collective effort in the achievement of our success.

As the Annual Report for 2024/25 is being prepared we have a clear focus on the future. We are facing significant financial challenge and tackling this head on.

Such is the severity of our financial position as a system, the ICB, along with three of our trusts, have been placed into NHS Oversight Framework Segment 4 and are receiving intensive support from the National Recovery Support Programme.

As an ICB we have been able to achieve a breakeven position at the end of the financial year however, this has only been possible due to deficit support from NHS England.

As an NHS system we have not lived within our means this year, overspending by £148m, which is 2.8 per cent of our total budget of £5.2 billion. We need to be honest that without deficit support we have an underlying system financial deficit of approximately £350 million as a system and we need to take action in partnership and through our commissioning as an ICB, to recover and work towards becoming sustainable. This overspending is unacceptable and reflects wider issues in our system, leading to signed undertakings with NHSE regarding financial planning, leadership, and governance.

I do want to recognise the significant achievements we made in delivering ambitious efficiency targets for the year. The ICB delivered £240.5m of cost efficiencies in 2024/25 and across our wider system this was more than £570m of savings, I want to recognise the considerable work across our teams and staff across the system for their diligence in improving our system's financial position. The decisions which have supported these efficiencies have been clinically led and with the necessary impact assessments in place.

Throughout the year, we proactively engaged over 26,000 members of the public through engagement events, surveys and community research which has contributed to our decision making and programmes of work. We have established a virtual panel of more than 2,000 local people, captured patient stories to ensure patient-centred decision-making and recruited more than 55 volunteer public advisors. Our public advisors are actively contributing to priority

transformation and commissioning programmes to bring valued public voice and perspectives to influence our work.

Despite disappointing staff survey results, the Executive team launched roadshows and established the People and Culture Group to improve staff experience. We are developing a new leadership programme to address specific system challenges and demonstrate our commitment to local talent development. Compassion, respect, integrity and inclusion are the four values that we identified to help us articulate the beliefs and principles that guide how we want to be recognised.

In July we published a State of the System Report reviewing our progress over the past year, focusing on recovery, transformation, and our strategic objectives. This set out reflections on the progress we needed to make and our in-year focus on moving towards delivery of transformation.

During the year, the general election resulted in a new government, and subsequent changes in the NHS. We needed to adjust to this change whilst remaining focused on delivering our plans and seeking opportunities for reconfiguring our system.

Throughout the year, we have been open and transparent with the public and in our ICB Board meetings where we have addressed and faced up to key issues such as our need to reconfigure services, deliver our financial and operational plans and addressing areas where quality needs to be improved.

At our final Board meeting for 2024/25, in March 2025, we discussed the ICB's commissioning intentions for 2025/26, which aim to support the improvement in our system's financial sustainability and service quality and drive forward transformation which will help tackle health inequalities. This change will be supported by careful management, stakeholder engagement, and adherence to legal service change processes. We go into 2025/26 with a clear set of commissioning intentions, which will provide a robust prioritisation process for the way we commission and ensure we remain within our budget whilst meeting all nationally mandated requirements.

Despite the challenges, I remain optimistic about the opportunities for effective change and collaboration for the ICB. The opportunities we have mean that we can achieve our vision for improving health and care in the region.

I want to finish by thanking our staff and partners for their dedication and loyalty throughout the year.

Sam Proffitt

Accountable Officer

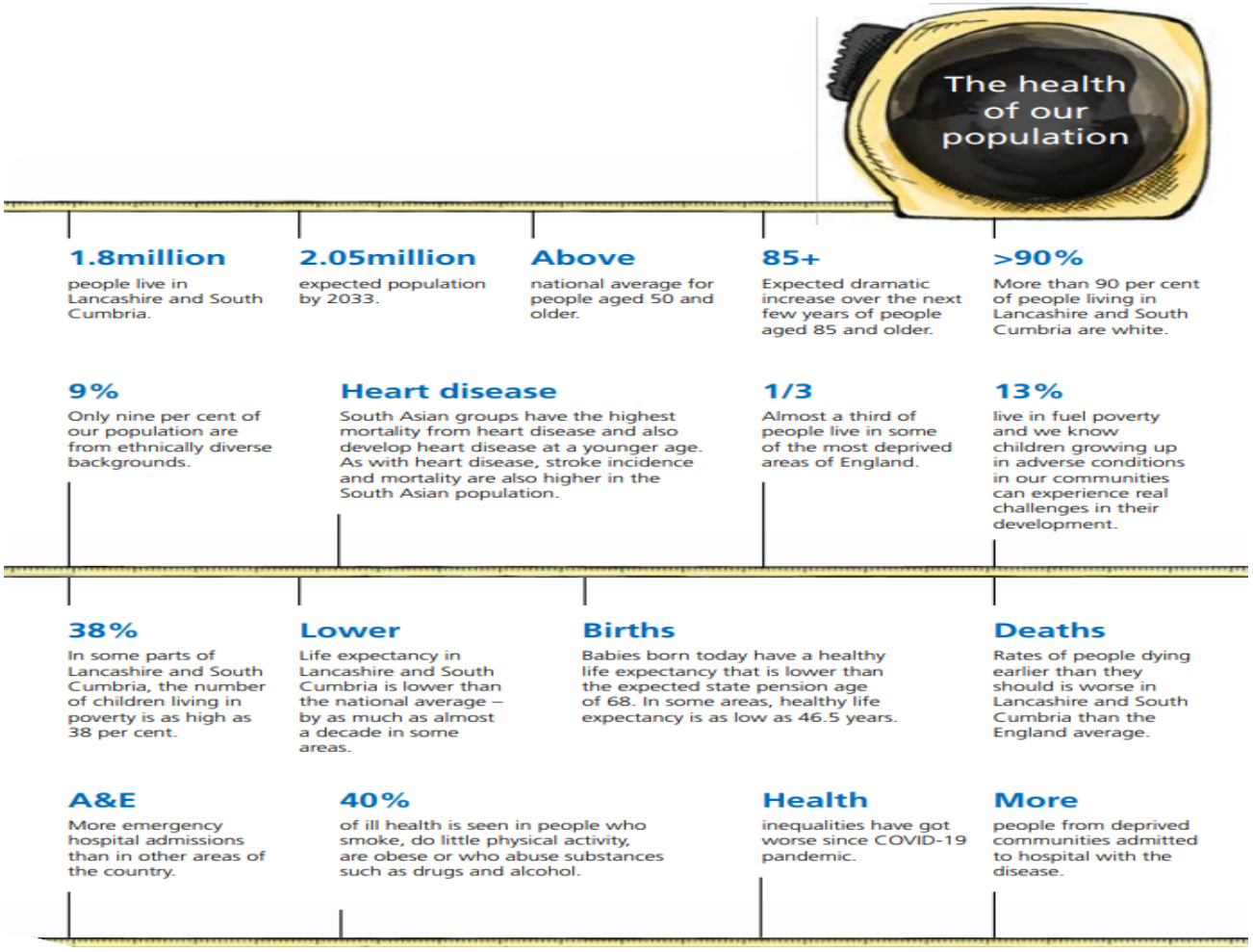
16 June 2025

Our purpose and context

An Integrated Care Board (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.

Nationally, the expectation is that an ICB will:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development



Our objectives and strategy

Our vision is to have a high quality, community-centred health and care system by 2035.

ICB strategic objectives

- Improve quality, including safety, clinical outcomes, and patient experience
- To equalise opportunities and clinical outcomes across the area
- Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees
- Meet financial targets and deliver improved productivity
- Meet national and locally determined performance standards and targets
- To develop and implement ambitious, deliverable strategies

Joint collaboration across NHS organisations in Lancashire and South Cumbria

Building on our ICB strategic objectives, we have agreed priorities in collaboration with NHS organisations in Lancashire and South Cumbria as part of our NHS Joint Forward Plan for Lancashire and South Cumbria:

1. We must strengthen our foundations by changing how organisations work together and how the NHS provides services to improve our financial situation.
2. We must take urgent action to reduce the level of long-term disease, working with partners to prevent illness and reduce inequalities.
3. We must move care closer to home wherever possible, strengthening primary and community care and integrating health and care services.
4. We must make sure there is more consistent and high-quality care. We will standardise, network, and improve our pathways of care.
5. We must take targeted action to deliver world-class care for priority diseases and conditions, population groups and communities.

Our operating model and structure

The structure of the ICB leadership team is shown on the ICB website: https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/leadership-team

More about this structure and ICB strategies and plans can be found on the ICB website at www.lancashireandsouthcumbria.icb.nhs.uk/about-us and details regarding principal risks to the ICB can be found within the Annual Governance Statement.

Our challenges

Some of the significant challenges faced across Lancashire and South Cumbria can be grouped under the following headings:

Deprivation

- Nearly a third of our residents live in some of the most deprived areas across England.
- The percentage of people living with fuel poverty and unable to afford to heat their homes: 13 per cent for Lancashire and South Cumbria, the national average is 10.6 per cent.
- A significant proportion of children experience adverse living conditions, including child poverty leading to significant variation in their development and school readiness. The percentage of children living in poverty ranges from a low of 12 per cent to as high as 38 per cent in Lancashire and South Cumbria, the national average is 30 per cent.

Life expectancy in Lancashire and South Cumbria is lower than the national average

- There is a significant level of unwarranted variation in the number of years people can expect to live a healthy life across Lancashire and South Cumbria. In some neighbourhoods, healthy life expectancy is 46.5 years.

Health and wellbeing

- Approximately 40 per cent of ill-health in Lancashire and South Cumbria is due to smoking, physical inactivity, obesity and substance misuse
- Only around a fifth of adults are meeting the recommended levels of physical activity.
- Just 15 per cent of young people aged 15 in Lancashire are meeting the recommended levels of physical activity, 14.1 per cent in Blackpool and 12.4 per cent in Blackburn with Darwen.
- 18.5 per cent of adults smoke in Lancashire and South Cumbria, the national average for England is 17.2 per cent.
- 21,442 people have five or more long term health conditions in Lancashire and South Cumbria. The main causes of ill-health are:

    - cancer,
    - cardiovascular,
    - respiratory,
    - mental health,
    - and neurological conditions.

- Suicide rates are significantly higher than average in Lancashire and South Cumbria, particularly in Barrow in Furness, Blackpool, Chorley and Wyre.

System challenges

- NHS England identified improvements needed for the ICB and three providers regarding financial planning, leadership, and governance as part of the recovery support programme.
- An organisation in a process of national intervention brings additional challenges which includes staff engagement and morale.

    - We continue to ask staff about how they feel about their own wellbeing with a monthly Wellbeing check-in. Staff are generally feeling neutral or positive, but half of respondents report concerns about system reforms and jobs.

Achievements

Some of the ICB's commitments to improving health and care services across the region.

Improving people’s experience of health and care

- Intermediate Care Model: A new model of intermediate care has been developed and is being rolled out to provide a seamless transition between hospital and community care, focusing on maintaining independence.
- The transfer of Child and Adolescent Mental Health Services (CAMHS) from East Lancashire Hospitals Trust to Lancashire and South Cumbria Foundation Trust resulted in a 3.3 per cent increase in the number of children and young people supported, and a decrease in referral to assessment waiting times.
- Adult Community Health Services Transfer: The transfer of adult community physical health services from LSCFT to ELHT improved access to stroke services and reduced waiting times
- Care Sector Collaborative Improvement: A multi-agency programme aimed at improving standards in care homes resulted in a 55 per cent decrease in attendances and a 60 per cent decrease in admissions in Blackburn with Darwen.
- Improving End-of-Life Care: In Blackburn with Darwen, efforts to improve end-of-life care included early identification and multi-agency care planning, leading to a 19% increase in the number of people with an advance care plan.

Early detection and treatment

- We have diagnosed more than 300 people with lung cancer early through Targeted Lung Health Checks as a pilot programme ahead of this approach being rolled out across the country.
- The BBC's One Show featured Football club community organisations offering 'prehab' sessions to cancer patients to improve their health and fitness ahead of treatment.

Supporting different communities

- The ICB signed the Armed Forces Covenant to support veterans and their families
- Integrated Neighbourhood Working: Improving primary care and integrated neighbourhood teams led to an 8.5 per cent decrease in emergency admissions due to falls in people aged 65 and over.
- WorkWell Partnership Programme: This pilot programme provided support to overcome health-related barriers to employment. Of those accessing support 44% showed positive outcomes in employment.
- The ICB has actively supported the workforce with an aim to reduce Gambling by delivering actions set out in a Gambling Harms Workplace Charter.
- Population Health Project Officers: ICB officers have helped to support socially isolated residents in our most deprived wards to improve their health and wellbeing.
- Pain Café in Millom: A Pain Café was launched to support patients with chronic pain, aiming to reduce the usage of opioid painkillers.

Managing pressures across the system

- A pilot programme in South Cumbria saw significantly reduced readmissions and length of stay for targeted patients in collaboration with local community partners.

Our work with partners

Integrated Care Partnership

The ICB continues to be committed to our Integrated Care Partnership (ICP) where we work with partners in Place and at System level to deliver the ambitions of our Integrated Care Strategy. The ICP is a statutory committee, jointly formed and convened by the NHS ICB and upper tier local authorities within the Lancashire and South Cumbria Integrated Care System (ICS) area.

The ICP brings together an alliance of partners and stakeholders from across Lancashire and South Cumbria who have a shared focus on improving the care, health and wellbeing of their population, with membership determined locally. Its focus is on tackling the most complex issues that cannot be solved by individual organisations or sectors by taking joined-up action with our partners.

Delivery though our Places is at the core of the strategy and through the ICP, partners have collaborated on the areas where the system requires significant

progress against each of the domains through partnership working. Domain Sponsors' have been identified to better connect the ICP's 'line of sight' to existing governance, partnerships and delivery mechanisms, and to strengthen the assurance of where and how the Integrated Care Strategy is being delivered. Domain sponsors are existing ICP members who can link the strategy in Places and across hospital footprints.

Quarterly meetings have been re-structured to enable time for business matters, but to also allocate space for 'deep dive' workshop sessions on specific themes. The workshop sessions bring together a wider range of system partners, beyond the ICP membership, with the aim of broadening the reach of the Partnership across the Lancashire and South Cumbria system. The first of these sessions was held in October 2024 with a focus on the role that the ICP can play in Transforming Community Services.

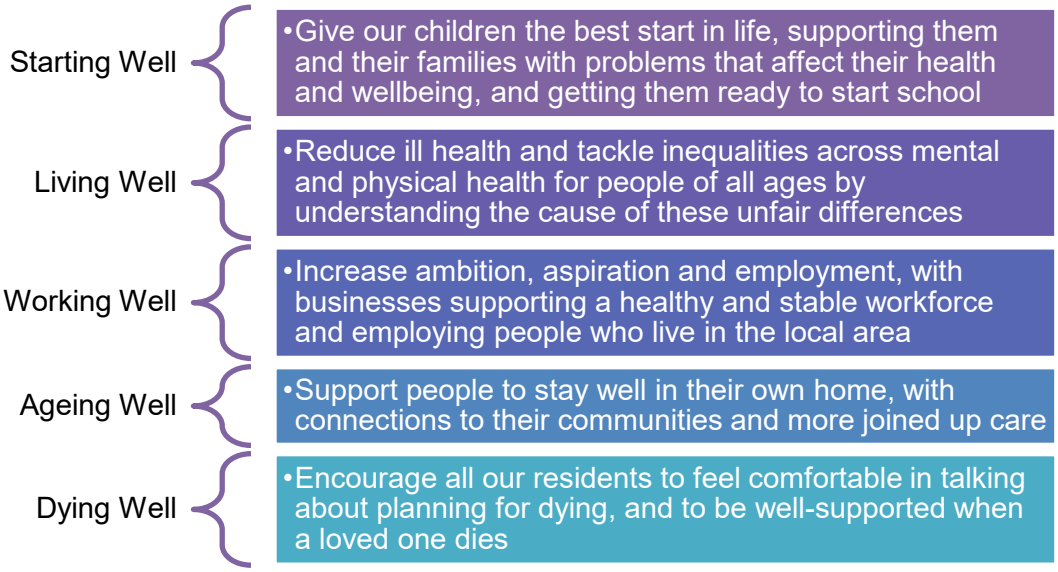
The ICP is one of our key vehicles to strengthen integrated working and tackle the most complex issues that cannot be solved by individual organisations through partnership working, where the potential achievements of working together are greater than the sum of the constituent parts.

Working across organisational boundaries, the partnership has developed an Integrated Care Strategy[1], to improve the health and wellbeing of our residents, by taking collective action.

The strategy takes account of expert advice from our local authority public health colleagues on population needs, captured within joint strategic needs assessments, and reflects both the health and wellbeing strategies that the Health and Wellbeing Boards in Lancashire and South Cumbria have developed. It aligns with the NHS Joint Forward Plan[2] developed by Lancashire and South Cumbria ICB.

The strategy sets out our intention to take joined-up care action with our partners to enable our population to thrive by starting well, living well, working well, ageing well and dying well.

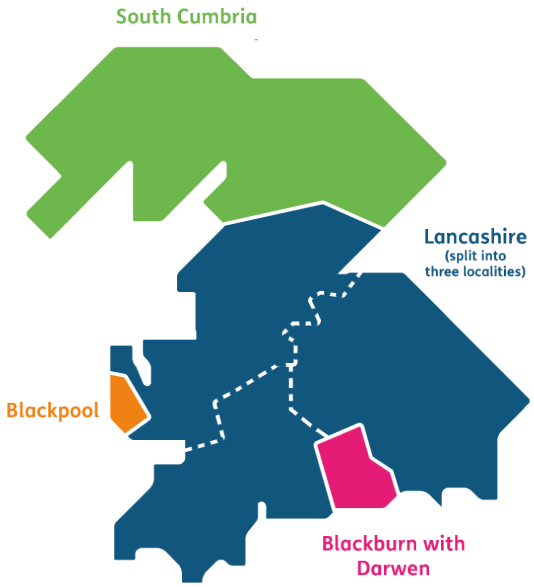
[1] https://lscintegratedcare.co.uk/our-work/our-strategy
[2] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/publications/strategies-and-plans/forward-plan



Whilst a significant amount of the strategy will be delivered through our four place-based partnerships on a neighbourhood, single-place or multi-place footprint, the ICP will also define a small number of systemwide priorities that we will focus on for the coming year to harness the opportunities of working in collaboration with all organisations within the NHS and our wider partners.

The ICP is one of our key vehicles to strengthen integrated working and tackle the most complex issues that cannot be solved by individual organisations through partnership working, where the potential achievements of working together are greater than the sum of the constituent parts. The delivery of our integrated care strategy is enacted through our place-based partnerships.

Our Places



A place-based partnership is a collaboration of planners and providers across health, local authority, voluntary and community groups and the wider community, who take collective responsibility for improving the health and wellbeing of residents – usually aligned to local authorities.

Most people's day to day care and support needs will be met within a place and delivered in neighbourhoods.

In Lancashire and South Cumbria there are four place-based partnerships each with a director of health and care integration.

Blackburn with Darwen

The Blackburn with Darwen place is matched with the Blackburn with Darwen Borough Council footprint and as such there is routine and regular engagement with the Health and Wellbeing Board, the local authority departments and the Health and Adults Overview and Scrutiny Committee.

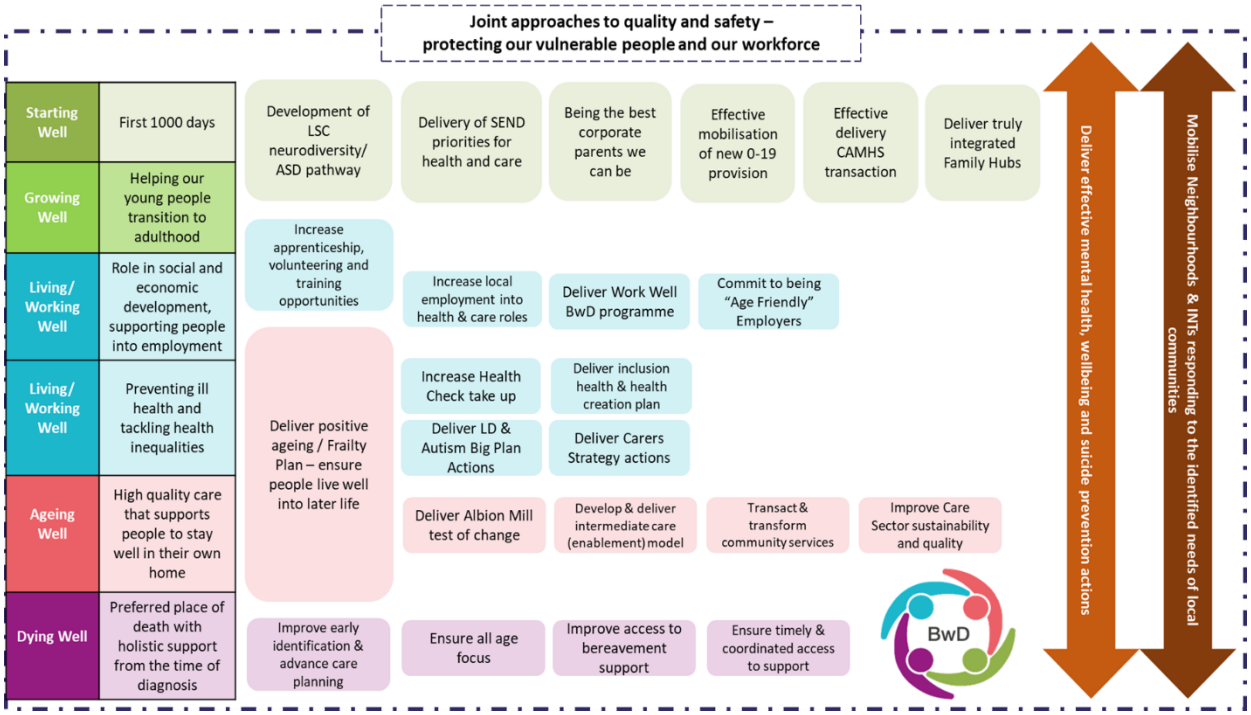
The role of the ICB place team in Blackburn with Darwen includes:

- To convene and facilitate the place-based partnership.
- Support partners to collaboratively plan and deliver improvements in population health and health-care service provision.
- Seize opportunities for integration and joint commissioning.
- Facilitate delivery of key ICB workstreams.
- Facilitate delivery of the NHS's contribution to the Blackburn with Darwen Health and Wellbeing Strategy.

During 2024/25, the place has continued to hold a monthly place-based partnership Board meeting which includes a wide range of stakeholders.

Blackburn with Darwen Place-based Partnership priorities for 2024/25

The priorities are aligned to the joint local health and wellbeing strategy (JLHWS), commissioning plans and the priorities of our partners.



Some examples of our work during 2024/25

A summary of delivery programmes and impact is outlined below.

Creating Healthy Communities	Integrated Neighbourhoods	Mental health, wellbeing and suicide prevention	Enhanced Community Care	Urgent and emergency care
Insight, engagement and co-production Health equity & reducing inequalities Enhanced health checks Workwell BwD Carers strategy & action plan Ageing well & falls prevention SEND	INTs & anticipatory care Primary care neighbourhoods End of life care Ageing well/frailty Integrating community services Community mental health teams Family Hubs and integration for CYP	Compassionate communities Suicide prevention Effective prevention & early intervention Responsive treatment services Health and wellbeing with people for severe mental illness (SMI) Equitable access	Albion Mill Enablement "hub" and transformation Care sector quality improvement Discharge/D2A improvements Community based crisis response (intensive home support, virtual ward, 2hr urgent response)	Keeping people safe and well at home Step-up crisis response In-hospital flow & optimisation Discharge and downstream flow Cohort interventions – end of life, over 65s & care homes
Key impacts				
22% increase in health checks for people with LD	5% reduction in emergency admissions for ambulatory care sensitive conditions 19% increase in number of people with an Advance Care Plan 16% increase in % of people who died in their preferred place	2% point increase in health checks for people with SMI On average there are over 300 more people on SMI registers than there were last year 79 BwD patients seen through community mental health teams	12% increase in number of care home beds considered good since Sept 2024 35% reduction in D2A costs, saving £201,000	24% decrease in ED attends from care homes 31% decrease in hospital admissions from care homes 23% increase in referrals into ICAT from care homes 44% decrease in people with 3+ admissions in their last 90 days of life (Pennine)

Starting Well

Child and adolescent mental health services (CAMHS) for Blackburn with Darwen and East Lancashire moved from East Lancashire Hospitals Trust (ELHT) to Lancashire and South Cumbria Foundation Trust (LSCFT). The goal was to improve patient outcomes by aligning services with a provider specialising in mental health. A six-month report shows:

- A 3.3 per cent increase in the number of children and young people supported (194 more people).
- Referral to assessment waiting times decreased by 0.4 per cent, with 100 per cent of assessments held within four weeks.
- 77.8 per cent had paired outcomes, with 48.4 per cent showing meaningful improvement.

Living Well

- Integrated Neighbourhood Working
    - After a neighbourhood review a plan was created to improve primary care and integrated neighbourhood teams by focussing on frailty with 50 per cent of case load discussions involving the frail elderly. Overseen by a specially formed Neighbourhood Leadership Group key results include:
        - ✓ An 8.5 per cent decrease in emergency admissions due to falls in people aged 65 and over.
        - ✓ A 5 per cent decrease in unplanned hospital admissions for chronic conditions.
        - ✓ An 8.8 per cent decrease in emergency re-admissions within 90 days.
    - Four Complex Case Managers have been employed using Better Care Fund and urgent and emergency care funding to support Integrated Neighbourhood Teams (INTs) and high intensity users for urgent and emergency care. A weekly multi-agency cell meeting has been in place since February 2025 to review changes needed to support individuals and avoid multiple attendances.
        - ✓ Early indications show that this approach is reducing unplanned attendances by up to 60 per cent.
    - The Place based partnership has revisited the current neighbourhood delivery model to align leadership, direction, and staffing resources for a more integrated and systematic approach to care.
- Adult Community Health Services Transfer
    - The Blackburn with Darwen Place Team also oversaw the transfer of adult community physical health services from LSCFT to ELHT. The six-month review shows positive impacts:
        - ✓ Improved access to stroke services with reduced waiting times.
        - ✓ A 7 per cent decrease in ambulatory care sensitive admissions for diabetes complications.

- ✓ An increase in the number of people receiving a 2-hour urgent community response.
- ✓ All community teams are now on EMIS, improving information sharing with primary care.

- WorkWell Partnership Programme.
    - WorkWell is a pilot programme providing support to overcome health-related barriers to employment. It focuses on individuals out of work for six months or less or those struggling in the workplace due to health conditions. Key data includes:
        - ✓ 42 per cent of referrals come from primary care.
        - ✓ 65 per cent of referrals are from priority wards.
        - ✓ Mental health and musculoskeletal conditions are the primary health barriers.
        - ✓ 44 per cent of those accessing support have shown positive outcomes in employment.

Ageing Well

- Building an enablement focused intermediate care model
    - A new model of intermediate care aims to provide a seamless transition between hospital and community care, focusing on maintaining independence.

- Test of change for intermediate care at Albion Mill
    - Albion Mill provides short-term, bed-based intermediate care. A new service delivery model was piloted, focusing on reablement. Initial results show positive feedback and a reduction in hospital attendances.

- Care sector collaborative improvement
    - A multi-agency program aims to improve standards in care homes and reduce hospital attendances. Key improvements include:
        - ✓ A 55 per cent decrease in attendances and a 60% decrease in admissions.
        - ✓ A 10 per cent increase in intermediate care allocation team referrals.
        - ✓ A 12 per cent increase in the number of beds rated ‘good’ by the Care Quality Commission.

Dying Well

- Improving care and support for people at the end of their life
    - Efforts to improve end-of-life care include early identification and multi-agency care planning. Key improvements include:
    - A 19 per cent increase in the number of people with an advance care plan.
    - A 16 per cent increase in the number of people dying in their preferred place of care.

- A 44 per cent reduction in admissions for people approaching the end of their life.

South Cumbria

Uniquely for our area, South Cumbria place is not co-terminus with any one local authority. Since the formation of unitary authorities from April 2023, the South Cumbria place includes:

- The geography of the newly created Westmorland and Furness Council, excluding the Eden district.
- The area around Millom which is within the newly created Cumberland Council.
- The areas around Bentham which is within the newly created North Yorkshire Council.

In July 2024, the Westmorland and Furness Health and Wellbeing Board adopted its new Joint Local Health and Wellbeing Strategies (JLHWBS) and in September 2024 the Board approved a supporting two-year action plan and outcomes framework. Cumberland and North Yorkshire councils had a pre-existing strategy.

In setting priorities for 2024/25 in the South Cumbria place, partners, including the three Health and Wellbeing Boards, reviewed the content for the three Joint Local Health and Wellbeing Strategies. There was clear commonality across the three.

Some examples of our work during 2024/25

Monthly Place Partnership Forum including the voluntary, community, faith and social enterprise sector; the NHS; local councils; police; fire and rescue; and large private sector organisations. This forum has enabled us to co-design the scope and ambitions of our key work programmes, as well as engaging on proposals for different ways of working.

Priority Wards in Barrow-in-Furness

This work explored why there were a high number of residents of the Central, Hindpool and neighbouring wards needing or using emergency care services.

Healthier Streets in the Central Ward	Happy Hopeful Hindpool	Self-Harm
• This initiative is driven through a citizen led group, engaging with residents to create a sense of belonging and neighbourliness to wrap around the most vulnerable residents. • The group initially focused on tackling public health issues such as litter, rat infestation and community connection. • With support from Barrow Integrated Care Community, we delivered health checks and health promotion activities.	• We have worked with Cumbria Police on a national, multi-agency partnership tactic called **Clear, Hold, Build** which is designed to tackle serious and organised crime and rebuild neighbourhoods affected by this. The challenge in Hindpool related to drug offences and county lines. • The three-phase initiative, known locally as 'Happy Hopeful Hindpool' included police action to **clear** target criminals and their associates; a persistent police presence to **hold** the community and action by partners and residents to improve the health & wellbeing of residents in Hindpool ward to **build** the community. • The project has focussed on increasing awareness of support for substance misuse/recovery & mental health crisis support. The project has increased the number of residents registered with GP practices, thus increasing their access to prevention services and health and wellbeing support.	• There is a significant pattern of self-harm within the priority wards of Barrow-in-Furness, driven by numerous complex factors. We have focused on three key areas: ○ **Starting Well - One school approach.** This included wrapping support around families, reducing the burden of paperwork and developing a more relational approach to care services. ○ **Living Well – Improve access & knowledge.** Work here included partnership working with SAFA (Self Harm Awareness For All), positive social media campaigns, and the development of an online community. ○ **Ageing Well – Reduce loneliness & isolation.** Through engaging with the community, we discovered that, alongside known patterns of self-harm within young people, there were less visible forms of self-neglect, particularly within older and more socially isolated residents. Stakeholders have come together to improve access and knowledge of local services that can provide support, increase access to activities for isolated individuals and improve access to day care and befriending services.

Outreach and Inclusion Projects

Lancashire & South Cumbria ICB has provided funding to general practices to support the detection of unmet need. During 2024/25, our Primary Care Networks have undertaken a wide range of projects, tailored to the needs of their residents, including:

- Addressing cardiovascular risk in hard-to-reach people.
- Engaging with patients with learning disabilities and/or serious mental illness who have not taken up the offer of routine best practice health checks.
- Outreach to migrant hospitality workers who live and work in the Lake District but who are not registered with a GP practice.
- Working with adults over the age of 55 who have not engaged with their GP practice in the last 5 years and who may have, or be at risk of, chronic disease.
- Providing relationship health services for children and their families who are experiencing difficulties with emotional and relational stress but do not meet the criteria for Child and Adolescent Mental Health Service (CAMHS) intervention.
- Engagement with agricultural workers and rural farming communities who are less likely to access healthcare services due to the nature of their work and culture.

Early outcomes include:

- As of January 2025, 46% of the targeted hard to reach patients within the Grange and Lakes community have been engaged and have attended Primary Care for routine health checks.
- Pop-up health and wellbeing sessions delivered in Dalton and Ulverston alongside the launch of the "Big Baggy T-Shirt Club", a weight loss programme for residents with a BMI over 30.
- The delivery of standard NHS and Learning Disability health checks to hard-to-reach residents in the Duddon Valley, Dalton and Ulverston.

- Population Health Project Officers in Carnforth and Milnethorpe to support engagement with socially isolated residents.
- Delivery of the iMatter Relationship Health service to children and families in Kendal with 29 families referred and supported.
- Launch of a Pain Café in Millom to support patients with chronic pain. Staff have undertaken accredited training to enable them to deliver a bio-psycho-social model of pain management, with the aim of reducing the usage of opioid painkillers.
- Engagement with rural families and related agencies such as Natural England, RABI (Royal Agricultural Benevolent Institution) and the Field Nurse Charity through a combination of one-to-one interviews, group events and pop-up activity at local shows and cattle markets.

Barrow Rising: Work and Health

Barrow Rising describes the vision developed by the local partners and people of Barrow. It is focused on making Barrow a better place to live, work, study, visit, and invest. It provides a chance for every resident, business, and visitor to play a role in shaping Barrow's future.

In 2024/25, a range of exciting actions and investments have been taken forward, including:

- The commissioning of a review of economic inactivity within Cumbria.
- The commissioning of a vulnerable children's needs assessment.
- Funding secured to extend the work of the Barrow Poverty Truth commission and the launch of a Work and Health commission
- The commissioning of VCFSE capacity to support people seeking to return to work, or at risk of leaving due to ill health (identified and delivered through the WorkWell vanguard)
- Investment to develop a Healthy and Inclusive Workplaces programme and accreditation.
- The scoping of estate and capital investment required to ensure health services are rightsized for the current and inbound population.

Intermediate Care

An intermediate care bed facility, hosted by Parkview Gardens residential home in Barrow, opened in August 2024. It provides a place for people who no longer need specialist hospital care, but still require support, to regain their independence in a residential setting before returning home.

- ✓ To date, around two-thirds of patients have returned to their own home after spending an average of 19 days in the unit.

Integrated Wellness Service

A review at Furness General Hospital found that a small number of patients, mostly over 70 and from deprived areas, had long hospital stays. A multidisciplinary team assessed a small group to understand how different agencies could support them at home and avoid lengthy hospital stays.

An Integrated Wellness Service was tested, focusing on residents with three or more unplanned hospital admissions in the past year. Holistic assessments were done by case workers, with regular meetings to decide the best support. The team included doctors, nurses, pharmacists, therapists, social workers, and the voluntary sector.

- ✓ In the two months following the interventions, unplanned hospital admissions for the selected group reduced by about 40 per cent, and 50 per cent of people were directed to support from the voluntary sector.

Supporting our current and future workforce

We have continued to work across a range of public and private sector partners to attract people into the work in South Cumbria, particularly to consider a career in health and care, as well as working with employers to support their workforce to stay healthy and thrive in work. Example of this include:

- Engaging with young people who are not in education, employment or training to better understand barriers to entering the workplace.
- Engaging with young people through schools and colleges to increase awareness around the wider range of professions and career opportunities in health and care.
- Offering an increasing range of step-into-work and access-to-work programmes.
- Working together to agree and implement a minimum standard of workplace accreditation pledges for partners, including Disability Confident Accreditation and Veterans Support.
- Implementing a Personalised Work Passport to support people in employment with a disability or health condition.

The WorkWell Partnership Programme

A national support service designed to help people with low-level health conditions to start, stay or succeed in work has been rolled out across Lancashire and South Cumbria, with one area of focus being Barrow-in-Furness. Created as part of the Government's plan to help people with health conditions back to work, the service provides tailored help and assessment for people aged 16 and above at risk of falling out of work or for those who have had to stop working because of a health condition.

To be eligible, individuals will be either out-of-work for approximately six months or less and need health-related support to return to work or be employed and absent through sickness or struggling in the workplace due to a health condition. As part of the offer, individuals will have access to a work and health coach, who will offer individualised support for approximately 12 weeks to address individuals' physical, psychological and social needs.

Launched in January 2025 in Barrow, the service is being promoted with residents in our priority wards (Central, Hindpool, and Barrow Island) as well as with local employers. We have partnered with MIND in Furness who will offer self-guided early intervention mental health support for a variety of mental health related challenges (e.g., stress, anxiety, loneliness, menopause) and Barrow Leisure Centre who will offer support physical health challenges linked to musculoskeletal problems.

Lancashire

During 2024/25 the Lancashire Director of Health and Care Integration, Louise Taylor retired and was succeeded by Sakthi Karunanithi as interim Director of Health and Care Integration.

Our geography

Lancashire Place has a population of c1.2 million spread across a large and varied geographical footprint, and we work within three sub-localities, North, Central and East Lancashire so as to be closer to our community needs. These communities vary greatly across the patch, and we work closely with our District Council partners.

Large health inequalities exist throughout the county with some of the neighbourhoods featuring in the top 10 per cent most deprived areas of the country. It is important we tailor our approach to ensure we are supporting our communities and residents to meet their specific needs and make best use of our joint resources and collective assets.

Our vision

Our vision in the Lancashire Place is 'Living Better Lives in Lancashire'. Our ambition is to help the citizens of Lancashire live longer, healthier and happier lives. We will do this by improving health and care services through integration and addressing health and wellbeing inequity across the Lancashire Place.

We are proud of our achievements as Lancashire Place during 2024/25, as we have continued to develop a strong partnership with good local foundations.

Summary of achievements and work during 2024/25

The Lancashire Place Partnership (Board) has matured with cross sector representation including elected member involvement as chair. Our elected member is the chair of the partnership. The Lancashire Place Plan for 2024-25 was

developed with significant collaboration from the ten Health and Wellbeing Partnerships and guided by the three Integrated Place Leads and three Clinical and Care Professional Leads. Following a data led approach, our key priorities for 2024/25 were identified as:

- Enhanced Care in the Community
- Integrated Working
- Creating Healthy Communities

To date Lancashire Place workplan has focused upon the three ICB workstreams above and also in each locality to drive forward local projects based on local need. The key achievements include:

- Enhanced Care in the Community
    - The 'Lancashire Model of Intermediate Care' has been fully implemented. The Short-Term Support Service has helped 197 people to remain at home (increase of 24 per cent since April 24) and visitors to 'Ask SARA' site increased by 18 per cent and reports completed increased by 30 per cent.
    - Targeted work programme to reduce not meeting criteria to reside (NMC2R) across University Hospitals of Morecambe Bay Trust footprint alongside South Cumbria Place and Lancashire County Council is demonstrating a positive impact. NMC2R reduced by 4.7 per cent and average length of stay by 31 per cent for Q3 position. Delays attributable to LCC reduced from 27 to 20.5 people per day.
    - Two Hour Emergency Community Response utilisation stands at 95per cent for Lancashire against target of 70 per cent and Virtual Wards Utilisation increased by 29.8 per cent since June (current occupancy Lancashire Wide is 292 from 205)
    - Better Care Fund reviews are completed and Lancashire BCF Board is currently being refreshed and reconvened for 2025/26 with outputs from the reviews informing the forward plan.
    - An Intermediate Care Group for Lancashire has been established to share best practice and support consistent improvement across Lancashire. Programme to increase the time-limited bed-based offer in Central Lancashire has been launched, targeted work commenced across Fylde Coast and Pennine Lancashire to support 'keeping people safe and well at home' and 'effective discharge and community support' offers. LCC, LSCFT, and LHT are also collaborating on a joint approach to single-handed care.
    - The Discharge to Assess review has been completed for Lancashire and outputs being used to inform future improvement through the Lancashire Intermediate Care Group

- Integrated Working:
    - We have spent 2024/25 developing a Lancashire model of Integrated Neighbourhood Working, hosting forerunning area events (both Lancashire wide and locality/ sub-locality specific) with our key stakeholders to ensure that the model meets the needs of the community, through the lens of those who job it is to support them.

- The Lancashire model provides the vision and core elements of the optimum business model for integrated working. It is intended that this is a blueprint which with be adopted and tailored specifically to the needs of each community it seeks to support. Recent work has begun to identify which elements are most appropriate to undertake at which geographical/ numerical section of the population in each locality/ sub-locality, such as across a PCN footprint.
- Two districts; Fylde and Wyre and West Lancashire, have been mobilised against the Lancashire Model in 2024/25 and are meeting regularly to progress this workstream. These pilot areas will be increased in 2025/26.
- Work on development of the shared care record is underway across partners led by the ICB Digital team and partners.

- Creating Healthy Communities:

  - The baselining from the Leisure Review and the Disabled Facilities Grant Report has been shared with the nominated District Chief Executives and both were received positively. Discussions and forward planning are ongoing. This includes implementation of the recommendations from the Disabled Facilities Grant report. It also includes creating a proposal for the transition of health services such as therapies into leisure facilities.
  - A virtual joint unit was developed to create closer links between Lancashire County Council's Public Health & ICB Population Health Team. During this year, we have focussed on the aligned procurement, design and delivery of NHS Health Checks and Enhanced Health Checks.
  - Progress has not been made in all areas on district-based health and wellbeing strategies. This partly due to capacity and partly due to a recognition that this may not be required at local level, however, connectivity to the Lancashire Health and Wellbeing Board strategy is planned for the year 25/26.
  - Progress has been made against the local priorities of the ten Health and Wellbeing Partnerships, please see below for further information.

Blackpool

Blackpool is an urban coastal area with a resident population of approximately 142,700 people. The town is well known for its thriving tourist economy along with a strong sense of local community, although the nature of the coastal community can also bring challenges around health and wellbeing. With high levels of deprivation and a transient population, Blackpool residents have some of the most challenging health needs in the country. Both men and women in Blackpool have the lowest life expectancy from birth of any local authority in England. Blackpool's male life expectancy is 5.5 years below England and 3.9 years below the North West. Female life expectancy is 3.8 years below England and 2.5 years below the North West (2021-23). The 2019 index of Multiple deprivation ranks Blackpool as the most deprived of 317 Local Authority areas in England, based on both the average Lower Super Output Areas (LSOA) score and concentration of deprivation measures. Of the 94 Blackpool LSOAs, 39 are in the 10 per cent most deprived in the country, with the most deprived neighbourhoods in the centre of the town. An important factor that we will see in Blackpool, as well as elsewhere across the country, is the rise in the

older population. Projections for Blackpool show the number of residents over-65 will increase considerably within the next 20 years, far in excess of the levels shown in all other age bands. The over-65 population is projected to rise over 20 per cent from 29,500 in 2023 to almost 36,000 in 2039 and will then make up over a quarter (26 per cent) of Blackpool's total population.

Blackpool is a town with a very strong sense of community and there are many exciting developments underway to ensure it remains a vibrant place. Blackpool Place is committed to putting residents at the heart of what we do, listening to people with lived experience, understanding their needs and co-designing solutions that work best for our communities. Our main ambition is to improve healthy life expectancy for the people of Blackpool.

The Blackpool Place-Based Partnership includes a wide range of health and care professionals from across different organisations and sectors. Colleagues from our local voluntary, community, faith and social enterprise sector are key members along with NHS, local authority and other organisations including Blackpool Teaching Hospitals NHS Foundation Trust, Blackpool Council, GPs as well as the Integrated Care Board.

The Blackpool Health & Wellbeing Board have produced a Joint Local Health and Wellbeing strategy for the period 2024 to 2028. The aim of the strategy is to drive change to help improve the health and wellbeing of the population of Blackpool and reduce the gap in health outcomes between Blackpool and England as a whole. It has identified a number of metrics and milestones to collectively work towards. These will be monitored biannually and reported to the Health & Wellbeing Board. These are grouped around four priorities:

- Starting Well
- Education, Employment and Training
- Living Well
- Housing

Priorities and actions agreed within the strategy were determined during a number of engagement sessions with representation from all Health & Wellbeing Board member organisations, including Lancashire and South Cumbria ICB. The strategy puts the challenge out as to what are those things that we can best do together in order to tackle the root causes of many of our ill health in Blackpool, and what are our greatest opportunities to show we can make a demonstrable change for our residents and communities. For example, reducing smoking in pregnancy and reducing the proportion of 16-17-year-olds who are not in employment, education or training (NEET).

Healthwatch Blackpool

Healthwatch Blackpool have collaborated with Public Health Blackpool to better understand experiences of menopause and perimenopause.

Specific attention was given to:

- Individuals who are or have been experiencing perimenopause/menopause.

- Professionals, including medical professionals and large employers in Blackpool who support individuals who are perimenopausal/menopausal.
- Family members, loved ones and friends of individuals who are perimenopausal/menopausal.

Between February and June 2024, Healthwatch Blackpool gathered feedback from 558 individuals via a survey and 136 people through focus groups/interviews. A comprehensive report including recommendations can be found on the Healthwatch Blackpool website.[3]

Healthwatch Blackpool continue to work with colleagues across the system to embed the recommendations and improve the lives of those experiencing perimenopause/menopause.

Urgent and emergency care

Another key area of focus is Urgent and Emergency Care. Our communities only want to be admitted to hospital when necessary and appropriate. As a Fylde Coast footprint, our work is split into three key areas -

- Keeping people safe and well at home
- Reducing time away from home
- Getting people home

As a collaborative place-based partnership, we are working hard to ensure we grasp further integration opportunities wherever possible, acknowledging that a person's health is shaped by a variety of factors.

A practical example of this is in relation to the Acute Respiratory Infection (ARI) hubs which involve targeted support for those with respiratory conditions. This was a national recommendation and one which we shaped to ensure that the offer was right for our local communities. We seized the opportunity to make every contact count by providing additional wraparound care and support at our Whitegate Drive facility. In addition to the health element of the hub, this included co-locating Citizen's Advice Bureau colleagues alongside health. In conjunction, and complementary to this, we also undertook some wide-ranging outreach work across the patch with Groundwork and other colleagues, so that a broad range of advice and support was available for Blackpool residents.

We are now taking the learning and feedback from this work to help shape our winter plans for 2025/26.

Population Health

The work of the Population Health team in Blackpool is focussed on how we can use our NHS resource "upstream" to prevent illness, and to prevent existing illness from worsening; with a focus on those people in our communities most in need.

Closely aligned with the Urgent and Emergency Care focus, specific work is being undertaken to address urgent care demand in our priority wards. Priority wards are

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[3] https://healthwatchblackpool.co.uk/menopausereport/

areas defined as being in the 20 per cent most disadvantaged nationally, as well as showing a higher than expected use of urgent care. Building on both quantitative and qualitative data, and working in partnership across Blackpool with colleagues including public health, primary and community care, CVFSE, and community representatives, specific work is now being undertaken to test new models of care. With a focus on providing one stop assessment and diagnostic services for adults with respiratory conditions initially, this test of change is intended to understand how different delivery models based on outreach and integrated working across statutory and voluntary services, can support residents to keep safe and well at home.

Spring Into Spring

Since 2023, the Blackpool Place-based Partnership (PBP) has hosted biannual community events; Spring into Spring and Active into Autumn. These events have given local statutory and voluntary, community, faith and social enterprise (VCFSE) sector organisations chance to showcase their work, network with other organisations, and connect with potential service users.

Feedback has been largely positive- people enjoyed the opportunity to meet in person, organisations were able to form stronger relationships, visitors liked being able to see so many opportunities and offers. Constructive criticisms focused on bringing in organisations beyond the 'usual', such as grassroots community organisations, greater advertising and coverage, in addition to requests for more events in community spaces.

In April 2024 the place-based partnership hosted a series of 'Spring into Spring' events in priority ward community spaces- five events in five days, making use of community centres in each of the priority wards, with a larger event at the Winter Gardens to close the week.

A subsequent series of five complementary community events, 'Active into Autumn' were hosted in October 2024. The events focused on needs identified by the hosting community organisations; for example, DWP attended venues where access to benefits is a concern for residents. The final event at the Winter Gardens brought together more than eighty services and organisations: a broad spectrum of services available in Blackpool to residents, patients, service users and volunteers.

New Hospitals Programme

On 20 January 2025, the Secretary of State for Health and Social Care, Wes Streeting made a statement on the outcome of the Government's review into the national New Hospital Programme.

The review, which was announced in July 2024, was designed to ensure that the New Hospital Programme could be delivered in a realistic and costed manner.

The outcome of the review showed an ongoing commitment to delivering two brand-new hospitals on two new sites to replace Royal Preston Hospital (Lancashire Teaching Hospitals NHS Foundation Trust) and Royal Lancaster Infirmary (University Hospitals of Morecambe Bay NHS Foundation Trust), which will create better outcomes for patients and staff across Lancashire and South Cumbria.

However, as referred to by Mr Streeting, the timescales for delivering these two hospitals are now delayed, with construction expected to begin between 2035 and 2039.

Under a revised delivery timetable published on 20 January 2025[4]:

- Construction work on a replacement Royal Lancaster Infirmary is expected to start between 2035 and 2038
- Construction work on a replacement Royal Preston Hospital is expected to start between 2037 and 2039.

Work on the two Lancashire and South Cumbria New Hospital Programme schemes continued whilst the review took place. In December 2024, proposed sites were announced for the two brand new hospitals[5], with the land acquisition process supported by the national New Hospital Programme. Earlier in January, a comprehensive series of public and colleague engagement events and a survey were launched to gather feedback and insights on the proposed sites.

In light of the significant delay to the timeframes in which the new hospitals are expected to be built, the local NHS has made the difficult decision to suspend public engagement on the proposed sites until further notice. The public and staff are thanked for their input so far. Further updates will be shared in due course.

[4] https://www.gov.uk/government/publications/new-hospital-programme-review-outcome/new-hospital-programme-plan-for-implementation
[5] https://newhospitals.info/ProposedSites

Performance analysis

This section of the annual report provides an overall explanation of how the ICB discharged its functions between 1 April 2024 and 31 March 2025 against the NHS Operating Plan and Planning Guidance. It includes information on specific areas as required in reporting guidelines. The Performance analysis gives detail for users wanting to know more than is included in the earlier Performance Overview.

The system has been subject to significant pressure throughout the year which has had an impact on performance across a range of areas. Not one part of the system operates in isolation, therefore pressures in one area are seen to directly affect another.

Domain	Metric	Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Latest comparable position	
															NW	National
Elective	Total patients waiting more than 78 weeks to start consultant-led treatments	**0**	21	18	13	16	29	43	62	37	19	28	36	11	85	1822
	Total patients waiting more than 65 weeks to start consultant-led treatments	**0**	786	960	1101	882	828	358	466	347	275	340	340	155	991	8488
	% Patients waiting more than 52 weeks to start consultant-led treatments		3.9%	3.9%	3.9%	3.6%	3.5%	3.2%	3.1%	3.0%	2.8%	2.8%	2.9%	2.8%	3.2%	2.6%
	% Patients waiting 18 weeks to start consultant-led treatments	**92%**	58.5%	59.3%	59.1%	59.3%	59.6%	60.0%	60.6%	60.9%	60.5%	60.6%	60.3%	60.7%	57.5%	59.8%
Diagnostic Waiting Times	% Patients waiting less than six weeks for diagnostic test	**95%**	73.5%	76.3%	74.4%	73.2%	71.0%	71.4%	71.9%	73.7%	72.0%	73.9%	79.6%	80.7%	88.6%	81.6%
CYP / Maternity	Smoking at time of delivery [Year-to-Date]	**6%**			8.0%			8.1%			7.7%			not available	6.60%	6.13%
	Population vaccination coverage - MMR for 2 doses (5yrs old)	**95%**			87.2%			86.2%			86.9%			not available	85.70%	85.00%
Cancer	31 Day First Treatment	**96%**	90.4%	93.3%	94.2%	92.7%	94.4%	92.9%	92.7%	92.1%	94.2%	90.9%	94.1%	91.9%	94.4%	91.4%
	62 Day referral to treatment	**85%**	65.9%	68.0%	70.9%	68.7%	68.6%	67.2%	68.2%	71.2%	73.6%	70.7%	68.1%	69.5%	72.8%	71.4%
	% meeting faster diagnosis standard	**75%**	75.2%	78.4%	78.3%	77.8%	77.6%	75.9%	79.8%	79.1%	80.6%	76.0%	80.8%	79.4%	78.7%	78.9%
Urgent and Eergency Care	A&E 4hr Standard	**78%**	77.8%	77.9%	78.4%	78.3%	78.3%	77.0%	76.4%	76.1%	75.0%	74.5%	76.4%	76.9%	73.1%	75.0%
	Average ambulance response time: Category 2 [NWAS]	**00:30:00**	00:21:48	00:25:54	00:26:53	00:27:44	00:21:03	00:28:53	00:35:06	00:36:47	00:42:21	00:35:44	00:28:40	00:25:31	00:25:31	00:28:34
Mental Health and Learning Disabilities	Inappropriate adult acute mental health Out of Area Placement (OAP)	**0**	19	12	9	10	6	10	15	20	16	19	22	14	not available	not available
	Estimated diagnosis rate for people with dementia	**66.7%**	68.4%	68.5%	68.4%	68.9%	69.1%	69.3%	69.4%	69.7%	69.3%	68.8%	68.4%	68.4%	70.1%	65.6%
	Reliable Improvement	**67%**	64.0%	69.0%	70.0%	68.0%	64.0%	67.0%	65.0%	66.0%	66.0%	66.0%	65.0%	66.0%	67.0%	68.4%
	Reliable Recovery	**48%**	49.0%	51.0%	52.0%	49.0%	46.0%	47.0%	46.0%	46.0%	47.0%	47.0%	44.0%	44.0%	46.0%	48.5%
Primary Care	Number of general practice appointments per 10,000 weighted patients		4193	4192	3892	4255	3821	4163	5822	4411	3912	4574	4071	4334	4328	5063
	Seasonal influenza vaccine uptake amongst GP patients in England - 65+ [Sep24-Feb25]							74.0%							73.7%	74.2%
	Proportion of diabetes patients that have received all eight diabetes care processes (YTD)		39.3%												37.7%	40.9%

Elective Recovery

The total number of patients waiting for treatment has reduced during the year, with a total of 240,358 patients waiting for treatment at the end of March 2025 at ICB level (0.81 per cent reduction from the March 2024 position). Chart 1. below shows the distribution of the waiting list by the length of time waiting. Chart 2. shows the percentage of the number of patients waiting under 18 weeks (60.7 per cent) and over 52 weeks (2.8 per cent). Both have shown improvements in year and these will need to be sustained and progressed further in 2025-26.

Chart 1. Waiting list by distribution of waiting time 2024-25

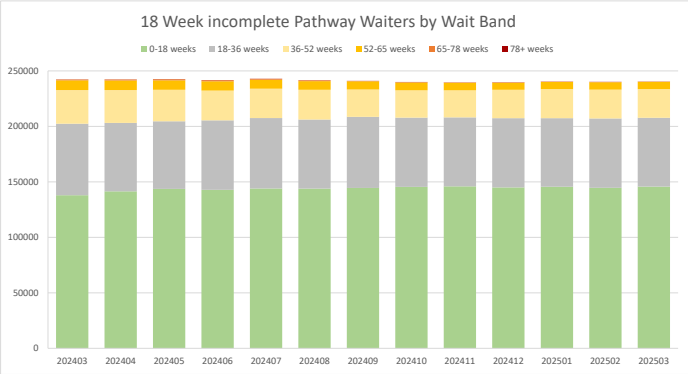
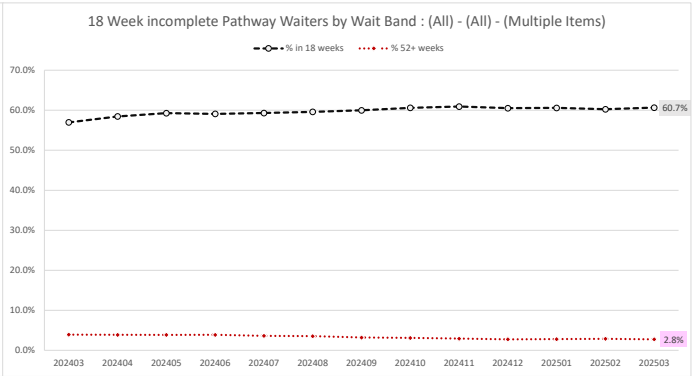


Chart 2. Percentage of patients waiting over 18 weeks and 52 weeks



There have been significant reductions made in the volume and proportion of patients waiting more than 78 weeks and 65 weeks for treatment during the course of 2024-25 on the way to a target of zero long waiting patients. At the end of March 2025, Lancashire and South Cumbria ICB commissioned activity reported:

- 0 x 104+ week breaches
- 11 x 78+ week breaches for ICB registered patients
- 155 patients waiting over 65 weeks
- 240,358 patients awaiting treatment.

The Lancashire and South Cumbria Elective Recovery Strategy has focused on six key areas during 2024/25 to maximise and optimise elective capacity while building on our system-wide approach to the management of waiting times and capacity. Key highlights around work ongoing to drive the reduction in waiting lists are:

- Working collaboratively and providing mutual aid across providers to support eliminating our longest waits. Most recent examples include University Hospitals of

Morecambe Bay and Lancashire Teaching Hospitals offering capacity to support the gynaecology challenges in other parts of the system.

- All Providers continue to improve and sustain excellent levels of theatre utilisation, demonstrated by LSC being regularly in the upper quartile of systems in the country for capped theatre utilisation.
- Optimising the use of Surgical Hub continues; expanding capacity to both reduce waiting lists and retaining High Volume Low Complexity (HLVC) cases on NHS waiting lists being treated in hubs.
- The Outpatient Productivity project, which commenced in September 2024 is progressing well.
- Several high impact improvements identified through the orthodontic transformation project have already been implemented to optimise the use of secondary care capacity.

Diagnostic Waiting Times

80.7%

38,742

People waiting less than 6 weeks for a diagnostic test DM01 (Target 95%)

The performance at the ICB level for the number of people waiting less than six weeks for a diagnostic test has not been achieved for the full financial year. The compliance at the end of March 2025 was an improved position and better than the previous year, although performance remains below that seen across the Northwest region and nationally.

At the provider level, East Lancashire Hospitals Trust has improved their DM01 position significantly and achieved compliance for the last 2 months of the year. University Hospitals of Morecambe Bay (UHMB) has seen a deterioration in performance over the last 8 months and is no longer complaint with the DM01 target. There is improving performance at both Blackpool Teaching Hospitals (BTH) over the year despite being below the target figure. The performance at Lancashire Teaching Hospitals (LTHT) is considerably below target in March 2025, this is due to significant number of patients waiting in almost every modality.

Community Diagnostic Centres (CDCs) are a key national policy, part of the elective care recovery plan, aimed at enhancing diagnostic services in England. They alleviate pressure on acute services, dedicate resources for elective diagnostics, and boost diagnostic capacity.

Across Lancashire and South Cumbria, eight CDC sites, managed by local NHS hospital trusts, conducted over 200,000 tests in 2024/25, totalling nearly 500,000 since

2022. CDCs contributed to about 14 per cent of diagnostic waiting time activity and 12 per cent of all diagnostic activity, with NHSE providing over £51 million in 2024/25.

While some sites exceeded expectations, others faced delays due to estate issues. The 2025-26 plan includes expanding current sites and increasing activity to 348,000 tests. Burnley CDC will introduce CT services, and Crosslands CDC in Barrow will start MRI services.

Healthwatch reviewed patient experiences at Rossendale CDC in East Lancashire in 2024, noting comfort, punctual tests, and reassuring staff. Patients appreciated having their questions answered and maintaining privacy and dignity. One patient found CDCs more convenient due to health conditions affecting travel to hospitals.

Transformation

The Lancashire and South Cumbria Diagnostic Collaborative have continued to support Imaging, Endoscopy and Physiological Science Networks, alongside Digital Diagnostics Programme and continued development of Community Diagnostics Centers during 2024/25. Optimising the delivery of Diagnostic services continues to support the wider system delivery, across cancer and elective pathways, UEC and primary care.

There have been multiple improvement projects and programmes of work which have supported the provider organisations to improve service delivery, optimisation of pathways, performance and productivity. There are now 8 Community Diagnostic Centres across the 4 provider organisations that delivered over 200,000 diagnostic tests in 2024/25.

Forward Plan 2025/26

To deliver against the Diagnostics delivery requirements contained within the 2025/26 memorandum of understanding between NHS England, the ICB, PCB Diagnostic Collaborative and provider organisations. The focus will be on delivery of performance and productivity improvement and sustainability of Imaging Services and Community Diagnostic Centres within Lancashire and South Cumbria.

Children and Young People and Maternity

The levels of smoking at time of delivery remain higher than national levels and significantly above in Blackpool. The proportion of women smoking at time of delivery continues to fall however and initiatives with more women seen by the treating tobacco dependency team and an increase in women who have supported care plans.

86.9%

4,087

Receiving two vaccination doses before fith birthday (Target 95%)

The population vaccination coverage for 5-year-olds compares favourably with the Northwest and national levels. The Primary Care Networks (PCNs) continue to work with the Improving Immunisation Uptake Team (IIUT) to increase uptake in vaccinations for 0–5-year-olds.

Latest information shows that there are currently 244 children waiting over 52 weeks for Community Services in Lancashire and South Cumbria. The number of 52 weeks waits have continued to increase despite the recovery of speech and language therapy services within Lancashire and South Cumbria Foundation Trust, as there continues to be pressure across all trusts on the Paediatric Community Services. There is an ongoing paediatric services review being led by the ICB children's team looking at a consistent delivery of service, however in the immediate term the ICB is working with providers on recovering the current position.

In 2024/25, a framework was created to handle palliative and end-of-life care responsibilities.

Efforts are being made to reduce waiting times for children's services, focusing on speech and language therapy, community paediatrics, ENT services, specialty dental work, and outpatient care.

Work continues to improve the health of children with long-term conditions, particularly asthma.

- An educational program has trained over 800 practitioners, and efforts are being made to optimise asthma care, including working with housing colleagues and supporting school nurses.
- Significant progress has been made in diabetes care, with 72 per cent of children and young people with type 1 diabetes now using hybrid closed-loop technology, improving their blood glucose control.

The epilepsy care team has piloted a lead Epilepsy Specialist Nurse, supporting new epilepsy specialist nurses, delivering a genomics support clinic, and co-producing a transition to adult services.

Children's voices are central to all work, with significant engagement through 'feedback fortnight' in March 2025, where over 500 surveys were completed.

The LUNDY model training course has been developed and adopted by the ICB and Lancashire County Council, funded by Youth Focus North West and Children's Safeguarding.

Working with the voluntary sector has been a priority, focusing on type 2 diabetes prevention, asthma management, child safety, accident prevention, education on common winter illnesses, and support for children admitted to hospital with emotional health needs.

The aim is to optimise the health of children with long-term conditions living in the Core 20 wards, addressing wider health needs of children frequently attending urgent care.

The Children and Young People's (CYP) Quality team has developed a Quality Assurance Framework to support the ICB in ensuring the quality and safety of services.

A system-wide task and finish group has been established to co-produce a quality reporting schedule, included in the 2025/26 contractual reporting requirements.

The CYP Quality Team has implemented a process to monitor compliance with local and regional guidelines, including recommendations from independent reports.

Inspections of Local Special Educational Needs and Disabilities (SEND) Partnerships have been ongoing, focusing on reviewing and redesigning the neurodevelopmental assessment pathway and improving the quality of education, health, and care plans.

Maternity

Throughout 2024/25 we have continued to develop plans and implement change against the four key themes outlines in the three-year delivery plan for maternity and neonatal services (SDP).

Theme	Achievements
Listening to women and families with Compassion which promotes safer care **Listening and responding to all women and families is integral to safe and high-quality care, which is essential for improving safety, and women's and families experience of maternity and neonatal services. Our ambition is to improve personalised care and choice, and equity of access and outcomes, working with service users to achieve this.**	Continued to embed our commissioning arrangements with HealthWatch for the hosting of our four Maternity and Neonatal Voices Partnership (MNVP) Leads, and have worked with both HealthWatch and the MNVP Leads to agree standardised reporting and sign-off process for MNVP workplans. Commissioned a bespoke piece of work to provide live qualitative data around the effectiveness of personalised care and support plans providing an ongoing audit for all four Trusts Undertaken surveys with service users and staff to underpin the ongoing optimisation of the maternity electronic record and woman's held digital record Completed the final year of implementing perinatal pelvic health services, and have a substantive service lead in post for transition into business as usual Our Lancashire and South Cumbria Reproductive Trauma Service (RTS) has consistently maintained an above target access rate with steady referrals into the service over the last 12 months RTS has also delivered 139 hours of peer support, initiated a number of pilot schemes to continually improve the experience for women and delivered training across staff groups to ensure a trauma informed approach to care

Theme	Achievements
Growing, retaining our workforce to develop their skills and capacity to provide high-quality care **The ambition of the Lancashire Maternity and Newborn Service (LMNS) is to create a career pathway that provides opportunities for the entire population within Lancashire and South Cumbria. Employing local workforce within the NHS offers numerous benefits, including improving aspirations and removing barriers for those with significant social determinant needs. This approach empowers individuals and enhances their ability to achieve promotions in a fair and equitable manner. Moreover, it ensures that the workforce is excellently trained to meet the needs of the diverse population within Lancashire and South Cumbria.**	Successfully launched a Health T Level pilot for 20 students in East Lancashire. The T Level equips students with the necessary knowledge and technical skills to become a Maternity Support Worker or to pursue a midwifery degree, with the long-term aim of reducing university attrition rates. Completed year 2 of our Introduction to Midwifery 2 Day Course, following its successful pilot in 2023-2024. The “Into Midwifery Course” provides prospective university students with insights into what is required of them as student midwives. Launched a pilot for a Registered Midwifery Degree Apprenticeship (RMDA). This pilot project is funded for a three-year cohort of nine apprentices commencing in September 2024. The RMDA project will be monitored and evaluated based on achievement, attitude towards learning, work experience, and skills, as well as its effectiveness concerning retention, learning experience, and staff satisfaction. Developed a perinatal workforce tracker set to begin in April 2025 to ensure accurate staffing levels and compliance with standards. In collaboration with Trust providers, this tracker will be used to monitor and evaluate the workforce, providing valuable data for decision-making and planning, including neonates and the medical workforce.
Developing and sustaining a culture of safety, learning and support to benefit everyone	Continued to facilitate collaborative working groups to align clinical pathways and share best practice, including audit tools and Electronic Patient Record (EPR) configuration. Commenced preparation, linking with the innovation agency, to roll out the updated observational tools: Maternity Early Warning Score (MEWS) and Newborn Early Warning Trigger and Track 2 (NEWTT2). In response to feedback from women, and triangulation of other data intelligence, the LMNS has provided financial resource for key clinicians (midwifery and

Theme	Achievements
	obstetrics) across the 4 maternity services to access a bespoke training course on informed decision making and consent.
Standards and structures that underpin safer, more personalised and more equitable care that underpin our national ambition	Agreed a system wide standard operating procedure for the management and monitoring of the perinatal mortality review tool (PMRT) meetings Financially supported Trusts to release clinical staff to attend PMRT meetings across the system to ensure the required external input into the reviews. Established a working group to ensure as a system there is a dedicated forum to progress with the associated recommendations from the North-West Maternal Death Review undertaken by the Maternal Medicine Network. The inaugural meeting took place in March 2025 with key stakeholders from acute, community, perinatal mental health and primary care. Outputs and any associated quality improvement projects are expected to be progressed over 2025-26. Developed a baseline dashboard of key clinical indicators, monitoring trends across the LMNS. These are reviewed by the lead obstetrician and midwife and presented as an exception report to the quality assurance panel. Collaboratively developed a wider set of maternity metrics to ensure that local dashboards are using the same data sources

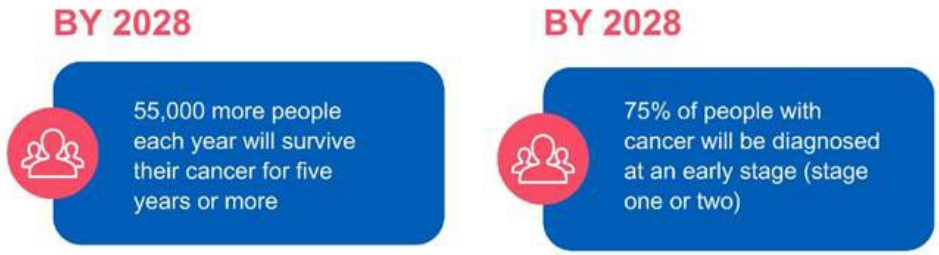
Cancer

The ICB has achieved the 28-day Faster Diagnosis standard for two-years and achieved the national improvement requirements for 62-day performance. However, whilst this is below the constitutional target, we continue to perform in line with northwest and national levels. The Lancashire and South Cumbria ICB Cancer Team has developed a series of key actions to support improvement. A robust programme of

pathway improvement is in place to drive clinical best practice and ensuring our patients receive swift diagnosis and treatment. The team are also transforming how and where care is provided to ensure services are close to patients.

Cancer is a key focus for the ICB to improve outcomes for its population and those patients, who are unfortunately diagnosed with this disease. The national standard is to treat 85 per cent of patients referred on a suspected cancer pathway within 62-days of referral. This has not been met since November 2020. Operational challenges across diagnostics and treatment in our system are contributing to longer pathways for patients in our providers.

One of the most important factors in improving outcomes for our population is improving the number of patients who are diagnosed with early-stage cancer. This means diagnosed with stage 1 or 2, whereas late stage is 3 and 4. Our population are typically diagnosed with later stage cancer and therefore have lower 1 and 5-year survival rates, than our Northwest ICBs and nationally. To do this we are investing in our places to increase screening uptake and to engage with our communities to understand signs, symptoms and how and where present to healthcare professionals earlier. This will support our ambition to reduce health inequalities and increase the number of patients diagnosed with early-stage cancer, greatly improving their outcomes. We are working closely with primary care, local authorities, public health, charities and faith groups to support this vital work for our communities Whilst this has resulted in an improvement between 2023 and 2024 of 2.5 per cent (compared to 1.2 per cent nationally) we are still the worst ICB nationally. As a result, this is an area of focus in 2025/26. This work supports the long-term plan ambitions of:



Our lung screening programme continued to be successful and is one of the most effective programmes nationally. We have successfully rolled out four phases and have diagnosed 113 cancers in 2024, 83 per cent at early stage which has improved our early-stage lung cancer rate by 12 per cent compared to 4 per cent nationally (30 per cent 2023, to 42 per cent in 2024 vs 36 per cent and 40 per cent nationally).

Case Study

Cancer Prehabilitation delivered by the eight English Football Leagues across Lancashire & South Cumbria.

No system-wide prehabilitation offer was available for patients within Lancashire and South Cumbria for those diagnosed with cancer. Prehabilitation is proven to improve outcomes for patients and has many benefits such as:

- Improved quality of life
- Reduce in length of stay

- Reduced post operative complications
- Help people prepare for treatments and improve recovery
- Reduce side effects of some treatments and a better tolerance of some treatments
- Impacts long-term health through a positive behaviour change

In partnership with the eight English League Football Clubs our population can now benefit from weekly one-hour exercise session followed by one-hour wellbeing session supported by the trust's local Macmillan information and support service. These sessions are out of hospital, within the local community providing a better, more accessible environment for patients. Clubs have been supported with expert cancer confidence training, club specific advertising and access to a prehab expert.

The work has featured on The One Show, BBC NW news, Granada and Radio Lancashire.

More Importantly what have our patients told us:

- I always feel positive and upbeat after the session-feel good hormones
- It's a time to forget cancer so gives mind a rest
- My confidence and self-esteem are back. I feel as though I am not judged as I am very bloated due to a fluid build-up. The social side has been amazing. It's a link to my cancer buddies. People who understand. I do feel fitter than at Christmas. It's made me more determined and stronger. At home, as I have some neuropathy, I have been doing finger exercises and ankle exercises that I wouldn't have done. I have feeling back in my pelvic area.
- Specific exercises have helped me with additional problems from treatment and diagnosis including improved bowels, less trapped wind and stress incontinence.
- It has been major for me to be part of a group. There are good dynamics, being part of a supportive environment and being part of a group has been really important. It nudges me in the right direction, it helps me overcome my fears and anxieties. I feel part of a team. it makes me feel part of the community as the club is invested in this. My psychological and physiological well - being is on the up and this is a part of that

We are evaluating this work with Lancaster University Health Economic Unit.

Urgent and Emergency Care

The national target for patients to be admitted, transferred or discharge within 4 hours was 78 per cent during March 2025. As seen in previous years, accident and emergency services were under significant pressure throughout 2024/25, with high numbers presenting for treatment. The position continued to be challenging particularly during the winter months, with approximately 44,000 additional A&E attendances during

2024/25 compared with the previous year. Over the last two years, this equates to 13 per cent more attendances.

During March 2025, Lancashire and South Cumbria narrowly missed the national target of 78 per cent for 4-hour performance, although recorded an improved position on the previous year and performed better than both the Northwest and National average.

The time that patients wait to be handed over when they arrive at hospital by ambulance was a key focus in year and resulted in a Lancashire & South Cumbria Strategic Ambulance Improvement Group being established in September 2024. The group coordinated action and improvement initiatives primarily around ambulance handovers at emergency departments that will continue into 2025/26.

Category 2 ambulance response times reported across the North West have been achieved for the majority of the year with the exception of four months over the winter period, but remained better than the national average. Lancashire and South Cumbria achieved an average of 26 minutes and 18 seconds across 2024/25, against the national ambition of 30 minutes.

Lancashire and South Cumbria ICB invested in a range of schemes, which created additional capacity with the aim of improving urgent and emergency care performance, patient experience and quality of care. These included services such as virtual wards, intermediate care services, acute respiratory infection hubs and palliative and end of life services.

Throughout the year the four UEC Delivery Boards reported on the delivery of their improvement plans to the ICB Strategic System Oversight Board for UEC and Flow. These plans focus on hospital avoidance, flow and discharge and are critical to the implementation of the UEC 5-year Strategy 2024-2029, which was approved by the ICB Board in September 2024.

Mental Health

The Talking Therapies (previously IAPT) indicator focuses on planning improved access to psychological therapies to address enduring unmet needs. The latest local data shows that the ICB is meeting the reliable recovery target (48 per cent), but is just under target for reliable improvement target year to date, for NHS talking therapy services.

The 2024-2025 ICB plan aimed to reduce the inappropriate adult acute mental health patients in an out of area placement (OAP) to zero by the end of the year. The OAP bed

days continue to remain above the plan in March 2025 but reported a decrease in numbers from the previous month.

68.4%

16,348

Dementia diagnosis rate (Target 66.7%)

Dementia diagnosis rates across Lancashire and South Cumbria remained above the 66.7 per cent target and are higher than the national average throughout the year. However, there is variation at the practice / sub-ICB level beneath this aggregate position.

Financial Years	2024/25[1] £000s	2023/24[2] £000s
Mental Health Spend	451,713	423,411
ICB Programme Allocation	5,348,016	4,474,390
Mental Health Spend as a proportion of ICB Programme Allocation	8.45%	9.46%

(1) The mental health investment standard data for 2024/25 has not been audited at the time of publication of this document.

(2) Revised mental health spend for 2023/24 following the completion of the mental health investment standard audit, finalised in April 2025.

Suicide Prevention

- The Suicide Prevention programme focused on providing suicide awareness and prevention training to workers across Lancashire and South Cumbria, with up to 1,500 people accessing it annually.
- The Orange Button scheme identifies people who have completed training and volunteer to hold conversations with those considering suicide. There are currently close to 5,000 members.
- Local engagement for World Suicide Prevention Day promoted community assets, attendance at events, and awareness of the Orange Button scheme.
- A podcast series was co-produced with Lancashire MIND, and sensitive media training was delivered with the Samaritans.
- The men's suicide prevention campaign titled "Honestly mate" has been developed and will be rolled out shortly.
- 2024 marked the first year of commissioning a Postvention service in Lancashire and South Cumbria to support those affected by suicide.

Dementia Post Diagnostic support

National guidance required amendments to post diagnostic dementia support, leading to a procurement that provides equity and a one LSC approach. A multi-agency 5-year dementia strategy was developed to improve the lives of those living with dementia and their carers, focusing on transformation in support, awareness, diagnosis, and care.

Out of area inpatient care

Demand for inpatient care for mental health exceeds the number of beds in Lancashire and South Cumbria, resulting in a need for out-of-area placements as part of the system response. The ICB aims to eliminate inappropriate use of out-of-area placements by reducing placements and strengthening the local offer. Efforts include weekly meetings to review cases, a housing improvement plan, and quality improvements on wards.

- In 24-25 the number of beds not within our local contracts reduced by 52 per cent.

NHS Talking Therapies

Progress has been made in increasing access to NHS talking therapies, with three of four providers meeting targets for completed courses of treatment. Despite achieving waiting times and recovery targets, overall performance is 10% below the target.

- Progress has been made in increasing access to NHS talking therapies, with three of four providers meeting targets for completed courses of treatment. 5060 more people accessed services in 2024/25 (34,860) compared to 2023/24 (29,800)
- Recruitment of 64 trainee therapists and continuous improvement programmes aim to meet future demands.

Physical Health Check for people living with Severe Mental Illness

Physical health checks for people with severe mental illness remain a priority due to their risk of premature death from physical health conditions.

- Efforts to increase uptake and quality of checks have exceeded the national target of 60 per cent, achieving 63 per cent which equates to an additional 569 checks?
- Procurement exercises established a service to engage this population and support attendance at checks.
- A document called "Practical Guide for SMI Checks" has been created and offers tips and advice to practices.

Primary Care Mental Health

A collaborative project defined Primary Care's role in the Mental Health system, involving practices and Primary Care Networks.

- The national Additional Roles scheme successfully recruited 70 workers across Lancashire and South Cumbria to work in GP practices.
- A transition pathway and training programme developed graduate psychologists into nationally recognised Mental Health Wellbeing Practitioners. Nineteen are currently being supported through the transition process.
- Access to evidenced-based mental health interventions for children and young people and perinatal populations surpasses Long-Term Plan targets. For perinatal target exceeded by 302 (13.7 per cent), for CYP target exceeded by 2170
- Individual placement support for people with severe mental illness has increased, supporting 1,132 people to date

Mental Health workers in practices

The national Additional Roles scheme successfully recruited 70 workers across Lancashire and South Cumbria to work in GP practices. Half are registered nurses specialising in assessment, treatment planning, and brief interventions, while the other half are graduate psychologists providing psychological interventions.

- A transition pathway and training programme developed graduate psychologists into nationally recognised Mental Health Wellbeing Practitioners.
- Access to evidenced-based mental health interventions for children and young people and perinatal populations surpasses Long-Term Plan targets.
- Individual placement support for people with severe mental illness has increased, supporting 1,132 people to date.

Learning Disabilities

NHS England aims to improve uptake of the existing Annual Health Check (AHC) in primary care for people aged 14 and over with a learning disability.

Lancashire & South Cumbria is exceeded the plan for people aged 14 and over with a learning disability receiving their annual health check and met the yearend target. Although Annual Health Checks are not included as a national priority in the planning guidance for 2025-26, the ICB has a planned trajectory and will continuing to support and monitor the delivery throughout the year reporting achievement to NHSE.

The ICB will continue to work with the Health Facilitation Teams (HFT), a team of learning disability and autism nurses in Lancashire & South Cumbria Foundation Trust to deliver training, raise awareness with GP practices, provide workshops for people with a learning disability and work with health partners to improve the number, quality and communication around health checks. We will also continue to monitor this activity via Primary Care, Partnership Boards and the ICB Quality & Outcomes Committee.

Since the end of 2024, Lancashire & South Cumbria Foundation Trust have been working with Paradise Gems, a VCFSE partner, local mosques and communities to encourage the uptake of health checks from people from ethnic minorities with a learning disability and improved understanding of their importance working with carers and parents.

Primary Care

189,907
More GP appointments

During the year general practice in Lancashire and South Cumbria have delivered 189,907 (1.9 per cent) more appointments than the same period last year (including vaccination programme appointments). This also represents a greater volume of appointments than initially planned for.

87.1%
Appointments offered within 2 weeks

The proportion of general practice appointments offered within two weeks and the proportion of same-day appointments have been maintained over the year with a March 2025 position of 87.1 per cent and 52.4 per cent respectively. These are slightly lower than national averages. Lancashire and South Cumbria ICB also has fewer full-time equivalent (FTE) doctors per 10,000 weighted population than national averages.

The most recent data for the proportion of patients with diabetes who have received all 8 care processes in the Apr-Dec 2024 period (39.3 per cent) reports that the position across Lancashire and South Cumbria is higher than the North West average though is behind the national position (40.9 per cent).

Flu and MMR vaccination uptake

73.97%
283,757
People over 65 immunised against Flu
(Target 85%)

The risk of serious illness from flu and consequent hospitalisation is higher among those aged 65 years and older as they are more likely to have an underlying health problem. The uptake of seasonal influenza vaccination among those aged 65 and over is therefore a critical measure. The 2024-2025 flu campaign reports that in the Sep24- Feb25 period, 73.97 per cent of patients aged 65+ were immunised (compared with 74.92 per cent nationally and 73.7 per cent across the Northwest).

Safeguarding

Safeguarding Children and Adults (including Children in Care and Care Leavers)

The ICB as with all NHS organisations, has a duty to safely discharge its statutory duties in relation to the safeguarding of children and adults as outlined in national guidance; this is inclusive of children in care and care leavers. The responsibility for safeguarding, serious violence and domestic abuse within the ICB is held by the Chief executive supported by the Chief nursing officer with a senior team in place ensuring governance and assurance structures.

The ICB provides assurance against its safeguarding duties, via the Safeguarding Commissioning Assurance Toolkit (S-CAT). Risks are identified appropriately on the functional risk register and mitigations are in place. These are reported through the Safeguarding Place-Based Assurance Meeting.

In year successes include;

- The Lancashire and South Cumbria Safeguarding Health Executive Group has been refreshed to improve connectivity, decision-making, and effectiveness in safeguarding practices.
- Collaboration with the Violence Reduction Network to reduce serious violence and continue training health staff on trauma-informed practices.
- Participation in a JTAI inspection, showing strong partnership arrangements and structures for implementing improvement actions.
- Publication of several important documents, including the ICB Safeguarding Strategic Plan and the NHS Sexual Safety Charter.
- Implementation of the IRIS Domestic Abuse model in Primary Care, enhancing the response to domestic abuse across 69 practices.
- Development of resources in response to MCA survey findings.
- Continued involvement in place-based leadership and Community Safety Partnerships to drive effective safeguarding practices.
- Leading the Pan Lancashire Safeguarding Adult Review Processes to facilitate understanding of issues and implement strategic system improvements.
- Secured funding for HOPE boxes to minimize trauma for mothers and babies separated at birth due to safeguarding concerns.

The ICB Safeguarding team plans to publish its 2024/25 annual report in July 2025.

Following local government review and a review of partnership arrangements there are now robust governance structures in place. Throughout the year full representation has been maintained for adults and children boards and any associated subgroup meetings, to fulfil the ICB commissioning and statutory safeguarding responsibilities.

Appropriate arrangements with surrounding border partnerships remain in place. Each safeguarding children partnership (SCP) has agreed priorities and have set out, and published, arrangements on how they will work together across agencies to safeguard and promote the welfare of children and adults across places. Each year the

partnerships are required to produce an Annual Report setting out how effective their arrangements have been, reports for the ICB Partnerships can found here:

- Lancashire Children's safeguarding assurance partnership[6]
- Cumbria SCP Annual Report 2023-2024[7]
- Blackburn with Darwen Safeguarding Children Partnership Annual Report 2023 to 2024[8]
- Blackpool SCP annual report. [9]
- Cumbria Safeguarding Adults Board Annual Report 2023 - 2024[10]
- Blackpool safeguarding adults board annual report[11]
- Lancashire SAR Overview Report [12]

The ICB is committed to ensuring staff have the necessary competencies through a culture of learning across the system. Regular information sharing with health providers and Primary Care includes key safeguarding messages, campaign material, lessons learned, and useful documents and tools to support practice. A system-wide safeguarding learning forum has been established to strengthen learning and practice change. Progress and learning from system reviews are reported to the ICB Quality Committee, with an annual analysis presented to the System Quality Group. The General Practice Named Safeguarding leadership, along with a team of Specialist Safeguarding Practitioners, supports Primary Care training events, reaching out to Pharmacy, Dentistry, and Optometry services. Assuring the impact of learning is a focus for the team in 2024/25.

The ICB Quality Committee receives regular safeguarding reports to ensure it is fully aware of safeguarding assurance, risks, and mitigation plans. Full details of safeguarding activity, risks, and assurances are contained within the ICB Safeguarding Dashboard, which is presented to the ICB Quality Committee and will feature in the ICB Safeguarding Annual Report for 2024-2025. Further detail regarding the business of the Quality Committee can be found in the annual governance statement.

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6 https://lancashiresafeguardingpartnership.org.uk/assets/52adba21/csap_annual_report_2023_24_final.pdf

7 https://cumbriasafeguardingchildren.co.uk/sites/default/files/13049103/2024-09/Cumbria%20Safeguarding%20Children%20Partnership%20Annual%20Report%202023%20to%202024.pdf

8 https://blackburn-darwen.org.uk/wp-content/uploads/Blackburn with Darwen-Safeguarding-Children-Partnership-Annual-Report-23-to-24.pdf

9 https://blackpoolsafeguardingpartnerships.org.uk/assets/b97d549a/final_masa_annual_report.pdf

10 https://cumbriasab.org.uk/sites/default/files/10694942/2024-11/Cumbria%20Safeguarding%20Adults%20Board%20Annual%20Report%202023%20-%202024_0.pdf

11 https://democracy.blackpool.gov.uk/documents/s95751/Appendix%206a%20-%20BSAB%20Annual%20Report%202023-2024.pdf

12 https://lancashiresafeguardingpartnership.org.uk/assets/52adba21/sab-annual-report-2023-24-reportfinal.pdf

Improving quality

In 2024/25, the ICB Quality Committee approved the Quality Governance Framework, outlining the ICB's accountability for quality and how it manages quality with its commissioned services.

The Quality Team refreshed the self-assessment of ICB evidence against National Quality Board (NQB) requirements, showing more robust governance processes. Quarterly quality review meetings with providers help monitor service performance and identify areas for improvement. The ICB also expanded its soft intelligence portal to improve discharge information.

Commissioning and transformation managers monitor specific service areas to ensure they meet local annual plans. Rapid quality review meetings were conducted for neurology services and histopathology provision, action plans and enhanced monitoring has continued to track the delivery of the agreed improvements.

The quality team reported progress against NHS Trust's sustainability and improvement plans to the Improvement and Assurance Group. Over 2024/25, the quality team has reported on the evidence of progress against each of the NHS trust's sustainability and improvement plan. This quality report goes into the ICB and trust executive meeting called the Improvement and Assurance Group, where all aspects of the oversight framework are formally governed.

The System Improvement Board, which was established and chaired by NHS England in relation to a range of concerns at Lancashire Teaching Hospitals Trust was integrated into the Improvement and Assurance Group for that trust, to reduce duplication.

Clinically-led groups worked on various improvements throughout the year.

Quality assurance is reported to the ICB Quality Committee, which can escalate actions for improvement to the System Quality Group (SQG). Further detail regarding the business of the Quality Committee can be found in the annual governance statement.

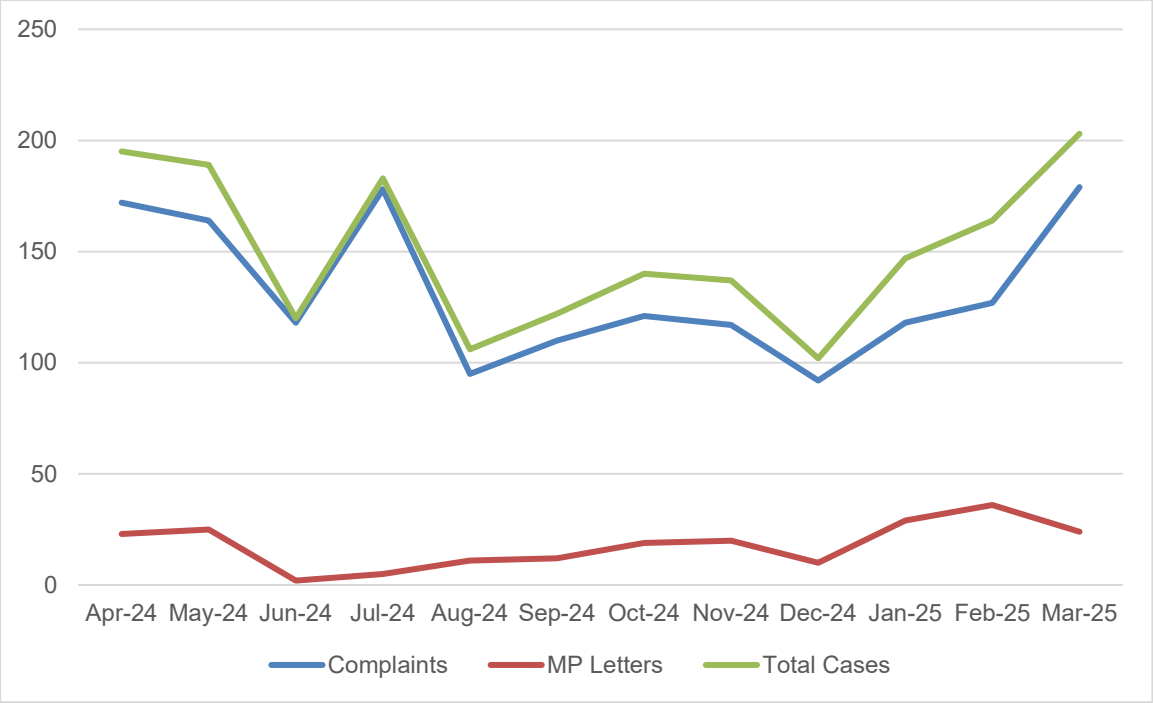
Patient Experience

The ICB is committed to listening to the experiences of our population and we have a statutory duty to respond to formal complaints. We also investigate and respond to correspondence from our local constituency MPs. The volumes for 2024/25 are set out in the table below:

Type of Case	2022/23	2023/24	2024/25
Complaint	514	1,255	1,522
MP letters	305	311	218
Total	819	1,566	1,740

The 2022/23 data is for nine months extrapolated over a full year to allow comparison.

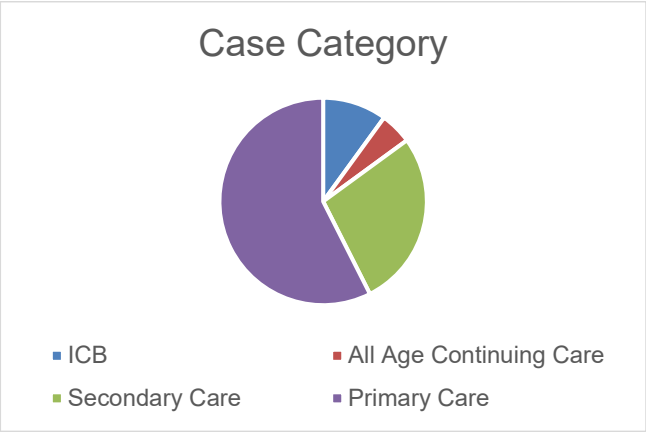
The monthly breakdown for 2024/25 is represented as a graph below.



The cases received can be divided into four categories:

- ICB All Age Continuing Care services,
- Other ICB activity,
- Secondary care providers and
- Primary care providers.

The chart below shows the proportion of each.



Patient experience and complaints were reported to our Public Involvement and Engagement Advisory Committee (PIEAC) which is an advisory committee of the Board. Each report contains volumes, outcomes and learning with a series of more in-depth analysis of selected areas of activity to identify themes or trends.

In late 2024, a dashboard was produced which brought together five patient experience indicators. This is collected at practice level but can be aggregated or by PCN, Place or

system. It is used to identify practices where feedback is particularly good or poor. It is used to support the programme of proactive and reactive support visits and forms part of the repository of support offers to practices.

Patient Safety

Lancashire and South Cumbria Integrated Care System (ICS) has continued to progress with the national Patient Safety Strategy. This includes training, involving Patient Safety Partners, and implementing the Patient Safety Incident Response Framework (PSIRF) across all NHS providers.

The ICS and ICB are focused on improving patient safety outcomes and experiences through collaboration. National guidance emphasises involving patients and their families in patient safety events, ensuring openness, transparency, and compassion. Whilst there is still more work to do, we commit to progressing this work.

All hospitals and ambulance services have implemented PSIRF within the national timelines. The ICB has supported smaller providers and partners with individual support, information sharing events, and model documents. There has been positive feedback on this approach. AQUA is helping the Regulated Care Sector with PSIRF implementation, and the ICS is considering how to implement the Primary Care Patient Safety Strategy.

The ICB has facilitated an ICS Shared Learning group that meets bi-monthly to share learning from patient safety events and develop actions. It has facilitated the development of a ‘Blue Light’ alert notification process when there is a clear theme/trend across the ICS. It has also developed and adopted some ‘Cross Organisational Principles’ for when a patient safety event occurs across more than one provider organisation in Lancashire and South Cumbria. They are working on a Patient Safety Training program for 2025/26.

The Patient Safety Specialist (PSS) role was introduced in 2019. The ICB has three PSSs, with one having completed advanced training. The ICS PSS meeting, chaired by the ICB, shares national developments and allows for open discussion.

Infection prevention and control (IPC)

The ICB Infection Prevention and Control (IPC) Team, which sits in the ICB Nursing Directorate, has continued to facilitate ICS IPC Collaborative meetings where the focus remains on reviewing data, shared learning and topic focus.

Our Lancashire and South Cumbria providers are using PSIRF methodology/principles to investigate when healthcare associated infections are reported and where an increase in case numbers is seen.

The team continue to attend all Provider IPC Committees and actively contribute to the discussions in a supportive/oversight capacity as well as supporting a number of ICS pieces of work including bladder and bowel services review (with an aim of reducing the risk of E Coli linked to incontinence), hydration promotion, Antimicrobial Resistance action plan.

- Joint working with ICS and national colleagues continues effectively for outbreak management; positive feedback has been received by the team on their collaborative approach and responsiveness when IPC support is needed.

Working with primary care the IPC Champion Programme will continue into 2025/26 to support practices in their knowledge along with a clear point of contact for any concerns.

Digital, Data and Technology Enabled Transformation

The Lancashire and South Cumbria Digital and Data Strategy 2024-2029 provides a roadmap to digitally underpin a unified, innovative and integrated health ecosystem. By focusing on collaboration, efficiency, and patient empowerment, this strategy supports our shared mission of delivering better health and care for all.

We have defined four digital and data strategic priorities (listed, with aligned programmes, in the table below) which set out our direction of travel and indicative end point for the most important areas of work to underpin delivery of the Integrated Care Partnership priorities and meet the ICB strategic objectives. They explicitly encompass bringing together both the people and the tools of the system so that support for the population can flow seamlessly through the system partners including the health, social care and VCFSE organisations.

These strategic priorities also underpin future ambitions for digital maturity, not only as a set of individual health and care providers but also as an ICS, which is in line with the requirements of the 'What Good Looks Like' framework. We are currently producing our 2025/26 digital and data delivery plan and ensuring that digital, data and technology are seamlessly woven through the LSC2030 Roadmap, aligning with the four strategic priorities, addressing our areas identified for development within the Digital Maturity Assessment and working within the current and anticipated resource constraints across the system.

A fundamental principal within the strategy is focusing on the needs of our population; central to this is improving digital inclusion through focused activity and non-digital communication channels maintained to support those who remain unable to access digital channels. Measures will be taken to ensure that digital and data developments do not further exacerbate health inequalities.

Strategic Priority	Key Programmes 2024-25
Single Digital Infrastructure	• Unified Active Directory and Office 365 tenant • Modern workplace and smart device strategy • Single Wide Area Network and Data Centre strategy • Cybersecurity tooling and benchmarking • Consolidated infrastructure contracts
Core Strategic System	• Shared Care Record expansion and roadmap • Patient Engagement Portal (PEP+) integration with NHS App and rollout

Platforms	• Single Electronic Patient Record (EPR) procurement and implementation milestones • Tactical EPR deployment at Blackpool Teaching Hospital • Digitising Adult Social Care with smart technology and digital care plans
Unified Data Architecture	• Secure Data Environment (SDE) and Trusted Research Environment (TRE) • Federated Data Platform (FDP) for direct care and operations • Population Health Intelligence tools and Health Inequalities tracker • Case studies demonstrating local impact of intelligence and improved targeting of service delivery
Single Digital & Data Service Model	• OneLSC workforce integration and leadership structure • Out-of-hours support model • GP IT service review and future model planning • Migration of ICB users to unified IT support platform

Key programmes of work undertaken during 2024-25 aligned to the four Digital and Data strategic priorities.

Reducing health inequalities

Improving the health of Cumbria continues to be a key priority for the ICB. It is committed to ensuring that all communities have access to the health services they need and that no one is left behind. This commitment is reflected in the continued work across local places and system-wide workstreams to reduce health disparities and promote fairness in health outcomes. The ICB continues to report on health inequalities as per section 13SA of the National Health Service Act 200622. These metrics and commentary are published on the ICB website.[13]

Strengthening Leadership and Accountability

- The Prevention and Health Inequality Steering Group continues to lead the work for inequalities and prevention, and formal reporting into the Quality Committee has been established.
- A Board development session was held that highlighted health inequalities Additionally, a workshop was held for the ICP with similar messaging.
- The population health team continued to work to improve understanding across the ICB about the importance of prevention and improving health inequalities, through events and workshops throughout the year.
- The place-based population health teams continued to work closely with local teams and partners like PCNs to provide bespoke support and interventions across the wide variety of communities in Lancashire and South Cumbria.

[13] https://www.lancashireandsouthcumbria.icb.nhs.uk/our-work/prevention-and-health-inequalities/health-inequality-metrics

- The LSC Population Health Academy's programme was delivered to 49 participants from Trusts, primary care and the ICB. This year the Academy is offering two Senior Leaders programmes and an Executive and Non-Executive Leaders programme. There are 66 participants from the ICB, Trusts, primary care and local government across all three programmes.

Inclusive recovery

Inclusive recovery remains a priority for the ICB and work this year has continued to ensure that the elective recovery programme is inclusive and does not worsen health inequity. This year has included:

- A monthly Elective Recovery Health Inequalities network with membership across all system acute providers, public health, and the Elective Recovery Programme Team.
- Continued monitoring of system elective waiting list Health Inequalities data.
- Played an active part in the establishment of a new monthly NW Regional Health Inequalities network.
- There was a 66.9 per cent reduction in children waiting over 52 weeks (year-to-date to Dec 2024) versus a 43.1 per cent reduction for adults, placing Lancashire and South Cumbria ahead of the NW regional average of 37 per cent.
- Delivery of a pilot patient engagement exercise to reduce the proportion of patients that have an ‘unknown’ or ‘not stated’ ethnicity, for which Lancashire and South Cumbria significantly outperforms both the regional and national average.

Digital inclusion

- As part of the national Wayfinder Programme, and to support the adoption of the NHS App and Lancashire and South Cumbria Patient Engagement Portal (known as PEP+), AgeUK Lancashire was commissioned to deliver support in the community for people to build digital knowledge, skills and confidence. The service has seen over 700 people supported.
- Digital health navigators have helped people with device basics, accessing services, communication and with online shopping, interests and hobbies.
- 96 per cent reported an improvement in health and wellbeing as a result of the support.

Prevention

Tobacco

- There was significant growth in the Inpatient Acute and Maternity Tobacco Dependency Treatment services across all four Acute Trusts and they are all now reporting to place-based Smokefree Alliances.
- The Smoking in Pregnancy Delivery Group was established.
- Smoke Free Communications & Engagement Working Group held a workshop emphasising the importance of consistent messaging and discussing successful campaigns.
- The Lancashire & South Cumbria Tobacco Free Strategy led to an implementation plan and governance arrangements.
- The ICB continues working on prescribing pathways for Varenicline and Cytisine as NRT alternatives, exploring innovative pathways to alleviate pressure on primary care.

Cardiovascular disease (CVD) prevention

- A crucial part of the ICB work on hypertension is supporting PCNs to meet their treatment-to-target rates. This is done with individual data packs for each PCN and tailored support as needed.
- The Lancashire and South Cumbria Population Health Academy also held its second Population Health/Primary Care Symposium.
    - This event allowed delegates to explore issues around cardiovascular disease prevention and management, with a population health and health inequalities focus, build on the fantastic growth already achieved through a health equity informed primary care approach in hypertension management, understand and agree what support delegates may need in order to build on the current model, utilising a Making Every Contact Count approach to this clinical issue and provide an opportunity to plan at Place, network with colleagues and build relationships.
- Multiple case finding initiatives took place in 2024-25, including:
    - the barbers pilot that saw 200 people,
    - the optometry pilot, and
    - ongoing BP testing for ICB staff.
- The 2024 Know Your Numbers week was successful, with good engagement across the community, particularly within priority wards due to effective collaboration with VCSFE sector.
- The Community Stroke Team project launched recording routine blood pressure monitoring at discharge, six weeks and six months.

Digital weight management programme

- At the end of January 2025, Lancashire and South Cumbria ICB was at 119 per cent of the referral target in the year to date, making it the second highest performing ICB in the country.

Place-based working

The Population Health team works closely with Place teams to deliver equitable care at a local level. The main areas that are universal across the Places are:

- Supporting Primary Care Networks (PCNs) to adopt more inclusive health approaches. This involves prioritising health equity by calling people forward for standard or enhanced NHS health checks. Health Inequality Clinical Leads are funded in each Place to ensure PCNs have dedicated time and specialist knowledge available to them.
- Reducing unnecessary use of urgent and emergency care through proactive care for the most vulnerable patients in specific geographical areas, including priority wards, to understand the underlying issues faced by the population.
- Mobilising community assets that can support prevention, promote health, and reduce inequalities while aiming to drive a community-powered culture.
- Supporting the development of effective governance and delivery infrastructure to enable collaborative decision-making around the allocation of collective resources. This includes drawing services into areas of greatest need, meeting people where

they are, and providing immediate support while breaking down barriers to accessing services in a standard way.

Maternity

We continue to develop and shape the details of our maternity and neonatal equity and equality plan ensuring that the key projects are outcome focussed and evidence-based. This work is now being supported by a Prevention and Health Inequalities Project Manager.

During 2024-205 we have:

- Rolled out the Good Thing's Foundation programme, which enables women and pregnant people to have 12 months of unlimited connectivity to the internet through provision of data loaded sim cards. This supports access to digital records, important resources and information, and reduces digital exclusion.
- Commenced the roll-out of a national smokefree pregnancy incentive scheme in all four provider Trusts.
- Remained on track to achieve Baby Friendly Initiative (BFI) level 3 accreditation across all four maternity services by 2027 with Lancashire Teaching Hospitals achieving level 2 accreditation for maternity in year, and Health Visiting Services in south Cumbria being reaccredited at level 3.
- Initiated key local projects, in line with the infant feeding strategy, to support seldom heard groups: Lancashire infant feeding team are supporting staff to understand the milk marketing code better in order to protect the asylum-seeking families in their establishments; initiatives to support babies born into care to have expressed breast milk.
- Updated and ratified the suite of infant feeding policies and guidelines
- Presented our completed Maternal Nutrition project and associated resources at Institute of Health Visiting "Healthy Weight, Healthy Nutrition" event, and were highlighted as an exemplar at the North West children and young people obesity conference at Alder Hey in March 2025. This now forms part of pre-registration midwifery training at the University of Central Lancashire (UCLan) and the University of Cumbria (UoC).
- Established vaccination clinics and successfully rolled out Respiratory Syncytial Virus (RSV) vaccines across all four trusts.
- Rolled out digital parent and feeding app (Anya app) in Westmorland and Furness, ensuring equitable access to digital support as an interim measure whilst community services are being recommissioned, aligning this area with the rest of Lancashire and south Cumbria.
- Set up culturally sensitive genetics services in East Lancashire with specialist midwifery leadership.
- The LMNS Equity & Equality Oversight Group meets bimonthly to ensure inequalities are being monitored in all Maternity and Neonatal Services projects and workstreams, as well as tracking system-level risks relating to inequity.
- Continued engagement work through the Maternity and Neonatal Insight, Co-production and Engagement Network included individual meetings with each member and setting baselines for monitoring, project plans and targeted projects.

- Development of culturally sensitive genetic services for consanguineous[14] couples was initiated to increase education and understanding about the genetic risks.

Respiratory

- A range of roving and place-based providers were commissioned to deliver the 2024/25 winter vaccination programme. It promoted dual vaccination of flu and COVID and included MECC activity as part of the offer. Twelve care homes across the area also initiated a programme where their staff delivered the flu and COVID vaccinations to residents.

Physical health checks for people with SMI

- The contract for bespoke services to deliver SMI physical health checks to the hardest to reach patients went live in December 2024, and is now being mobilised.
- Close working with Primary Care has included communications campaigns for professionals and service users and a best practice that is being launched across primary care.
- Partnership working continued, with opportunities being developed for capturing health checks, particularly with LSCFT, the Individual Placement Service and pharmacy colleagues.

Children and young people

- The uptake of diabetes technology including continuous glucose monitoring (CGM) and hybrid closed loop (HCL) pumps continues to be very successful. Data is monitored through postcode, ethnicity and sex. This is now showing improvements in overall blood glucose control, which is a positive step to improve the child's long term health outcomes
- All Trusts now have access to an Epilepsy Specialist Nurse (ESN) for children with epilepsy. The cohort of CYP with both learning disabilities or autism and epilepsy has been identified to ensure these children have access to ESNs.
- Asthma remains a priority:
    - The launch of FeNO and Spirometry training with Primary Care colleagues has been a significant achievement, along with the development of the referral management pathway and work with PCNs on asthma optimisation for high-risk populations.
    - Discharge planning quality improvement work continues across all Trusts to replace salbutamol weaning plans with Personalised Asthma Action Plans (PAAP).
    - Regular teaching sessions from the ICB team are upskilling practitioners across Primary Care with over 700 members now trained.
    - Additionally, grassroots football coaches have been trained in some areas of Lancashire and South Cumbria.

[14] Relating to or denoting people descended from the same ancestor.

    - Targeted asthma management work is commencing in Blackburn and Blackpool, with continued efforts to pursue funding options for the community champion model of self-empowerment for underserved populations.

- New programmes based around reducing waiting times through early intervention based on the Thrive Model have had positive outcomes for young people's mental health and are helping parents support their children at home. The Mental Health Support teams are also demonstrating positive results in schools, with data on new providers awaited. A 16-25 Transitional plan has been implemented at Lancashire and South Cumbria NHS Foundation Trust to ensure a consistent approach for young people transitioning from Children Services to Adult Services.
- Overall waiting times for dental extractions for children and young people have improved although long waits remain for children requiring general anaesthesia. A strategic partnership with the Local Authority, ICB, and Population Health is developing investment proposals for prevention activities, aiming to extend current initiatives like supervised toothbrushing and toothbrush pack distribution. The children's access and oral health improvement pathway has benefited over 400 children since September, with referrals tripling each month as the CYP teams increase their efforts.

Our Equality Objectives

As part of the ICB's legal requirement to meet its obligations under the Equality Act (2010), the Public Sector Equality Duty (PSED) and the Specific Equality Duties (SEDs), the ICB is required to publish one or more equality objectives, at intervals of no more than four years since the previous objectives were published.

Equality Objectives 2024-27

The ICB has developed a set of refreshed equality objectives for the ICB to work towards between 2024 and 2027. These objectives are focused on both service delivery and workforce.

Service delivery focused equality objectives

- By March 2025, to demonstrate that maternity and neonatal insight, co-production and engagement (ICE) activity is focused on service users and their families who are representative of the diversity of the local (maternity) population. This will support delivery of "Intervention 6: ensure the MVPs in your LMS reflect the ethnic diversity of the local population, in line with NICE QS167". This will be demonstrated through:
    - Development and implementation of a robust, system-wide data collection tool for ICE activity
    - Updated population health needs analysis of the maternity population which will include population demographics
    - Delivery of targeted ICE activity with identified cohorts and communities
- To improve completeness and accuracy of ethnicity coding in primary care for patients assessed as having mild-moderate frailty. This will enable us to understand

frailty in different ethnic groups, to map need and to tailor services to better reflect needs. The objectives for 2024/25 are:

  - to have completed an audit of completeness and accuracy by December 2024, to provide a baseline for future improvement for patients within the assessed frailty cohorts.
  - aspiration of 80 per cent having up to date and accurate ethnicity coding for those patients who have received a frailty review by March 2025

- By March 2025 to have used the 2021 census data to map the LGBTQ population for Lancashire and South Cumbria and to understand the correlation with engagi20plus populations.

Workforce focused equality objectives

- Increase the proportion of staff declaring their diversity monitoring information via ESR to enable a better understanding of the diverse composition of the ICB workforce.

  - Increase ethnicity sharing rates across the overall workforce from 91.9 per cent to 98 per cent by the end of 2026/27.
  - Increase disability sharing rates across the overall workforce from 59.9 per cent to 75 per cent by the end of 2025/26, increasing to 85 per cent by the end of 2026/27.
  - Increase sexual orientation sharing rates across the overall workforce from 56.6 per cent to 70 per cent by the end of 2025/26, increasing to 80 per cent by the end of 2026/27.

- Increase diverse representation across all levels of the workforce by:

  - Increasing BME workforce representation from the current position of 7.1 per cent by the end of 2026/27.
  - Increasing disability workforce representation from the current position of 6.3 per cent by the end of 2026/27.
  - Increasing LGBQ+ workforce representation from the current position of 3.2 per cent by the end of 2026/27.

- Improve the experiences of our diverse workforce and reducing incidents of discrimination, bullying and harassment by:

  - Undertaking a full reset of organisational values and behaviours by the end of 2024/25.
  - Achieving the NW Anti-Racist Framework Bronze award by the end of 2025/26 with an aspiration to achieve the Silver award by the end of 2026/27.
  - Delivering a programme of cultural learning opportunities (e.g. webinars and listening rooms) via our Belonging workstream.
  - Strengthening and amplifying the voices of our Staff Networks

- Provide targeted progression and development opportunities to under-represented, diverse groups within our workforce by:

  - Implementing a refreshed Inclusive Recruitment Toolkit to be fully rolled out throughout 2025/26

- Implementing a Reciprocal Mentoring Scheme to be fully rolled out throughout 2025/26
- Utilising the Apprenticeship Levy to provide targeted development opportunities for under-represented, diverse groups within our workforce.

Gender pay gap summary

NHS Lancashire and South Cumbria ICB employed 811 full-pay relevant employees—77.9 per cent of whom were female and 22.1 per cent male. This reflects a continued female-majority workforce in line with wider NHS trends.

Headline gender pay gap figures include:

- Mean hourly pay gap: 30.88 per cent – with male employees earning an average of £11.26 more per hour than female employees
- Median hourly pay gap: 14.15 per cent – with male employees earning £3.69 more per hour at the median

Both the mean and median pay gaps have narrowed since 2023, reflecting early signs of progress.

Gender representation by pay quartile

Pay quartile	% Female	% Male
Quartile 1 (lowest)	82.97%	17.03%
Quartile 2	85.97%	14.03%
Quartile 3	81.54%	18.46%
Quartile 4 (highest)	62.09%	37.91%

While women remain well represented across the workforce, there is still an imbalance in the upper pay quartile, where men occupy a disproportionately high number of the most senior, highest-paid roles. However, the proportion of women in the highest pay quartile has increased by approximately 10 per cent compared to 2023.

To reduce the gender pay gap, the ICB is committed to the following strategic priorities:

- Enhanced workforce data analysis at senior levels, disaggregated by additional protected characteristics
- Targeted support for women's career progression, especially into Very Senior Manager (VSM) roles, through mentoring, sponsorship, and inclusive recruitment practices
- Promotion of flexible working and shared parental leave, to support equity in caring responsibilities
- Increased support for women's health, particularly through menopause awareness and wellbeing initiatives

These actions form part of a long-term strategy to build a more equitable and inclusive organisation, ensuring fair representation and opportunity across all pay levels. Additionally, in 2025/26, the ICB intends to publish its first combined pay gap report, encompassing gender, ethnicity and disability pay gap data.

ICS Belonging Plan

The Lancashire and South Cumbria ICS Belonging Plan underpins the Belonging workstream and sets out a system-wide commitment to collaboratively create inclusive workplaces that enable our people to do their best work and create opportunities for our communities to thrive.

From a compliance perspective, the ICS Belonging Plan is also a key document in evidencing that the ICB and wider system partners are meeting their obligations to the Equality Act (2010) and routinely demonstrating due regard to the main aims of the Public Sector Equality Duty.

Development on the ICS Belonging Plan began in October 2022 when the ICB Culture and Inclusion Team engaged with representatives from each of the NHS Provider Trusts within the system to assess their current progress and priorities within their own EDI functions, and their EDI-related successes and challenges.

Throughout Q1 and Q2 of 2023/24, the draft Belonging Plan was socialised for suggestions and feedback with a range of colleagues and stakeholders from across the LSC system. This provided the ICB with a wealth of insightful and practical feedback which was incorporated into the final version of the Belonging Plan. The Belonging Plan was approved for publication by the ICB in November 2023 and can be accessed here.

Since the development of the Belonging Plan, the EDI, Culture and Belonging landscape has changed due to the publication of key strategic documents such as the national NHS EDI Improvement Plan and the regional Anti-Racist Framework, along with the heavy focus on financial recovery across our system. This is likely to impact on how we are able deliver upon the objectives and actions included in the Belonging Plan.

With this in mind, the Culture and Inclusion Team will continue to work with the ICS Belonging Strategic Group and Belonging Delivery Group throughout 2025/26 to develop specific priorities and actions for EDI, Culture and Belonging that can be effectively delivered in collaboration across the system within the confines of the current financial pressures we face.

NHS EDI Improvement Plan

The national NHS Equality, Diversity and Inclusion (EDI) Improvement Plan, published in June 2023, sets out a strategic framework to tackle bias, discrimination, and inequality across the NHS workforce. Its purpose is to ensure a consistently inclusive and equitable experience for all NHS staff, particularly those from underrepresented or disadvantaged groups. The plan outlines six *High Impact Actions* that must be implemented by all NHS organisations—including Integrated Care Boards (ICBs) and NHS Trusts—with a focus on leadership accountability, equitable recruitment and talent management, reducing pay gaps, improving experiences for internationally recruited staff, addressing health inequalities within the workforce, and eliminating bullying and

harassment. The plan provides a clear and measurable set of expectations that hold NHS organisations accountable for creating inclusive cultures where all staff can thrive.

In 2024/25, Lancashire and South Cumbria ICB aligned its Belonging Plan and broader EDI programme with the NHS EDI Improvement Plan to support consistent implementation of the six high impact actions across the system. Notable progress includes:

- Ongoing development of an inclusive recruitment toolkit to address diverse under-representation across all pay bands.
- Publication of the Gender Pay Gap report and groundwork laid for an upcoming combined pay gap report (gender, race, disability) in 2025.
- Improved data collection and declaration rates, especially for disability and sexual orientation, enabling more accurate monitoring of workforce inequalities.
- Delivery of a broad programme of Belonging webinars and training sessions.

As part of its responsibilities under the NHS EDI Improvement Plan, Lancashire and South Cumbria ICB submits quarterly assurance returns to NHS England's regional EDI team. These submissions provide structured evidence of the ICB's progress against the six high impact actions, alongside insights into system-wide delivery and collaboration. The LEAF framework enables NHS England to monitor both the ICB's internal EDI performance and the support it provides to its system partners. In 2024/25, the ICB coordinated the collation of provider trust returns across Lancashire and South Cumbria, ensuring a consistent approach and shared learning across the ICS. The assurance process has strengthened accountability, supported local alignment with national priorities, and enabled targeted action in areas such as inclusive recruitment, leadership diversity, and cultural transformation.

Equality Delivery System (EDS2022):

All Lancashire and South Cumbria ICB employees were invited to a grading event in March 2025. Grading for both Equality Delivery System Domain 2 and 3 were completed during one single grading event.

Grades received for EDS Domain 2 are as follows:

EDS Domain 2: Workforce Health and Wellbeing	2024/2025 Grade
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Developing
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Developing
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Achieving
2D: Staff recommend the organisation as a place to work	Undeveloped

EDS Domain 3: Inclusive Leadership	2024/2025 Grade
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Developing
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Developing
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Developing

Equality and Health Inequalities Impact and Risk Assessments

Lancashire and South Cumbria ICB utilises an Equality and Health Inequalities Impact and Risk Assessment (EHIIRA) toolkit. The EHIIRA toolkit provides a framework for undertaking Equality and Health Inequalities Impact and Risk Assessments in all aspects of ICB decision-making.

This tool combines two assessments consisting of Equality and Human Rights. This enables the ICB to assure itself against the Public Sector Equality Duty and ensures that consideration is given prior to any policy or commissioning decision being made by ICB committees that may affect equality and human rights.

The ICB is committed to embedding the use of EHIIRAs in every aspect of service development, policy development and workforce development.

Between April 2024 and March 2025, 65 EHIIRAs relating to a wide range of service design and workforce decisions were completed or are currently in progress. Further information regarding health inequalities can be found in the next section of this report.

Engaging people and communities

Since its inception the ICB has been, and remains, committed to engaging and involving people and communities at the heart of all aspects of our work.

ICBs have a legal duty to involve patients, their carers and representatives in decisions about their care and treatment, as outlined in the NHS Act 2006 and the Health and Care Act 2022. This duty ensures that individuals are involved in planning, developing and making decisions that impact on their care, including the prevention, diagnosis and treatment of illness. In addition, the ICB is accountable for the related duty to reduce health inequalities between people in terms of access to care and outcomes achieved, and the need for effective involvement of those with protected characteristics to fulfil the required duty.

The ICB has agreed a strategy for Working in Partnership with People and Communities which aligns to national guidance. The ICB's approach recognises the value of partners in providing a voice for communities such as local Healthwatch and voluntary, community, faith and social enterprise organisations. The ICB has set out ten principles for working in partnership with people and communities which aim to be aligned, adopted, adhered to and carried out across priorities and programmes of work. This is underpinned by a policy for public engagement and involvement. The policy can be found on the ICB website[16]

Since the ICB's establishment in July 2022 and up to March 2025, a Public Involvement and Engagement Advisory Committee has supported the ICB Board in providing assurance on the mechanisms and processes for engaging, involving, informing and codesigning with our communities, partners, patients and stakeholders. Following recommendations from a review of committees, and the progress in developing engagement approaches for the ICB Board, in March 2025 it was agreed that the committee would be disestablished, and that engagement and involvement updates would be reported directly to the Board. Insights from engagement and involvement activity, in addition to patient experience and complaints intelligence, contributes to the Quality and Outcomes Committee agenda.

All ICB staff are expected and encouraged to embed engagement and involvement in their work. The communication and engagement team provides advice, guidance and support to teams and work programmes across the organisation to empower them to embed involvement to their work. An example where this is clearly evident is the population health team who actively undertake outreach and partnership working with some of our most deprived communities in ways which align to the principles agreed by the ICB. A number of functions and teams across the ICB are provided with strategic advice, guidance and support to enhance the ICB's reputation and relationships with people and communities as well as partners.

In addition to proactive public engagement, the ICB listens to patient experience through a range of methods including responding to feedback, complaints and concerns about the decisions and work of the ICB and about the services we commission from our provider organisations. We see this as valuable feedback that will help us, and our provider partners learn from experiences and make improvements. We are open, honest and transparent in all in all our dealings with patients and the public. The ICB

has a single point of contact for all new complaints including those received from Members of Parliament. All formal complaints are recorded on a case management system through the ICB's Patient Experience service. The ICB has an agreed and published policy[17], and all complaints and responses are reviewed by the Chief Nursing Officer.

Principles for working with people and communities

As an ICB, we have adopted the following principles for working with people and communities:

1	Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.	Our strategy and policy for engagement which is supported by our model of engagement, puts the voices of people and communities at the centre of decision-making and governance throughout the ICB. The board has historically obtained assurance on this from the PIEAC.
2	Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.	Our transformation engagement team is involved with transformational programmes from the outset and we have a culture of pre-engagement to elicit people's views, and involve them early. The series of roadshows we ran in each of our communities : 'Your health, your care, your say' is a good example of involving people and communities early to influence our priorities and programmes.
3	Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.	Our yearly cycle of engaging with communities through listening events and roadshows has enabled us to understand their needs, experiences and aspirations for health and care. The recent 'Your Health, Your Care, Your Say' has influenced our commissioning intentions for 25/26. The sessions are used to sense check progress and measure impact of change.
4	Build relationships with excluded groups, especially those affected by inequalities.	The engagement coordinators in each place have built engagement and communication networks and tapped into existing networks particularly supporting excluded groups. In 2024/25 the team supported engagement with seldom heard groups for the new hospital programme and this has created strong relationships with all of the groups engaged with. All engagement is subject to equality impact assessment and excluded groups are a key focus of this to ensure their voices are heard.
5	Work with Healthwatch and the voluntary, community, faith and social enterprise (VCFSE) sector as key partners.	The ICB has agreed a partnership approach with the VCFSE, and both Heathwatch and the ICB have regular meetings to coordinate work and identify opportunities for collaboration and improvement.

6	Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.	The ICB has provide this information on our website: LSC Integrated Care Board :: Our vision, objectives and priorities and the establishment of our vision, plans and progress include the involvement of patients, carers and partners.
7	Use community development approaches that empower people and communities, making connections to social action.	As part of our model for engagement we have established engagement coordinators and communication and engagement networks in each of our places, as well as the citizen's panel and citizen's health reference group (CHRG) where we adopt community development approaches in working with people and communities. This has been evident in our work around winter resilience and readiness, as well as the development work for campaigns such as male suicide prevention.
8	Use co-production, insight and engagement to achieve accountable health and care services.	This principle is adopted throughout our work, where we use all the methods of co-production, insight and engagement to ensure that our health and care services are accountable. This is evident in our work on SEND, safeguarding and with children and young people, using the Lundy Model.
9	Co-produce and redesign services and tackle system priorities in partnership with people and communities.	Our engagement is undertaken both at place and across the system through transformation programmes which are key priorities of the system, and in partnership with local communities. We use coproduction approaches to support the redesign of services and tackle our prioriites. The CHRG is a great example over the last year where we have done this, as well as Feedback Fortnight where we have worked with children and young people to establish their experiences and views.
10	Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.	As well as sharing our insights on our website: LSC Integrated Care Board :: What you've told us the ICB has a programme of webinars and briefings where we share best practice and insights through our engagement networks within place and across the system.

Virtual Citizen's Panel

The ICB has developed a citizen's panel of members of the public who have agreed to participate in surveys, and engagement and give their insights concerning health, wellbeing and health services in Lancashire and South Cumbria. The majority of these have been through a process of opting in to be part of the panel from previous CCG databases. This model has been presented as good practice nationally and has been adopted by several ICBs. At the time of this report, the membership consists of 2,025

members from across the region. Panel members receive a monthly bulletin with opportunities to engage with the work of the ICB and information.

In response to demand from ICB colleagues, and interest from members of the citizen's panel, we have established a Readers' Group. The group reviews documents, information, letters and leaflets and offers suggestions on how these can be more patient and public-friendly. We currently have 179 members who have joined the group. Members of the reader's group have contributed to the development of the ICB priorities and strategy, and our policy on volunteer expenses and is a good example of how policies and documents can be improved with public engagement and involvement. A recruitment campaign took place in 2024/25 which has successfully increased the membership of the panel.

Citizens Health Reference Group

The Citizens Health Reference Group provides the ICB and its programme of transformation of services with a bank of citizen 'advisers' with a range of backgrounds and experience who can offer insight, and advice in various forms to the work of the organisation. The group provides the ICB and its teams with a resource for timely engagement.

In 2024/25, membership of the group increased to more than 50 people following an extensive recruitment process. The group includes members from all across Lancashire and South Cumbria with a range of backgrounds and experiences.

The group has received extensive training in engagement, and NHS governance. Scheduled meetings take place on a quarterly basis, but its real value is in the much more focused level of engagement from members who are aligned to specific workstreams based on their own individual interests and expertise.

Workstreams that have been supported during 2024/25 include:

- Urgent and emergency care strategy development: Members provided feedback on the draft strategy and were able to shape updates and amendments, such as the introduction of a glossary and some expanded narrative sections to improve readability and accessibility.
- Physical health checks for people with severe mental illness (SMI): Members with lived experience supported the development of a communications campaign aimed at raising awareness of health checks.
- Dental access: Members provided rich insight into a prioritisation exercise to support the development of a new five-year strategy for access to NHS dental services.

Support is also being provided to a number of ongoing or planned workstreams in the future, such as:

- Transformation of services for head and neck cancer, urology and cardiac
- Virtual wards
- Transforming community care
- GP access
- Mental health crisis services redevelopment

- Non-emergency patient transport services

Engagement at Place

Members of the ICB communication and engagement team act as place-based engagement coordinators in each of our places. They have developed an inclusive networked approach to establish engagement networks with local communities in each of our places. These build on existing networks and groups and provide an opportunity for the ICB to listen to community representatives, including existing patient voice groups, and GP practice patient participation groups. In 2024/25 listening events in our places continued, as well as focused listening events on our commissioning intentions.

Engaging on specific topic or with specific patient groups

In addition to the core engagement activities outlined above, the ICB undertakes bespoke engagement on a range of topics or with specific patient groups to support co-production of services and to ensure that the ICB meets its legal duty to involve.

To meet the ambitions set out in our strategy, bespoke engagement covers four main areas of activity:

- Engaging on the overall commissioning intentions approach and prioritisation process - this is to ensure a robust process which involves stakeholders in determining which commissioning intentions should be a priority for the organisation.
- Supporting individual commissioning intentions – this ensures that any impact of proposed service changes and options are fully understood during the design and decision-making process. Activity supports the patient voice being a central part of this.
- Service change and reconfiguration responsiveness - engagement and communications activity supports the patient to continue to access services appropriately when temporary or permanent service change or reconfiguration is implemented.
- Collaboration with provider communications teams supporting consistent and messaging and a robust sequencing of communication to patients and staff.

Outputs from the above domains of activity are collated into a report which is shared at the appropriate committee or decision-making body and also shared on the ICBs website.

Communications and engagement activity undergoes robust evaluation for continuous improvement, and we aim to validate the impact of patient voices via “You Said, We Did” reporting.

Your health. Your future. Your say. engagement

Throughout October and November 2024, the ‘Your health. Your future. Your say.’ roadshow events programme took place in seven locations across the Lancashire and South Cumbria ICB area. The events sought views on the work of the ICB and its vision and priorities, along with design principles for urgent care service recommissioning.

A total of 188 members of the public attended the roadshows to share their views. Insights were also gathered through an ICB perception survey, an Integrated Urgent Care (IUC) survey and targeted engagement with health inclusion groups. We spoke directly with 415 people through the roadshows, online meetings and community health inclusion groups and received a total of 1,836 responses to the two surveys.

A number of recommendations were made, based on the findings of this report:

- Keep everything as simple as possible to ensure good patient experience of services.
- Continue with a community approach but make this a one-stop shop for all services including primary care, community services, mental health, council services and voluntary services.
- Improve IT systems so that all services use, or have input into, a central system that can be accessed by everyone including the patient.
- Involve people earlier in projects.
- Ensure GP practices all offer the same services, especially blood tests.
- Improve communication and awareness of services. This includes between health professionals but especially the public.
- Educate people on which service to use and when.
- Keep patients involved and provide information on what to expect at every stage.

The findings, and recommendations from these conversations have paved the way forward in our discussions and developments of key programmes of work regarding recovery and transformation such as the New Hospitals Programme, Integrated Urgent Care recommissioning, clinical reconfiguration, Transforming Community Care and others. People now have a better knowledge of what the ICB is working on and why. We also now know what is most important to people and can address those issues more readily when talking about programmes in more depth. The full report can be found on our web site[18]. Over two thousand people shared their views with the insights contributing to:

- the system vision presented at the Board in January 2025
- the commissioning intentions process and
- a future commissioning process for integrated urgent care.

Integrated Urgent Care

As part of the Integrated Urgent Care Programme that is exploring and agreeing the options available to re-commission urgent care services, we have engaged with members of the public to find out what is important to them and their families when it comes to urgent care services. We asked what urgent care services they are aware of, which they use, why they choose them and what their experience has been. The insight gathered has been fed into the Integrated Urgent Care Programme Group to help shape the design of the new proposed clinical model.

Urgent care conversations formed part of the seven face-to-face and two virtual ‘Your health. Your future. Your say.’ events that the ICB held across Lancashire and South Cumbria, and conversations with health inclusion groups. These were supplemented by

an online survey that ran from 25 October to 10 November 2024. In total 1,474 people were engaged with.

Members of the public told us that access to urgent care is inconsistent, with a lack of walk-in facilities in some areas and a significant gap in providing services tailored to address health inequalities. Many of those we engaged with were unaware of the available urgent care options, often defaulting to A&E due to familiarity, and we were told people have an increased reliance on A&E when they are unable to secure GP appointments.

There was support for the programme's draft design principles, with strong support for easier navigation for patients and professionals, accessible, secure and connected IT systems, having the right care, in the right place, at the right time and providing pathways to 24-hour access.

In summary, the public called for accessible, 24-hour, person-centred urgent care solutions, emphasising the importance of integrating mental health and physical health services. Addressing the demand for urgent care requires not only improving access to services but also fostering greater awareness and understanding of the options to ensure patients seek the right care, at the right time, in the right place.

The findings and recommendations have been considered and integrated into the programme. The full report can be found on our website.[19]

Community equipment services

Community equipment is a free service provided to residents of Lancashire and South Cumbria through a series of joint contracts between the NHS and local authority partners. The equipment, which ranges from profile beds and mattresses to hoists and commodes, is integral to supporting people to live independently and help them carry out day to day tasks and activities.

Each place currently has a different provider, but the NHS and upper tier local authorities of Lancashire County Council, Blackpool and Blackburn with Darwen wish to improve the service to patients and move towards having one provider for all partners.

Before developing a new specification for the community equipment service, all partners wanted to talk to staff involved in the process on a daily basis and to patients and carers, benefitting from their lived experience of the service in each locality.

A survey and several online focus group sessions and interviews were undertaken to understand the views, comments and concerns of those experiencing the community equipment service. These asked for feedback on the five key elements of the service: assessment; delivery; set-up and instructions; faults, repairs and replacements; and collection of equipment.

Approximately a third of respondents considered most if not all of these steps went well. For many others the process was let down at one or more stages. No stage in the process, in any locality, was without a level of concern, some of which were significant.

Patients and carers were also asked to consider what worked well overall, what did not work well and what improvements they would prefer to see.

The engagement report has been used to inform the development of the draft service specification, promotional development work, and as a result of their involvement in the project, several patients will act as the lived experience patient voice during the development process and beyond. Following the move we have continued to monitor feedback, which has been broadly positive.

The full report: Community equipment service patient feedback [20] can be found on our website.

Relocation of PWE Accrington Victoria GP practice

It has been identified by East Lancashire Hospitals NHS Foundation Trust that Accrington Victoria Hospital is no longer fit for purpose and presents a safety risk to patients. For that reason, all services need to be relocated. One of the services based within the Hospital is a GP practice, called PWE Accrington Victoria.

The process required to relocate a GP practice involves approval from the ICB's primary care commissioning committee, which needs to see evidence of robust engagement that has helped to shape the decision.

Almost 200 people (around five per cent of the total number of patients registered at the practice) provided feedback through either an online survey or face-to-face drop-in session.

The overriding feedback from patients is a concern regarding the distance from the current site to the proposed new building, which is 1.3 miles away. 52 per cent of respondents to the survey said they access the current practice on foot, so would be significantly disadvantaged by the move.

The full report can be found on our website.

Relocation of Dr Bello's Surgery and King Street Medical Centre

Dr Bello's Surgery in Church and King Street Medical Centre in Accrington are two separate GP practices with separate contracts and patient lists, but the same management team. The list size at Dr Bello's Surgery is 2,484 while at King Street Medical Centre it is 1,761.

Due to both buildings being no longer fit for purpose, Dr Bello's Surgery building being currently without a lease and the lease at King Street coming to an end, and with both practices requiring suitable modern premises from which they can deliver efficient services, it has been proposed to relocate the two practices to more modern and purpose-built facilities at Acorn Primary Health Care Centre in Blackburn Road.

Space has been identified within the centre, which is 0.3 miles from Dr Bello's and 0.7 miles from King Street. The new site has ample parking and sits on a main road and bus route.

Engagement took place throughout October and November to understand any issues patients of the two practices would face from relocating. This took the form of an electronic survey, the link to which was distributed to all practices via a direct letter and/or text message. Printed copies were also available in the practices and physically handed to people as they went for appointments. In addition, face-to-face engagement sessions were held in each of the practices.

During the engagement, very few concerns were raised about the move. Some respondents were worried about parking and a loss of the friendly service they had come to expect and enjoy. The findings will be considered at a future primary care commissioning meeting and help influence the decision relating to both practices.

Both reports can be found on our website:

- Dr Bello's Surgery
- King Street Medical Centre

Pharmacy First

The ICB is the organisation responsible for organising primary care services – including pharmacy services – across the region. Under the Pharmacy First service, most pharmacies can offer prescription medicine for some conditions, without people needing to see a GP or make an appointment.

In order to support planned promotion of Pharmacy First, the ICB carried out a survey to understand what existing awareness was of the service and what people's experiences of it were. The survey also explored people's attitudes to pharmacy in general which will support with upcoming communications and engagement activity around pharmacy access.

The survey was completed by 448 people, 72.5 per cent of which said they had heard of the Pharmacy First service. The majority of those who had heard of the service had seen adverts in their GP practice, while social media and TV advertising also scored highly.

Despite the high levels of awareness of the service, only 21 per cent of respondents said they had used the Pharmacy First service, and of those, 76.5 per cent had accessed the service via walk-in and only 12 per cent had arrived following a GP referral.

Asked to provide feedback on the service, 78.5 per cent said they had received the treatment and/or support the needed from the pharmacy, 61 per cent did not need to return to their GP practice for any aspect of the ailment, 69 per cent were able to access the required medication they needed to treat their condition and 75 per cent were satisfied with the treatment they received.

All survey respondents were asked if they would be happy to visit a pharmacist instead of their GP practice, and almost 85 per cent of those who answered the question said they would. The survey also asked if there were any reasons they would not visit a pharmacy, and the most common negative response was the lack of privacy available at a pharmacy (17 per cent).

The findings have been used to support promotion of Pharmacy First , with insights used to shape messaging to the public. The full report can be found on our website.

Cardiac service reconfiguration

Following a review of cardiac services and the wider model of care in Lancashire and south Cumbria a list of 'drivers for change' has been established which, on paper, warrant reconfiguration of those services. To support this a series of engagement through focus groups and online questionnaires was conducted in July and August 2024.

We spoke to people about their experience in the Trusts they were treated at asking specifically if they had experienced any of the issues highlighted in the drivers for change. We also asked what good hospital care for cardiac patients should look like and whether changes to the service might create any other issues.

A report on the findings can be found on the ICB website.

The following is a summary of the key themes and issues from the feedback:

- Waiting times for appointments are too long.
- Some diagnostics, particularly echocardiogram testing take too long.
- Trusts do not communicate well between themselves.
- Provision at the cardiac centre at Blackpool Teaching Hospitals NHS Foundation Trust is excellent but delays in appointments are of concern.
- The severity of cardiac conditions requires patients to have more reassurance in their treatment.
- Patients want either to see the same consultant every time or to be reassured that the person they are seeing has access to all their records and is familiar with them and their situation.
- In-hospital care is usually excellent, but rehabilitation/repatriation is slow and communication with out-of-hospital services needs to be improved.
- Being seen at the centre of excellence is seen as preferable to anywhere else.
- There are a number of services that patients would feel confident in accessing in the community; those being services that are post-operative and do not need specialist facilities or consultant input.

In general, feedback from patients supports the case for change and echoes some of the issues raised as drivers of the need for change. Issues around staffing, waiting times for appointments and delays in echocardiogram testing and other diagnostics were highlighted as most pressing. These findings and insights will be integrated into the development work.

The findings also show a level of support for a network of services with the condition that communication between all services is improved and robust.

Barriers to cancer screening – listening to views from black and minority ethnic women in Preston

A number of published studies indicate that South Asian women generally have lower screening rates for cancer than white British women. Evidence suggests they have

poorer knowledge of the signs and symptoms of cancer and cancer prevention and experience more barriers to screening.

This engagement project aimed to seek the views of those women connected with Sahara in Preston to understand what the barriers are to attending the national screening programmes for cervical, breast and bowel cancer and what can be done by health services to improve uptake.

Sahara in Preston is a voluntary organisation for women, working predominantly for the benefit of black and minority ethnic women. It was established to ensure that the social, economic and welfare needs of the women from BME communities in Preston were fully recognised and met by the public and voluntary sectors and that they were enabled and encouraged to participate in the wider society.

Over 200 South Asian ladies were invited to a listening event at the end of June 2024 at Sahara's community centre in Preston. Sixty-three ladies turned up ranging in age from those in their 20's to those in their 70's.

There were a number of key themes which arose from across all of the discussions. Overall, we heard there is a lack of understanding and education about cancer and signs and symptoms. There are some key barriers to attending for screening, mainly relating to language, culture, fear of pain and the unknown and what to expect which also comes from the lack of information supplied, whether in English or other languages.

Language does remain a main barrier with information primarily supplied in English with an expectation that a family member can translate for them. However, this is not always appropriate, given the sensitivity, or complexity, of some of the issues and information. While family can help to some extent, there is difficulty when children have to get involved if they are the only option for translation. It was felt by the group that this isn't appropriate, and a child can misunderstand the information and interpret it incorrectly. Equally, people do not like to use Language Line, which again is not felt always appropriate to discuss intimate health issues via a stranger, especially if the interpreter is male. The group shared that there can be little or no support from home or the health system with language, a professional who has the appropriate language skill who can explain pathways and treatments is needed.

Another main barrier remains cultural. Some topics are still not discussed within the home, especially with unmarried females if relating to sex or the female body. The women explained they come from a faith where their bodies are always covered up and apart from their spouse no one has even had sight of their arms let alone other private parts. For this reason, they find going forward for intimate examinations a huge challenge.

A key finding for this community was, that husbands do not understand the reasoning for a mastectomy (especially if reconstruction is not carried out) or accept it. In these instances, some mothers-in-law tell their sons to re-marry and take a new wife. The reality is that women are opting not to have lifesaving surgery in order to save their marriage.

Some of the ladies thought screening might be painful, or it might be a male carrying out the procedure. They are embarrassed about people looking at them, it can scare them and put them off. In addition, fear if they had cancer and fear about going through treatment. Reassurance was given that whilst some of the procedures may be a little uncomfortable, there should be no pain. Women also have the right to request a female practitioner, and that in the instance of breast screening this is always a female mammographer. They also have the right to request a chaperone, whether a staff member from the clinic or a friend/family member.

More education was felt to be needed around the different signs and symptoms of cancer and the reasons why the screening programmes are so important.

When an appointment is sent, all of the information included should include the benefits and limitations of the test, as well as the practicalities. Information should be provided in the appropriate language or format.

The full insight report has been shared with the ICB's women's health team and the ICB's cancer team to consider the points raised and use the insight to influence future service provision. Education and awareness will be considered as part of the work to improve uptake and will be considered and developed in due course.

Scoping survey to gauge satisfaction with existing women's health services across Lancashire and South Cumbria

There are around 1.8 million residents in Lancashire and South Cumbria – of those, around 917,000 are girls, women and people assigned female at birth (AFAB), aged from birth to over 90 years old.

To align with national priorities, Lancashire and South Cumbria ICB was awarded £595,000 of funding to deliver women's hubs focusing on areas of need. As part of this work, a requirement was to have one of the hubs operational by December 2024; in order to make the hubs as meaningful as possible to as many people as possible, we decided that we needed to ask women what they wanted to happen with any potential contraceptive and menopause services.

Lancashire and South Cumbria ICB received £595,000 of funding to deliver women's hubs through the Women and Children's programme workstream. A scoping survey was sent to over 300 organisations and individuals asking for women and people assigned female at birth to share their thoughts on current provision of contraceptive and menopause services.

The survey received 1549 responses, representing 0.2 per cent of the eligible population, which seemed to indicate that whilst contraceptive services are reasonably accessible and useful there is a significant gap in provision for those in need of menopause care. Primary care services seem to struggle to meet demand and refer on to specialist gynaecology services when a specialist service might not be necessary. This has a knock-on impact on delivery of specialist services which are unable to meet demand. Specialist women's hubs may be ideally placed to support provision of menopause services and would be very much welcomed by people seeking support for peri-menopause and menopause symptoms.

The survey was designed to ask women and AFAB people about their contraceptive and menopause needs. There were 1549 responses, with a number of themes and recommendations:

- Address unwanted variance in primary care - Issues around services provided, accessibility, knowledge and specialism of staff.
- Make sure any future engagement is in non-medicalised language. .
- Greater provision of specialist/focused clinics staffed by well-trained, compassionate, and knowledgeable staff.
- Provide services locally at Place rather than centrally - Consider issues such as transport, deprivation, rurality when planning service delivery.
- Utilise primary care/community spaces as people are already familiar with them - No need to build additional clinical spaces.
- Be mindful of LGBTQ+ service users - Avoid gender-stereotypes in comms materials, use inclusive terms.
- Address menopause as an holistic condition. It does not always require referral to gynaecology or mental health services.
- Improve accessibility- language/ location/ estates e.g. disabled access

The team leading this work have considered the findings and are integrating them into the development of the hubs. The insights have also been helpful in raising awareness concerning the needs of women and have helped inform the strategy more generally.

Unpaid carers: Understanding the carer experience: challenges and insights from racially minoritised communities on NHS services and hospital discharge

In response to Healthwatch's report on the lived experience of carers in Westmorland and Furness which was shared at the PIEAC in December 2023, PIEAC members discussed the need for a focus to understand the lived experience, insight and views of people from minority ethnic groups. Following this discussion, NHS England invited bids for funding to engage with seldom heard groups and marginalised populations. The engagement team, working with Inclusive North bid for and was successful in obtaining funding to engage with minority ethnic groups to understand their experience of caring in the Lancashire health and care system.

This work has highlighted the insights of the experience of ethnic minoritised unpaid carers and their experiences of navigating NHS health care, focusing on:

- GP services
- Urgent care
- Outpatient appointments
- Inpatient care
- Hospital discharge planning

The report of the engagement has now been published and seeks to understand the entire process and difficulties faced by unpaid carers navigating various NHS services, with a particular emphasis on what constitutes a good hospital discharge from their perspective. It identifies common themes, key issues, and provides recommendations for improvement based on the carers' feedback.

The key findings underline the critical areas where improvements are needed to enhance the experiences of unpaid carers from racially minoritised communities in navigating and using NHS services.

- GP services
    - Appointment accessibility and delays: Long waiting times for GP appointments and difficulties in booking systems were major concerns, with some carers waiting up to six months for an appointment.
    - Communication barriers: language barriers and poor communication from GPs were significant issues, leading to misunderstandings and inadequate care.
    - Staff attitude and stereotyping: carers reported feeling dismissed and stereotyped by GP staff, with frequent use of locum doctors resulting in inconsistent care.

- Urgent care (111 and A&E services)
    - Response times and efficiency: carers experienced long waiting times for ambulances and in A&E departments, causing significant stress during emergencies.
    - Communication Issues: The 111 service was criticised for being too scripted, and carers often had to repeat information multiple times to different staff members.
    - Staffing levels and attitudes: understaffed departments and unhelpful reception staff were common complaints, with carers feeling that urgent care services lacked efficiency and empathy.

- Outpatient appointments
    - Long waiting times: delays in outpatient appointments and receiving test results were highlighted as major issues, adding to carers' anxiety.
    - Appointment cancellations and coordination: frequent cancellations and poor coordination between NHS Trusts disrupted care and caused confusion.
    - Professional attitudes and communication: healthcare professionals in outpatient settings often appeared rushed, making it difficult for carers to receive comprehensive information about treatment plans.

- Inpatient care
    - Hospitalisation experience: carers reported long waits for room admission, inadequate facilities, and patients being left on trolleys in corridors.
    - Staff attitudes and cultural sensitivity: rudeness and a lack of cultural sensitivity from hospital staff were significant concerns, with carers feeling their needs were not respected.
    - Communication and support: carers expressed the need for better communication and regular updates from hospital staff, as well as more support services tailored to their cultural and linguistic needs.

The report and the findings have been reviewed by the Public Involvement and Engagement Advisory Committee of the Board, and in more detail, by the Lancashire and South Cumbria Carers Group, and an action plan developed in response to the findings. In addition, the findings will be shared with the equality, diversity and inclusion teams across the health and care system to increase awareness and encourage action.

Winter awareness and resilience campaign 2023/24

This was a campaign with the objective of supporting a reduction in system pressures. It was a joint effort across LSC Trusts and the ICB. The campaign sought to signpost people to the right services, the first time, prevent injury and ill-health and to promote self-care. It was branded 'Think' and although was run without a budget, we saw significant activity seen across many channels and outlets, and on the ground in each place. Despite this 2024 A&E attendance was higher than 2023.

We asked of, and flexed support through community engagement networks in each place. Our ask of these networks was how can we use your networks and channels to enhance the impact of the right messages and spread the word, as well as engage in dialogue. One tangible, and measurable impact was that we were able to distribute 22, 920 winter well booklets to vulnerable people throughout Lancashire and South Cumbria. Key messages were shared with a wide range of partners including the VCFSE, housing associations, local authorities and other partners. Key insights from this work have included the importance of local networks, particularly newly found connections such as housing associations, and small of the smaller voluntary, community, faith-based organisations. Feedback from our networks suggests that an earlier process of engagement with partner campaigns should be considered. Historically the winter awareness and resilience campaign has relied on traditional communication and social media approaches to reach people.

This new approach which the ICB communication and engagement team has championed, places community and face to face engagement with the people, groups and networks that can ensure that the most vulnerable, seldom heard, and least reached people are engaged and involved. Adopting a targeted approach has meant that working with our partners at place we have been able to reach those who are less likely to receive messages via traditional methods such as the media, online or through social media. This has enabled people to receive useful and informative information, including self-care and posting to essential alternative services in each place during the winter months.

Shaping Care Together

The NHS Shaping Care Together programme has been looking at changing urgent and emergency care services across Southport, Formby, and West Lancashire.

Between July and October 2024, pre-consultation engagement was carried out during which people were asked to share their views on urgent and emergency care. And in-depth analysis of the views put forward during that period has now been published and can be viewed here on the Shaping Care Together website[2] This will help shape and inform the planned public consultation later this year.

The programme is now going through a series of checks with NHS England to make sure everything in the pre-consultation phase was done as it should be. All being well, the programme hopes to start public consultation later this year. That will be the chance for everyone to share views on the option(s) put forward, but also to introduce new insights and perspectives so that the conversation around future services is based on all available facts.

Preventing male suicides

To help develop and shape phase 2 of the 'Let's Keep Talking' to prevent suicide campaign, the ICB's suicide prevention team held several engagement events across Lancashire and South Cumbria.

The engagement ran from 22 January to 11 February, during which the survey received 343 responses. Ten individuals attended the online engagement sessions and there were 31 participants in total attended a face-to-face session. The feedback received indicated the campaign needed to be positive, shows greater understanding about how men communicate, and challenge the language used by health services. Respondents were particularly concerned about the help-seeking for males and their support networks and wanted the campaign materials to help address this.

The feedback received helped to shape the messaging and imagery for the campaign and effectively coproduce it with men throughout Lancashire and South Cumbria. The new campaign was launched in March 2025.

The full report can be found on the ICB website.

Engagement and involvement toolkit and guidance for ICB staff

As part of our development of the communications and engagement team, along with a robust and resilient engagement infrastructure and process, the team have developed an engagement toolkit and guidance for use by ICB teams and to support wider partnership working across the ICS, including the Provider Collaboration Board and the wider workforce. The toolkit aims to support teams to embed the ten principles for engagement and involvement in all areas of the organisation and partnership.

Alongside this, the engagement team developed a workforce training programme that complements the toolkit and guidance. The toolkit and the training, including best practice in engagement webinars was introduced to the workforce throughout 2024/25 having been tested internally. The webinar series has been successful in bringing together the workforce, partners, patients and patient groups and offers the system the opportunity of shared, consistent and high quality engagement methods and models.

Health and wellbeing strategy

Health and Wellbeing Boards are formal committees of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government. They have a statutory duty to, with others, produce a joint strategic needs assessment (JSNA) and a joint local health and wellbeing strategy (JLHWS) for their local population.

There are six Health and Wellbeing Boards which are either entirely or partly within the Lancashire and South Cumbria ICB area:

- Blackpool Health and Wellbeing Board.[15]
- Lancashire Health and Wellbeing Board[16]
- Blackburn with Darwen Health and Wellbeing Board[17]
- Cumberland Health and Wellbeing Board[18]
- Westmorland and Furness Health and Wellbeing Board[19]
- North Yorkshire Health and Wellbeing Board[20]

Lancashire and South Cumbria ICB is represented on each Health and Wellbeing Board, except for North Yorkshire, by an ICB Director. Some residents of Lancashire and South Cumbria receive health services from, or in, North Yorkshire. It has been agreed that while there will be no member of Lancashire and South Cumbria ICB on North Yorkshire's Health and Wellbeing Board, there will be mutual engagement on matters of relevance.

The ICB Place directors of health and care integration have been involved with the NHS contribution to the joint local health and wellbeing strategies. They have helped to ensure consistency and coherence across wider system strategies and to identify key areas requiring stronger focus, such as mental health and preventing homelessness. Specific work that has contributed to the achievement of goals in the JLHWSs in included in our Place updates earlier in this annual report.

The strategies can be found at:

- Blackpool Health and Wellbeing Strategy
- Lancashire Health and Wellbeing Strategy
- Blackburn with Darwen Health and Wellbeing Strategy
- Cumberland Health and Wellbeing Strategy
- Westmorland and Furness Health and Wellbeing Strategy is currently being created following the formation of the new local authority. Information can be found here.

[15] https://democracy.blackpool.gov.uk/mgCommitteeDetails.aspx?ID=169
[16] ttps://www.lancashire.gov.uk/practitioners/health-and-social-care/health-and-wellbeing-board/
[17] https://www.blackburn.gov.uk/health/health-strategy-and-reports/health-and-wellbeing-board
[18] ttps://cumberland.moderngov.co.uk/mgCommitteeDetails.aspx?ID=177
[19] ttps://westmorlandandfurness.moderngov.co.uk/mgCommitteeDetails.aspx?ID=271
[20] https://www.nypartnerships.org.uk/healthandwellbeing

- North Yorkshire Health and Wellbeing Strategy

WorkWell Vanguard

The work, skills and health agenda is one area where the ICB has taken a leadership role in the past year. Working with local authority, business and VCFSE sector colleagues, the ICB and NHS provider partners, we have implemented the Vanguard programme which will run until March 2026. The programme helps people with low level physical and mental health conditions to start or return to work or stay in work.

WorkWell is part of a national evaluation, but locally the ICB is working with partners to devise a local evaluation aligned to local priorities. This will help to shape our learning and build the evidence base for an integrated work, skills and health strategy.

VCFSE Alliance

The ICB continues to work closely with the VCFSE Alliance to strengthen partnerships and collaboration with sector organisations. There is recognition of the intrinsic social value that the sector delivers and the role it plays in tackling inequalities in outcomes and access within some of our most marginalised communities. We will continue to pursue strategic opportunities for joint working on priority programmes.

Our joint work plan for 2025-26 was informed by the NHS England's Quality Development Tool and focuses on:

- Leadership Development & Capacity
- Strategic Influence and co-design of core programmes
- Fair and accessible commissioning and contracting

Supporting our Armed Forces community

The ICB has a statutory role to play, both as a major employer in the region and as a planner and commissioner of NHS services.

The first major milestone was the signing of the Armed Forces Covenant, by the ICB Chair and Chief Executive, in November 2024. This signalled our commitment to the Armed Forces community, which includes those with serving partners/spouses, military families, veterans, reservists, and voluntary leaders in military cadet organisations.

We are developing strong partnership and collaboration links with Third Sector and statutory organisations throughout Lancashire and South Cumbria, to signpost and raise awareness of resources, information, activities, and support tailored to, and often provided by the Armed Forces community.

We will continue to build on this progress in 2025/26 by gaining accreditation through the Covenant Employer Recognition scheme and developing priority actions focused on the ICB as a facilitator, enabler and connector.

Environmental matters and sustainability

On 1 July 2022, the NHS became the first health system in the world to embed net zero into legislation, through Health and Care Act 2022[21].Net zero is achieved by both reducing greenhouse gas emissions and removing them from the atmosphere.

National NHS goals:

- Emissions we control directly to be net zero by 2040, aiming to reach an 80% reduction by 2028-2032.
- Emissions we can influence to be net zero by 2045, with an ambition to reach an 80 per cent reduction by 2036 to 2039.

As an ICB, we play a key role in reducing emissions across our healthcare sites, influencing our providers, and building healthier communities. Our ICB Green Plan[22], published in March 2023, outlines how we will support NHS England and the UK government in fulfilling these emission goals.

The ICB plays a pivotal role as an anchor institution in promoting the green agenda. It collaborates with partner organisations with linked environmental goals and supports both primary and secondary care providers in progressing their green plans. The ICB's regional influence ensures that local green initiatives are supported and integrated into broader health and wellbeing objectives. Additionally, the ICB is committed to fostering a circular economy by reducing waste and increasing reuse initiatives, such as the 'WARP IT' program, which encourages the reuse of equipment and supplies.

Climate change is already affecting the health of our population, with the greatest impact on the most vulnerable. Extreme weather events such as heatwaves can exacerbate asthma and cardiovascular disease, flooding has a significant impact on mental health and poor air quality can exacerbate respiratory disease. Implementing the Green Plan will improve the health of our population, support a reduction in health inequalities and contribute to financial sustainability by improving efficiency and reducing waste

A Net Zero Project Manager co-ordinates the work plan with the support of a Primary Care Clinical Lead. The ICB Net Zero Board meets every six weeks to review risks and progress made within the ICB, primary care and Trusts, ensuring that net zero principles are strategically embedded across key aspects of the system's health services. The Board is chaired by the Director of Strategic Estates, Infrastructure and Sustainability and comprises Senior Leads for the named areas of focus within the Green Plan. Thematic working groups attended by operational leads feed into the Board.

A quarterly Highlight Report from this group informs the ICB's Business and Sustainability Group. Issues are escalated to the ICB Board as appropriate with

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[21] https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted
[22] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/publications/strategies-and-plans/green-plan-2022-25

monitoring of progress at a senior manager meeting (BSG), Green Plan progress is reported to the Board annually. Climate related risks are included as part of the infrastructure risk identified on the Corporate Risk Register and reviewed quarterly.

This governance structure ensures that Directors from all areas of the ICB have a degree of oversight of the Green Plan and that staff in all areas remain informed. To further embed environmental sustainability and risks associated with climate change, the ICB's sustainable impact assessment (SIA) is completed by staff during project initiation or strategy development and in January 2025 was incorporated within VERTO, the ICB's project management software. The SIA uses a series of criteria covering issues relevant to the Green Plan chapters to measure the environmental impact of an activity or change in process.

The ICB submits data quarterly against a set of Key Performance Indicators set annually by Greener NHS England. This data alongside a Highlight Report is used by the North West Net Zero Board to assess ICB progress.

The following highlights key progress for 2024-2025 within each of the nine focus areas included within the Green Plan, followed by a quantitative update and high-level plans for 2025-2026. Additional detail will be contained within the Green Plan 2025/30 scheduled for endorsement by the ICB Board in July 2025:

Workforce and leadership

- Environmental sustainability is embedded within all ICB HR processes from recruitment and induction through to appraisals and training opportunities.
- LSC Greener NHS website has resources for staff working across all health sectors, to support environmental sustainability.

Sustainable models of care

- Primary Care Clinical Lead for Environmental Sustainability has delivered workshops to over 100 GPs in training. A number of attendees have opted to deliver projects within practices that focus on sustainability.

Digital tranformation

- The ICB's Digital Strategy issued in 2024, includes progress towards Net Zero: becoming responsible digital citizens as one of its key objectives

Travel and transport

- BetterPoints Lancashire, adopted in January 2025, is an App based technology that encourages and monitors behaviour change through supporting and rewarding sustainable travel choice.
- Council funding has enabled GP practices to use e-bikes for practice visits and improved facilities for staff and patients wanting to cycle.

Estates and facilities

- Sustainability is embedded in the ICB's Infrastructure strategy 2023-2040 and this will ensure any larger capital schemes across Lancashire and South Cumbria will be Net Zero. Planning is underway to assess the work and associated costs bringing our Hospital estate up to Net Zero standards.
- A 3y Space Utilisation Programme, initiated in 2024, aims to achieve an average 85% utilisation for all buildings across L&SC by October 2027. Governance established to ensure a joined up approach and baselining of current utilisation.
- Trusts across the region have accessed national funding in 2024/25, including £13m from the NHS National Energy Efficiency Fund (NEEF) for LED lighting and solar panels.This will lead to significant ongoing energy savings.
- 'WARP-IT, a digital furniture and equipment redistribution software, available across all Trusts, has reduced waste that goes to landfill by around 83 tonnes and spend on new items by c£653k. This is estimated to have reduced carbon emissions by 283tCO2.

Medicines

- High-quality, lower-carbon respiratory care supports patients to improve their lung health while reducing inhaler emissions. High Carbon inhalers have reduced by 34% compared with the 2019/20 baseline.
- The use of desflurane, an anaesthetic gas with high global warming potential, has been eliminated, while Nitrous oxide use had reduced by more than 43% compared with the 2019/20 baseline.

Supply chain and procurement

- The ICB Procurement and Contracting policy was published in January 2025 and includes a chapter on social value and net zero. This will ensure our procurement processes are in line with the NHS Net Zero Supplier Roadmap.

Adaptation (adapting to environmental change)

- Introducing Adaptation Plans will ensure our healthcare facilities can withstand the impacts of climate change such as floods and heatwaves into the future.

Food and Nutrition

- The ICB promotes lower carbon food and waste reduction initiatives with our staff and the public.

Success through Collaboration

Collaboration, whether this is between sectors within the NHS or alongside external organisations is vital to ensure our journey towards Net Zero is undertaken as effectively and efficiently as possible. Trust Green Plan leads meet regularly providing opportunity for both resources and best practice to be shared.

The ICB has been working with councils across Lancashire and South Cumbria on initiatives, including:

- Lancashire's Active Travel team have facilitated events across ICB and hospital sites to support and encourage sustainable travel amongst staff, visitors and patients.
- Council support for small businesses has enabled over 45 of our GP practices to access a free specialist audit and calculate the carbon footprint of their building and operations, including waste and staff travel. Each organisation is presented with a bespoke carbon reduction plan and guidance on how they can work towards becoming Net Zero.

As part of the Green Plan update, we are conducting extensive stakeholder engagement to collaboratively develop the next Green Plan and ensure alignment with related strategy and plans within our healthcare providers, councils and VCFSE sector.

Performance

Publishing performance data in our annual report is not mandatory, but it is good practice and allows us to track our progress and adapt our plans as we move to becoming a Net Zero NHS. The 2024/25 system-wide performance data should be available in late 2025 and the extract in the table below is only to 2023/24. Most of the ICB's carbon footprint stems from commissioned services, as office-based activities have lower carbon intensity compared to direct healthcare delivery. The table therefore includes carbon footprint data reported by Trusts, except for inhaler data, which relates to primary are only.

An ICB performance dashboard to support monitoring of Green Plan implementation is in development by the National NHS Greener team and will be released during 2025/26, to enable closer monitoring.

Trust Carbon Footprint and Primary Care Carbon Footprint for Lancashire and South Cumbria (inhaler component only) (Greener NHS national dashboard)

	Baseline 2019/20	2020/21	2021/22	2022/23	2023/24	Annual change (2022/23 to 2023/24)
Trust Estate Carbon footprint (tCO_2e)	84,533	94,594	83,008	79,468	80,348	1% increase
Energy (tCO_2e)	79,873	89,893	79,560	76,647	77,812	2% increase
Water & Sewage (tCO_2e)	1,575	1,256	578	412	376	9% reduction
Waste (tCO_2e)	3,085	3,445	2,870	2,409	2,160	10% reduction
Medical Gases (Nitrous oxide and Entonox) (tCO_2e)	10483	8839	7691	6496	6011	7% reduction
Anaesthetic Gases (tCO_2e)	1,681	595	569	584	437	25% reduction
Inhalers (tCO_2e) Primary Care prescribed data only	33,783	31,698	32,226	27,636	22,797	18% reduction
Total of Emissions listed (tCO2e)	130,480	135,726	123,494	114,184	109,593	4% reduction

- Data within this table has been extracted from the Greener NHS national dashboard. This dashboard is being developed so that next year it will include additional ICB level contributions to the national carbon footprint and footprint plus.
- The Trust estate Carbon Footprint arising from electricity, heating, water and waste use increased over the year by one per cent. There has been an overall reduction of five per cent since the baseline year. Office spaces used by ICB staff are leased. We work alongside landlords to reduce carbon emissions for these building.
- The carbon footprint of medical gases has decreased by seven per cent, showing the impact of manifold decommissioning within Trusts.
- The carbon footprint of anaesthetic gases decreased by 25 per cent, as desflurane use has been phased out.
- The carbon footprint of inhalers prescribed in Primary Care decreased by 18 per cent, due to changes in prescribing.
- An ICB staff survey indicates that 47 per cent of ICB staff typically/ always work from home and most other staff only commute to the office one or two days a week. The

carbon footprint of staff travel is therefore relatively low, however, sustainable travel initiatives such as cycling to reduce the number of single occupancy vehicles are promoted and uptake will be monitored.

Priorities for 2025/26

The high-level priorities identified for 25/26.

- Publication of the Green Plan 2025 – 2030 in July 2025 and progress towards delivery of the supporting workplan for 2025/26.
- Include environmental sustainability and the impact of climate change within the ICB's Clinical Strategy.
- Extend the use of a Sustainable Impact Assessment across Trusts to ensure environmental sustainability is considered when redesigning care pathways.
- As part of the Space Utilisation Programme an ICS wide universal booking system is planned to be implemented to ensure the efficient use of rooms and spaces within healthcare sites across Lancashire and South Cumbria. Optimising space utilisation and reducing the need for additional buildings will lower the overall carbon footprint of our estate.
- Expand the **Green Champions/ Leads** network across every site to act as advocates, support sustainability initiatives and share good practice across the system. Establish a forum that meets on-line quarterly.
- Increase the current level of GP practices with Carbon Reduction/ Green Plans or using the Green Impact for Health Toolkit
- Support Trusts to develop Heat Decarbonisation Plans for relevant hospital buildings.
- Enhance procedures to incorporate environmental sustainability into the contracting and commissioning framework.
- Support Trusts to develop a system-wide Sustainable Travel Strategy.
- Work with stakeholders across Lancashire and South Cumbria to develop a comprehensive, long term Climate Adaptation Plan by July 2026.

Task force on climate-related financial disclosures (TFCD)

The DHSC Group Accounting Manual (GAM) has adopted a phased approach to incorporating the recommended Taskforce on Climate-related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally, by NHS England.

TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year.

The earlier part of this 'Environmental matters and sustainability' section incorporates the disclosure requirements of the following 'pillars'; Governance, Risk management,

and Metrics and targets. A finance and contracting committee is being established in Q1 2025 that will review progress against the new Green Plan 2025-30 and scrutinise the ICB's financial/investment plans in relation to environmental sustainability (including statutory duties as to climate change).

Emergency preparedness

All NHS organisations have a duty to be properly prepared for dealing with emergencies such as major incidents, outbreaks of infection, severe weather or acts of terrorism. The responsibilities for emergency planning are set out in the Civil Contingencies Act 2004, NHS Act 2006, the Health and Social Care Act 2022 and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework 2022.

The ICB has an Accountable Emergency Officer Board level Director who is responsible for EPRR. The Board agree arrangements for preparing for, responding to, and leading recovery from incidents, and ensure that the NHS and partner organisations work together at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England.

Lancashire and South Cumbria ICB works closely with partner NHS organisations, the emergency services and local authorities to ensure a co-ordinated, system wide response to emergencies to minimise the impact on the population we serve. The ICB is a Category One responder with statutory responsibilities, and is committed to preparing for, and responding to, incidents and emergencies that could affect the health of the community or the delivery of patient care.

Digital solutions are critical to both the safe and effective delivery of information to front line care staff and for the provision of effective business decision making to health and care leaders across the health and care economy. The ICB is aware that attacks against digital solutions and attacks against NHS organisations are increasing in both quantity and severity. In order to mitigate this risk, the ICB has worked with our health partners to agree a system-wide Cybersecurity Strategy (2024-2025) which proposes a collaborative approach to the safety and security of our digital tools, aligned with the national What Good Looks Like framework, and the national NHS Cyber Strategy. Durning the year, the ICB has led the response on a number of challenging incidents; including industrial action and system pressures.

NHS organisations are subject to an annual assurance process to assess their plans, policies and procedures relating to emergency planning. For 2024/25 the ICB has been assessed as partially complaint, a significant improvement on the non-compliant rating for 2023/24. The five Trusts within Lancashire and South Cumbria have also undergone an assessment, and all have improved their compliance ratings on 2023/24. A gap analysis has been undertaken and robust action plans have been developed to improve compliance levels for 2025/26 onwards. For the ICB, this is monitored at the Emergency Preparedness, Resilience and Response Co-ordinating Group. For the Trusts, these are monitored at the multi-agency Local Health Resilience Partnership for Lancashire and South Cumbria.

A series of other control mechanisms are in place including;

- Development and monitoring of an EPRR Work Programme and EPRR Risk Register.
- Comprehensive training for tactical and strategic on call staff to respond to incidents and emergencies on behalf of the ICB
- A training needs analysis and personal development portfolio has been developed for on call staff to complete to ensure compliance with the minimum occupational standards (for EPRR)
- A robust on call rota is in place, with monthly meetings to share experiences and advise of any updates in relation to EPRR matters
- Regular EPRR awareness sessions are offered for all staff to attend
- Review of the Incident Response and Business Continuity Plans

Through this process, the ICB continues to regularly review and make improvements to its emergency planning and response arrangements.

Financial review

Financial Performance Overview

2024/25 has been another challenging year. The ICB was set a control total for 2024/25 which meant it received £87.5m of deficit support funding to facilitate a breakeven plan. This still required achievement of a planned Quality Innovation Productivity and Prevention (QIPP) programme of £270m and therefore included significant risk in achieving a balanced year-end position.

The Aligned Payment and Incentive (API) approach which commenced in 2023/24 continued in 2024/25. This incorporated both fixed and variable elements and therefore increased the risk to the ICB in terms of potential overperformance on the variable elements. In addition, in-year cost pressures, most significantly on All Age Continuing Healthcare expenditure required the ICB to identify further mitigations during the year to offset these pressures.

The pressures identified in-year led the ICB to introduce increased grip and control measures, including an incident management approach designed to strengthen the monitoring of QIPP delivery and facilitate the identification of new QIPP and mitigation opportunities. However, identifying new opportunities proved difficult because of the largely fixed expenditure base.

In September 2024, practical external support was provided to the Lancashire and South Cumbria health system through NHS England's Investigation and Intervention (I&I) process. This aimed to improve the run rates of systems most at risk of not meeting their agreed financial plan.

However, as the financial position of the system continued to deteriorate during the year, NHS England identified that further action and intervention was needed. The ICB and three of the acute trusts in the Lancashire and South Cumbria system were placed in National Oversight Framework segment 4 (NOF4), the highest level of intervention,

which indicates that there is a requirement for mandated intensive support via NHS England's Recovery Support Programme (RSP).

The ICB entered the RSP on 28 January 2025. This programme provides a collaborative approach with intensive support to help to address the complex, historical problems faced by the organisations within the health system, with an aim of embedding lasting solutions for a sustainable system and to ensure expenditure levels remain within resources allocated.

The increased grip and control measures introduced by the ICB during the financial year along with the external support received assisted the ICB in achieving a breakeven position for 2024/25, despite the considerable risks and pressures observed. QIPP savings of £240.5m were delivered against the original planned target of £270m and the ICB was able to identify additional in-year mitigations to cover the shortfall and the in-year pressures.

The following section provides a brief overview of the ICB's financial performance in the 2024/25 financial year. The financial accounts have been prepared under a Direction issued by NHS England under the National Health Service Act 2006 (as amended). A full set of accounts, including associated certificates, is included later in this report.

Performance Summary

Over the last year, we tracked the progress of our service providers (for example local hospitals, community services and primary care practices) against several national outcomes indicators and ensured that patient rights within the NHS Constitution were maintained. Additionally, we set local priorities against which provider progress was monitored. Performance reports were presented to and scrutinised by the Finance and Performance Committee and a summary of key issues reported to the ICB Board.

More information about the Finance and Performance Committee can be found in the Corporate Governance report.

Financial Key Performance Indicators

The ICB's performance is measured against a number of financial key performance indicators as outlined below:

Key performance indicator	Target	Actual	Result
Revenue resource use does not exceed the amount specified in Directions	Maintain expenditure within the allocated in-year resource of £5,380.938m	Total expenditure £5,380.938m	Achieved
Delivery of a control total of breakeven	Deliver a control total of breakeven	Total position breakeven	Achieved
Maintain expenditure within the Annual Cash Drawdown Requirement	ICB Annual Cash Drawdown Requirement total £5,379.323m	Total cash outflow £5,357.910m	Achieved
Revenue administration resource use does not exceed the amount specified in Directions	Maintain administration (running costs) expenditure within the allocated resource of £32.922m	Total administration (running costs) expenditure £29.720m	Achieved
QIPP savings targets identified and savings achieved	Overall QIPP savings target £269.992m	Total QIPP savings £240.458m	Not achieved (shortfall covered in part by other mitigations - additional allocations and underspends in other areas)
Capital resource does not exceed the amount specified in Directions	Maintain expenditure within the allocated in-year resource of £nil	Total expenditure £nil	N/A – no capital allocation received in 2024/25
Comply with the Better Payment Practice Code (BPPC)	Ensure 95% (by value and volume) of all valid invoices are paid by the due date or within 30 days of receipt of a valid invoice, whichever is	NHS payables: - 98.93% by value - 97.43% by volume Non-NHS payables:	Achieved

Key performance indicator	Target	Actual	Result
	later	- 97.35% by value - 99.11% by volume	

Allocation

The total in-year allocations to NHS Lancashire and South Cumbria ICB for 2024/25, rounded to the nearest £m, were £5,381m. This can be broken down as follows:

- We received allocations totalling £4,361m for commissioning NHS services for the local community. Of this:
    - £175m was non-recurrent deficit support revenue allocation, of which £87.5m was transferred to local provider trusts
- We received a further allocation of £370m for delegated commissioning of primary care medical services
- We received a further allocation of £212m for delegated commissioning of other primary care services (pharmacy, dental and optical)
- We received a further allocation of £405m for delegated commissioning of specialised services
- We received a further allocation of £33m from which we were expected to cover all our running costs

2024/25 financial duties

The ICB's performance against each of its financial duties, as reported in Note 2 to the Accounts and outlined above, for the 2024/25 financial year was as follows:

- The ICB achieved its in year control total of a breakeven position.
- The ICB maintained its administration expenditure within its Running Costs Allowance.
- The ICB had no capital resource limit or capital expenditure.

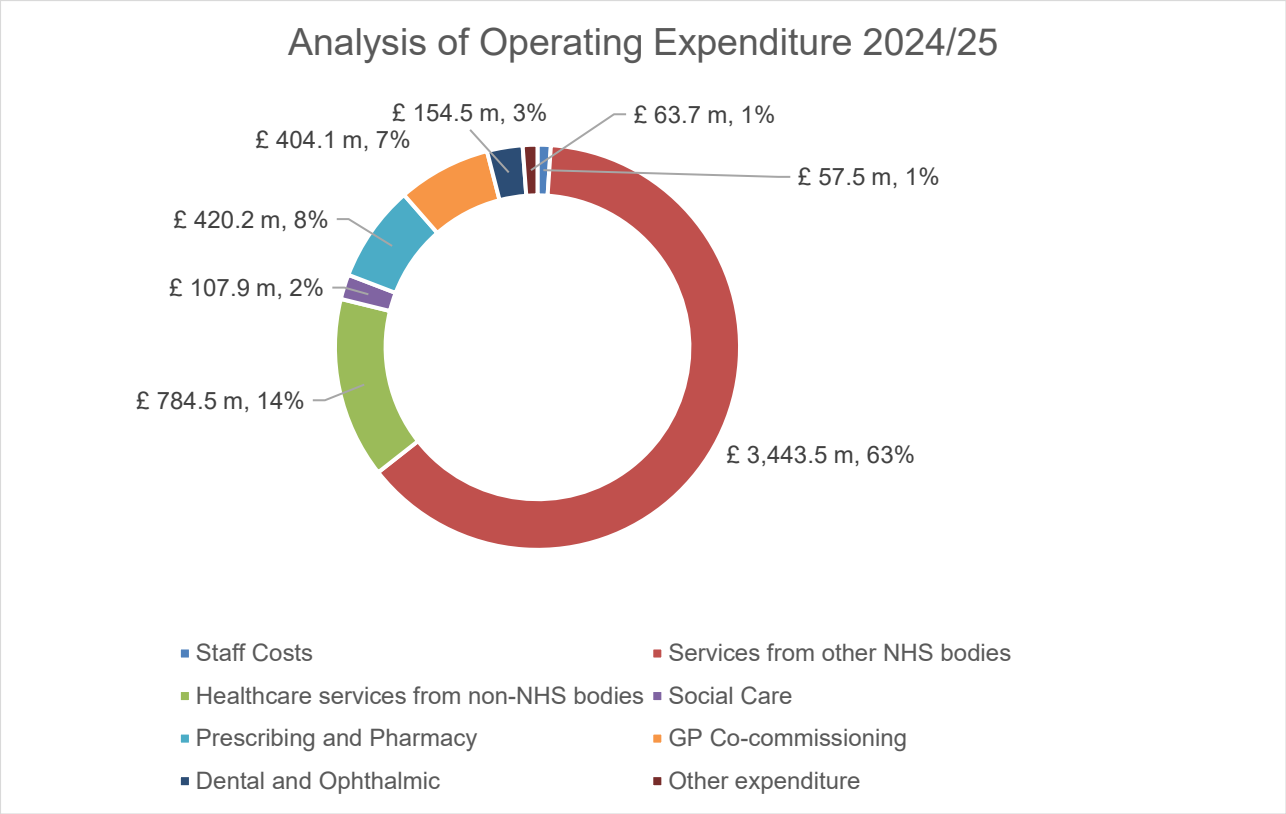
Accounting policies

The ICB's accounting policies are shown in full in Note 1 to the Annual Accounts. The accounting policies follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury.

We have made no changes to accounting estimates during the 2024/25 financial year.

Further details of accounting estimates made are reported in Note 1.29 to the Accounts, "Critical accounting judgements and key sources of estimation uncertainty".

Analysis of 2024/25 operating expenses



Sam Proffitt

Accountable Officer

16 June 2025

ACCOUNTABILITY REPORT

Sam Proffitt

Accountable Officer

16 June 2025

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The Corporate Governance Report sets out how we have governed the organisation during the period 1 April 2024 to 31 March 2025 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The Remuneration and Staff Report describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The Parliamentary Accountability and Audit Report brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

Members Report

The Board has established a number of committees and full details of the Board, and its committees can be found within the Governance Statement of this annual report.

GP practices

There are currently 196 GP Practices across the ICB footprint. The list of Providers of Primary Medical Services is held in the Governance Handbook and can be accessed via the following link: https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook.

Register of Interests

The ICB maintains and publishes registers of interests for members of the Board, its committees, sub-committees and those who hold decision making roles within the ICB. The registers of interests including registers of gifts and hospitality and register of procurement decisions (over £20k) are publicly available via the ICB's website:

https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/declarations-interest

Copies of the registers are available upon request or to view at the ICB Headquarters.

Personal data related incidents

There have been two data breaches which have been reported to the Information Commissioner Office and closed following satisfactory submission of corrective actions taken by the ICB. These can be found in the 'information governance' section of the statement

Modern Slavery Act

NHS Lancashire and South Cumbria Integrated Care Board fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2025 is published on our website at:

https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/equality-diversity-and-inclusion/modern-slavery-statement

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Lancashire and South Cumbria Integrated Care Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

Make judgements and estimates on a reasonable basis;

State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,

Prepare the accounts on a going concern basis; and

Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed me to be the Accountable Officer of NHS Lancashire and South Cumbria Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Lancashire and South Cumbria Integrated Care Board's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

To the best of my knowledge and belief, and subject to the disclosures set out below, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my ICB Accountable Officer Appointment Letter.

Disclosures:

Section 14Z61 of the Act gives NHS England powers to direct ICBs when it is satisfied that an ICB (a) is failing or (b) is at risk of failing to discharge its functions.

The ICB has been issued enforcement undertakings by NHS England in connection with financial governance and joint system financial objectives for the ICB and its partner trusts.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Lancashire and South Cumbria ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Sam Proffitt

Accountable Officer

16 June 2025

Governance Statement

Introduction and context

NHS Lancashire and South Cumbria Integrated Care Board is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The NHS Lancashire and South Cumbria Integrated Care Board's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2024 and 31 March 2025, the Integrated Care Board was subject to directions from NHS England issued under 14Z61 of the of the National Health Service Act 2006 (as amended).

Section 14Z61 of the Act gives NHS England powers to direct ICBs when it is satisfied that an ICB (a) is failing or (b) is at risk of failing to discharge its functions. NHS enforcement guidance is published here and sets out the steps NHS England will follow when considering its ICB enforcement powers under the NHS Act 2006.

The NHS System Oversight Framework sets out the overall purpose and approach to NHS oversight. On 4 February 2025, the ICB was placed into segment four of the NHS Oversight Framework (NOF4) due to the significant risk in controlling its expenditure. Three provider trusts also entered NOF 4; Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, and Lancashire Teaching Hospitals NHS Foundation Trust.

NHS England accepted a Lancashire and South Cumbria System deficit plan of £175m; £87.5m of which is from the ICB for 2024/25. A significant financial risk to the delivery of the deficit plan was highlighted throughout the financial year which lead the ICB to introduce increased grip and control measures and receive practical external support through NHS England's Investigation and Intervention (I&I) process. Further detail regarding these measures can be found at the 'Financial Review' section of this report.

Associated to this the ICB also entered mandated intensive support through the nationally coordinated Recovery Support Programme (RSP). The RSP is provided to all Provider Trusts and ICBs in NOF 4 and provides focused and integrated support, working in a coordinated way with the ICB, regional and national NHSE teams.

The ICB has been issued enforcement undertakings by NHS England in March 2025 in connection with financial governance and joint system financial objectives for the ICB and its partner trusts. The ICB has agreed to these undertakings and these are published in full here.

NHS England has also provided the system with a nominated system financial turnaround director and external support to work with the system to aid delivery of the 2024/25 financial plan and enhanced oversight arrangements have been established by NHS England, to include Improvement and assurance groups (IAGs).

The ICB has met its year-end plan for 2024/25, and support is expected to continue in 2025/26 and will be aligned to achievement of exiting the NOF4.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the ICB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Lancashire and South Cumbria Integrated Care Board's Accountable Officer Appointment Letter.

I am responsible for ensuring that the ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Board is to ensure that the organisation has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

The following sections provide details of how this has been achieved.

The ICB has a distinct purpose, with governance and leadership arrangements designed to promote greater collaboration across the NHS and with other local partners. The main power and duty of the ICB is to commission certain health services which are set out in Sections 3 and 3A of the NHS Act 2006 (as amended), as inserted by Section 21 of the Health and Care Act 2022. These provisions are supplemented by other statutory power and duty that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the NHS Act 2006. In accordance with Section 14Z25(5) of, and paragraph 1 of Schedule 1B to the NHS Act 2006, the ICB must have a Constitution, which must comply with the requirements set out in that Schedule.

The ICB's constitution describes how we organise ourselves to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and public we serve. The constitution is underpinned by the duty that requires NHS bodies to consider the effects of their decisions on the health and wellbeing of the people of England, the quality of services and the sustainable and efficient use of resources.

The constitution incorporates the ICB's Standing Orders, which form a central part of the ICB's governance framework. The standing orders describe the processes that are employed for the ICB to undertake its business. They include procedures for; conducting the business of the ICB, the procedures to be followed during meetings, and the process to delegate functions. The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the Board.

The constitution was updated as approved by NHS England (NHSE) in October 2024 to align to updated governance guidance published by NHSE. The amendments included clarity around terms of office for Board members; the introduction of the Provider Selection Regime, removal of clauses related to ICB establishment, updated cross references to legislation, and updates in line with national guidance for the Fit and Proper Persons Test and managing conflicts of interest.

The constitution outlines that the ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year, and that the annual report must in particular to explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards).

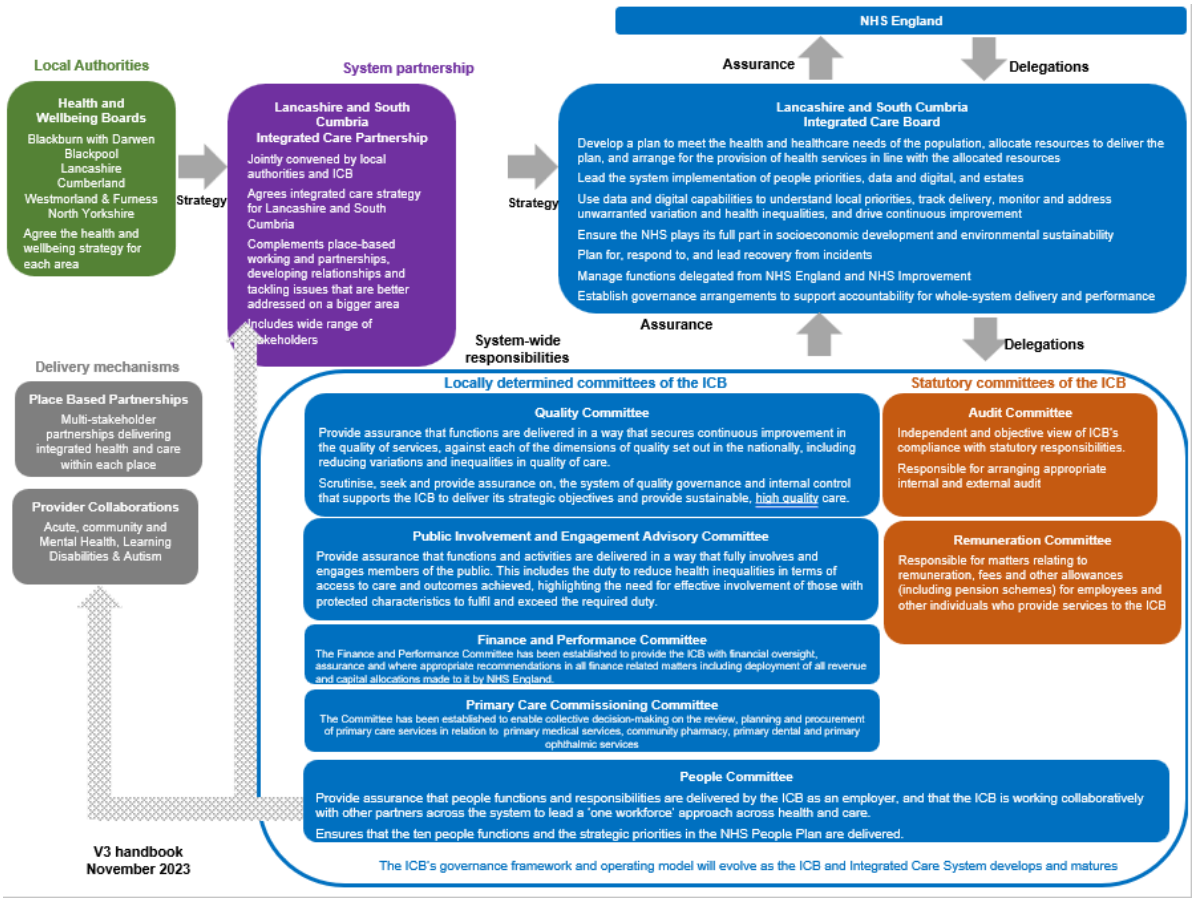
Governance Handbook

The ICB's Governance Handbook brings together all the ICB's governance documents. The governance handbook has been reviewed and updated further to the approval of the amendments to the constitution to align with the latest governance guidance from NHSE. In this regard an updated handbook, scheme of reservation and delegation (SORD), Operational Scheme of Delegation (OSOD), standing financial instructions, and conflicts of interest policy were all approved by Board on 13 November 2024. The review of the OSOD also included clarity regarding Board approval of the financial plan and budgets, and to reflect the Provider Selection Regime.

The handbook includes:

- The SORD which sets out key functions reserved to the Board of the ICB; functions delegated to committees and individuals; functions delegated jointly, and any functions delegated to the ICB.
- The OSOD is included within the overarching SORD and sets out delegated financial thresholds for functions and officers of the ICB.
- Standing Financial Instructions – which set out the arrangements for managing the ICB's financial affairs
- Terms of Reference for all committees and joint committees of the Board
- Delegation arrangements where ICB functions are delegated in accordance with section 65Z5 of the 2006 Act
- Key policy documents

- The Functions and Decisions Map (below) is a high-level structural chart that sets out the committees of the ICB, and where decision making is taken by which part or parts of the Integrated Care System.



The ICB's constitution and governance handbook can be accessed via the following link:

https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook

The mechanisms described above have enabled the Board and its committees to take the effective decisions as described in the next section of this report. A full review of the ICB's committee structure has been undertaken over quarter 4 of 2024/25 and these proposals were approved by the Board at its meeting in March 2025 and will be implemented in the next financial year.

The Board

The Integrated Care Board is a unitary Board, and its members are collectively accountable for the performance of the ICB's functions. The main function of the Board is to ensure that the organisation has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it. The following sections provide details of how this has been achieved.

The Board is responsible for:

- Formulating a plan for the organisation
- Holding the organisation to account for the delivery of the plan; by being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable
- Shaping a healthy culture for the organisation and the system through its interaction with system partners.

The appointment process for Board members varies according to the role they undertake and the appointment process specific to each role is outlined in detail within section 3 of the ICB's constitution. In accordance with paragraph 3 of Schedule 1B to the 2006 Act, membership of the Board must consist of at least:

- Chair
- Chief executive
- Three executive members, namely:
    - Chief finance officer
    - Medical director
    - Chief nursing officer
- At least two non-executive members
- Three members who will bring knowledge and a perspective of their sectors. These members are known as Partner members, who are jointly nominated by their respective organisations and sectors

The ICB is committed to tackling health inequalities and ensuring its Board membership brings a balance of perspectives. The Board is made up from diverse individuals including a wealth of clinical experts, with a range of backgrounds and perspectives to ensure all the best decisions are made for its communities.

The Chair of the Board keeps under review the skills, knowledge and experience considered necessary for members of the Board to possess collectively in order for the Board to carry out its functions effectively and take such steps to address or mitigate any shortfalls. All Board members undertook an annual appraisal process during 2024/25, this allows the Chair and Chief executive to keep the skills, knowledge and experience of members under review. Over the reporting period the following appointments have been made:

- The deputy chair undertook the role of acting chair from 1 April 2024 until 31 August 2024, whilst an appointment process was undertaken was undertaken with NHSE to appoint a new Chair. The new chair took up appointment from 1 September 2024.
- A joint nomination and appointment process was successfully undertaken to appoint two new partner members on the Board for the roles of local authority and primary medical services from July 2024, and to reappoint to the role of partner member Trust/Foundation Trust (for mental health) from October 2024.

Composition of the Lancashire and South Cumbria Integrated Care Board

The Board is made up of 15 members and the table below includes those individuals who have taken up those positions over 2024/25:

Board Member	Position
Roy Fisher (*acting chair from 1 April 2024 to 31 August 2024)* Emma Woollett (*from 1 September 2024)*	Chair
Kevin Lavery (until 30 April 2025)	Chief Executive (Accountable Officer)
Roy Fisher *(deputy chair from 1 September 2024)*	Deputy Chair / Non-Executive Member
James Birrell	Non-Executive Member
Debbie Corcoran	Non-Executive Member
Sheena Cumiskey	Senior Independent Non-Executive Member
Professor Jane O'Brien	Non-Executive Member
Vacant post	Non-Executive Member
Dr David Levy (from 1 April 2024 to 28 February 2025) Andy Curran (Acting Medical Director from 1 March 2025)	Medical Director
Professor Sarah O'Brien	Chief Nursing Officer
Samantha Proffitt	Chief Finance Officer (Acting Chief Executive Officer from 01 May 2025)
Dr Geoff Jolliffe *(up until 30 June 2024)* Dr Julie Colclough *(from 01 July 2024)*	Partner Member, Primary Medical Services
Chris Oliver	Partner Member, Mental Health Services
Aaron Cummins	Partner Member, Acute and Community Services
Angie Ridgewell *(up until 30 June2024)* Denise Park *(from 01 July 2024)*	Partner Member, Local Authorities

The Board is quorate if nine members are present, including at least four Non-Executive members, either the Chief Executive or the Chief Finance Officer, two clinical members and one partner member.

The Board includes three clinically qualified members (medical director, chief nursing officer and partner member primary medical services). All committees reporting into the Board (except for the statutory audit committee and remuneration committee) have clinical representation on the membership.

Regular Participants

Participants are individuals who the Board invite to make an informal contribution to their discussions on a regular basis. These individuals are invited to all meetings, receive copies of the meeting papers and may take part in discussions. Because they are not a member, they cannot vote, and they have no accountability for decisions made by the Board. Since establishment, the Board has invited the following regular participant to each of its Board meetings:

ICB Executives:

- Chief Operating Officer
- Chief Digital Officer
- Chief People Officer

Sector representatives and other professionals:

- Chief Executive, Healthwatch Lancashire
- Chief Executive Officer, Citizens Advice, Blackpool representing Voluntary, Community, Faith and Social Enterprise sector
- Director of Public Health
- Director of Children's Services
- Director of Adult's Services

The Board has met in public on eight occasions between 1 April 2024 and 31 March 2025. All meetings were quorate, were held in public and were livestreamed.

Attendance at Board Meetings for the period 1 April 2024 to 31 March 2025:

Member	10 April 2024	15 May 2024	19 June 2024	17 July 2024	11 Sep 2024	13 Nov 2024	15 Jan 2025	19 Mar 2025
Emma Woollett					✓	✓	✓	✓
Roy Fisher	✓	✓	✓	✓	✓	✓	✓	✓
Jim Birrell	✓	✓	✓	✓	✓	✓	✓	✓
Professor Jane O'Brien	✓	✓	✓	✓	✓	✓	✓	✓
Sheena Cumiskey	✓	✓	✓	✓	✓	✓	✓	✓
Debbie Corcoran	-	-	-	✓	✓	✓	✓	✓

Kevin Lavery	-	✓	✓	✓	✓	✓	✓	✓
Samantha Proffitt	✓	✓	✓	✓	✓	✓	-	✓
Dr David Levy	✓	✓	✓	✓	✓	✓	✓	-
Dr Andy Curran								✓
Professor Sarah O'Brien	✓	✓	✓	✓	✓	✓	✓	✓
Chris Oliver	✓	✓	-	-	✓	-	✓	✓
Aaron Cummins	✓	✓	-	-	✓	✓	✓	✓
Angie Ridgewell	✓	✓		✓*				
Denise Park				-	-	-	✓	✓
Dr Geoff Jolliffe	-	✓	✓					
Dr Julie Colclough				✓	✓	✓	✓	✓

*Angie Ridgwell attended on behalf of Denise Park

Board Performance

Each meeting held in public includes a patient story that allows the Board to reflect on where both learning and good practice can be contextualised during the course of the meeting. At each meeting regular reports are received from the Chair and Chief Executive to provide context of national, system and local key messages to Board members. Updates are also regularly provided in relation to the Board Assurance Framework, financial performance and system recovery and performance.

To ensure the Board had direct oversight of the ICB and system partner trust's financial positions the Finance and Performance Committee has met on eight occasions and provides escalation and assurance reports to the Board. This focus has been supplemented with regular reporting and focused discussions at each meeting of the Board.

Plans to mitigate the financial risk during the year has been overseen by the Board which agreed a number of mitigating plans and actions to address challenging financial position. Given the escalation of risk during the year, regular private sessions have also been held with the Board over this period, in particular in Quarter 3 and 4, to focus on plans to address the risk to the year-end financial position and plans for 2025/26. During 2024/25, the Board has considered and approved significant areas of business including:

- 5 Year Joint Forward Plan 2024 onwards
- *Joint Capital use Resource Plan
- High-level budget and Financial Plan for 2025/26
- Board Assurance Framework

- Delegation agreement for North West specialised commissioning services and subsequent approval of the variation to the delegation agreement ahead of 2025/26
- commissioning intentions for 2024/25
- Progress against commissioning intentions for 2024/25 and approval of proposed approach for 2025/26
- Commissioning intentions for 2025/26
- Five-year workforce strategy
- Five-year digital and data strategy
- Research and Innovation priorities
- New Hospitals Programme
- Policy updates in the areas of emergency planning and conflicts of interest
- Blackburn with Darwen Transaction Programme for the transfer of Child and Adult Mental Health and Adult Physical Health Service Provision
- **Case for Change for the Shaping Care Together programme and terms of reference to form a Joint Committee
- Equality, Diversity and Inclusion Annual Report 2023/24
- Complaints Annual Report 2023/24
- Urgent and Emergency Care Five Year Strategy and urgent and emergency care and winter planning updates
- UEC capacity investment funding allocations for 2025/26
- Constitution and Governance Handbook: Variation and amendments
- Overarching Scheme of Reservation and Delegation
- Signing of the Armed Forces Covenant
- Clinical Vision - Improving health and care in Lancashire and South Cumbria
- Update regarding the ICBs duty to reduce health inequalities
- Emergency Preparedness, Resilience and Response core standards assurance report
- Revised Committee Structure from 1 April 2025
- Maternity and neonatal services update
- Special Educational Needs and/or Disabilities (SEND) Position Statement

*ICBs are required to publish a Joint Forward Plan (14Z52) and a Joint Capital Resource Use Plan (14Z56) and report against them within this annual report. The Joint Forward Plan is referenced in more detail in the performance report at 'Our objectives and strategy' and 'Our work with Partners'. The Joint Capital Resource Use Plan was approved by Board and published in July 2024. The ICB plan sets out the ICS-wide Infrastructure Strategy 2024 – 2040 and sets out the longer-term vision of the infrastructure / estate. The key strategic priorities for 2024/25 were the new learning disability and autism facility lead by Lancashire and South Cumbria Foundation Trust as well as the completion of the elective recovery and Community Diagnostic Centre schemes started in 2023/24. Further priorities identified in the plan were the implementation of electronic patient record systems where these are not currently present or fit for purpose as well as reducing backlog maintenance in Trust estates. The Strategic Estates function has re-established Strategic Infrastructure Groups at Place and are working with the Place agenda for planning and overseeing the infrastructure elements for service planning and transformation. The Infrastructure Strategy sets out some of the longer-term plans across the system and associated investment required to deliver these. The availability of capital and investment and the timing of that availability will determine the progress / speed of transformation and service change. Capital

Planning at System considers organisation pressures, Trust wants and needs, backlog / Critical Infrastructure Risk / infrastructure risk reduction, amongst a number of measures.

**The Shaping Care Together programme is referenced in more detail in the performance report at 'Shaping Care Together' and further detail can also be found at the 'Joint Committee' section of the statement.

On 19 June 2024, a meeting of the Board was held to approve the submission of the annual report and accounts for the period 1 April 2023 to 31 March 2024.

The ICB held its second Annual General Meeting on 11 September 2024 at which the Annual Report and Accounts were presented from 2023/24. Presentations were given covering key achievements and challenges during the year, with a forward view to 2024/25.

There was an opportunity for members of the public to submit suggested themes in advance to be covered by the presentations made and members of the public were given the opportunity at the meeting to ask questions to our Board.

The annual report and accounts are published on the ICB's website and can be accessed here: https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/publications/lsc-icb-annual-reports.

The Board has also met informally via seminars over the period. These seminars focused on the following key themes:

- Board Assurance Framework, Strategic Objectives and Risk Appetite
- Transformation and Recovery
- Staff survey and culture
- Clinical strategy
- Health inequalities
- NHS Impact

Agendas, papers, venue and time for each Board meeting in public are published on the ICB website seven days in advance of the meeting, and members of the public are able to attend to observe the meeting and can submit public questions for items relating to the agenda. Further details can be accessed via the following link: LSC Integrated Care Board :: Meetings and papers (icb.nhs.uk)

Committees of the Board

To support the Board in carrying out its duties effectively, seven committees reporting to the Board have been formally established. Together, they have supported the delivery of the ICB's statutory duties and enabled effective oversight, scrutiny and decision-making arrangements.

All committees of the Board are chaired by a non-executive Board member Formal minutes are produced for each meeting and when ratified are submitted to the Board at its meeting in public. A standing item on the Board agenda is a committee escalation and assurance report which is in the form of a 'Triple A' report; Advise, Assure and Alert. This is presented by the Chair of each committee and allows for the Board to

have timely oversight of the decisions taken, the assurances gained, and any areas of concern.

The committees of the Board are:

Statutory committees

- Audit Committee
- Remuneration Committee

Non-statutory committees

- Quality Committee
- Finance and Performance Committee
- Primary Care Commissioning Committee
- People Committee (formerly People Board until July 2024)
- Public Involvement and Engagement Advisory Committee

Joint Committees

Under s65Z5 of the act the ICB is able to jointly exercise its functions with other relevant bodies and the ICB Board has jointly established two such Committees:

- North-West Specialised Services Joint Committee
- Shaping Care Together Joint Committee

The purpose and arrangements for both of these committees are included further within this section of the report.

Committee Effectiveness

Each committee meeting has concluded with a dedicated section of the agenda whereby the Chair of the committee seeks views from members to assess the effectiveness of the meeting to include reflections on; items to be escalated to the Board, items to be referred to other committees, items for the risk register, and effectiveness of the discussions.

A robust process is in place whereby a committee can refer business or an action to another committee where findings or concerns overlap. These referrals are reported to the Audit Committee bi-annually as part of a committee effectiveness report, that provides a summary of the focus of each committee over the period and assurance that the committees are effective and remaining within their agreed terms of reference and interacting within the governance structure.

The Chair of the Board led a full review of the ICB's committee arrangements during quarter 3 and quarter 4 to identify those areas which are functioning well and providing well rounded assurance to the Board, and those areas that could be enhanced in order to ensure the committees can support the ICB with the structure and levers it requires to deliver significant transformation. The outcome of the review proposed a series of recommendations to strengthen the structure and associated arrangements for 2025/26. These proposals were approved by the Board in March 2025 and will be enacted from 1 April 2025.

Further to earlier reference in the statement to the ICB being placed into segment four of the NHS Oversight Framework, representatives from the recovery support programme have observed the ICB committees from March 2025 and have provided feedback to the committee Chairs which is being driven forward into the delivery of the 2025/26 meetings and business.

Audit Committee

The Audit Committee is a statutory committee of the ICB in accordance with its Constitution. It is a non-executive chaired committee and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

The Audit Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, including quality governance, risk management and internal control processes within the ICB. The Audit Committee is required to produce an annual report, which was presented to the committee at the March 2025 meeting and will be recommended to the Board when it receives the ICB annual report and accounts in June 2025. The duties of the committee are driven by the organisation's objectives and the associated risks. The committee agrees an annual internal audit plan with sufficient flexibility to be able to respond to new and emerging priorities and risks. Regular updates are received against this plan and any amendments are presented to the committee.

The Audit Committee has no executive powers, other than those delegated in the SORD and specified in its terms of reference. The terms of reference can be accessed via the following link:

https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook

The Audit Committee agreed a business plan for 2024/25 which was regularly monitored and aligned to the meeting's agendas.

Audit Committee Membership

Member	Position
James Birrell	Non-Executive Member (Chair)
Sheena Cumiskey	Non-Executive Member
Roy Fisher	Non-Executive Member
Ian Cherry *(until 31 December 2024)*	Co-opted Independent Lay Member

The chair of the committee is also the ICB's Conflicts of Interest Guardian.

The committee met on five occasions between 1 April 2024 and 31 March 2025 including an extraordinary meeting to recommend the Annual Report and Accounts to the Board. All meetings were fully quorate and the quorum necessary for the transaction of business is two members.

Attendance at Audit Committee meetings for the period 1 April 2024 to 31 March 2025:

Member	19 June 2024	25 July 2024	26 Sept 2024	19 Dec 2024	27 Mar 2025
James Birrell	✓	✓	✓	✓	✓
Sheena Cumiskey	✓	✓	✓	✓	✓
Roy Fisher	-	-	✓	✓	✓
Ian Cherry	✓	✓	✓	✓	

Audit Committee Performance

The Audit Committee has an annual business plan that incorporates the review of reports and positive assurances from Executives, managers, Internal Audit and External Audit and counter fraud on the overall arrangements for governance, risk management and internal control. Significant items that were considered during 2024/25 are shown below:

Governance, risk management and internal control:

- ICB policies for debt management, budget virement, data protection and security, information governance handbook and code of conduct,
- Board Assurance Framework and risk management updates
- ICB registers of interests, gifts and hospitality
- Financial management including single tender waivers, losses, write-offs and special payments, procurement decisions and registers
- Progress on the Data Protection Security Toolkit (DSPT) Submission
- Committee Effectiveness: Overview of key decisions and escalation of business made by the committees of the Board
- Annual Governance Statement: Early assessment
- Assurance against delivery to achieving the ICB's strategic objectives
- Annual report of the Audit Committee 2024/2025
- Update on process for QIPP and PIDs
- Information governance oversight update
- Mental health investment standard

Internal Audit (MIAA):

- Progress reports against the internal audit plan 2024/25
- Final 2023/24 Head of Internal Audit Opinion
- The Internal Audit Network Insight Reports and Technology Risk briefings
- Audit charter
- Interim draft Head of Internal Audit Opinion
- Draft internal audit plan 2025/26

External Audit (KPMG):

- Health technical updates and progress reports

- Annual auditor reports relating to the ICB annual report and accounts 2023/24 and associated documents
- Draft audit plan 2025/26 including value for money risk assessment
- Benchmarking of ICB efficiency performance

Anti-fraud (MIAA):

- Anti-fraud Annual Report 2023/24
- Progress reports against the annual workplan
- Workplan 2025/26

Committee Effectiveness

The committee committed to conducting deep dives into agreed areas of focus, and in-year this was undertaken into All Age Continuing Care (AACC) to review the ICB's position and seek assurance on the overarching outcomes of this and how they will be taken forward. The committee gained assurance that quality standards had improved, and that due to the high risks associated with the delivery of the QIPP target, monitoring would continue until the committee were assured of delivery of the QIPP schemes. Further deep dive areas are being planned for 2025/26 meetings.

Remuneration Committee

The Remuneration Committee is a statutory committee of the Board in accordance with its Constitution. It is a non-executive committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

The committee's main purpose is to exercise the functions of the ICB relating to paragraphs 18 to 20 of Schedule 1B to the NHS Act 2006. In summary:

- Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including Board members) but excluding the Chair and Non-Executive Members of the Board.
- Where matters are discussed relating to Non-Executive Members of the ICB, a Remuneration Panel has been established and will be convened under its own Terms of Reference.

The Board has also delegated the following functions to the Committee:

- Elements of the nominations and appointments process for Board members
- Oversight of executive directors' performance and appraisal
- Approve human resources policies for ICB employees and for other persons working on behalf of the ICB
- Provide assurance of ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and proper person regulation (FPPR)
- For the Chief Executive, Directors and other Very Senior Managers; determine arrangements for termination of employment and other contractual terms and non-contractual terms.

The committee meets in private at least twice a year and membership comprise of three Non-Executive Members of the Board. During 2024/25 the committee met on nine occasions and was quorate for each meeting. Professor Jane O'Brien chaired the

committee in the period the Committee Chair undertook the role of acting Chair for the ICB Board.

Remuneration Committee Membership

Member	Position
Roy Fisher	Non-Executive Member *(Chair from 01 September 2024)*
Professor Jane O'Brien	Non-Executive Member *(Chair until 31 August 2024)*
Sheena Cumiskey	Non-Executive Member

Attendance at Remuneration Committee meetings for the period 1 April 2024 to 31 March 2025:

Member	15 May 2024	19 Jun 2024	17 July 2024	5 Sept 2024	10 Oct 2024	16 Oct 2024	19 Dec 2024	27 Feb 2025
Roy Fisher	-	-	-	-	✓	✓	✓	✓
Sheena Cumiskey	✓	✓	✓	✓	-	✓	✓	-
Professor Jane O'Brien	✓	✓	✓	✓	✓	✓	✓	✓

Remuneration Committee Performance

During 2024/25, the Remuneration Committee reviewed and approved significant areas of business including:

- ICB Executive appraisal and performance
- HR policies in the areas of; Recruitment and selection, special leave, flexible working, career break, and Statutory Mandatory Training Policy
- Remuneration for Very Senior Manager (VSM) positions
- VSM and Executive Senior Manager review 2024/25
- Executive director portfolios

The ICB has also established a Remuneration Panel to agree salaries of the ICB's Non-Executive Members. Members of the Panel are the ICB's Chair (whose salary is determined by NHSE), the Chief Executive and Chief People Officer. The panel met on three occasions during 2024/25.

Quality Committee

The Quality Committee is a formal committee of the Board in accordance with its Constitution. It is a non-executive chaired committee, and its members are bound by the Standing Orders and other policies of the ICB.

The Quality Committee provides the Board with assurance that the ICB is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the shared commitment to quality

and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care as per the 'triple aim'.

The committee considers information and evidence to be assured about the internal ICB systems which oversee quality; the quality of commissioned providers of services, and to identify whether any ICB assistance is required to continue to improve services.

During 2024/25 the committee met on nine occasions.

Quality Committee Performance

Each meeting includes a patient story that relates to other items of the agenda which allows the committee to reflect on where both learning and good practice can be shared.

The committee received a series of regular reports for assurance throughout the year including updates in the areas of; patient and safety (including Patient Safety Incident Response Framework PSIRF), provider updates, risk management, maternity and neonatal, community services providers, infection prevention and control, equality and diversity, and medicines optimisation and safety. The committee also received regular updates against statutory functions including; All Age Continuing Care (AACC), learning disabilities and autism, children and young people and SEND, and safeguarding.

The committee has also taken additional responsibilities this year in relation to oversight of the quality of specialised services following the first delegation of specialised services to the ICB from April 2024.

The Quality Committee alerts the Board to quality concerns and quality improvements through its escalation and assurance reports and through critical review of the ICB risk register and Board Assurance Framework.

Committee effectiveness

The terms of reference have been reviewed during the year as part of the committee review which informed recommendations which were approved by the Board at the March 2025 meeting. A Quality and Outcomes Committee will be established for 2025/26 to focus on whether the ICB is ensuring continuous improvement in quality across the system and the performance of commissioning services insofar as they relate to patient experience, access and outcomes.

The Committee met in workshop form in June 2024 with a session hosted by Advancing Quality Alliance (AQUA) looking at developing a quality management system.

System Quality Group

In line with guidance from the National Quality Board the ICB has established a System Quality Group, (SQG). Whereas the Quality Committee has a function to assure the Board on the quality and safety of services, the SQG is focusing on quality improvement and learning. The SQG reports into Quality Committee and any areas of significant concern would be escalated to Quality Committee. This group is multi-agency and multi-disciplinary.

Minutes and attendance at the Quality Committee meetings are published on the ICB's website via the Board meeting papers at:

https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/Board/meetings-and-papers

The terms of reference including the membership of the Quality Committee can be accessed via the following link:

https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook.

Finance and Performance Committee

The Finance and Performance Committee is a formal committee of the Board in accordance with its Constitution. It is a non-executive Chaired committee and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

The purpose of the committee is to oversee the performance of the ICB in delivering its statutory financial duties, national targets and objectives, and to drive the effective and efficient use of resources.

The Committee is chaired by a Non-Executive Member of the Board and is led by the Chief Finance Officer. Membership of the committee includes two additional Non-Executive Members, the Chief Digital Officer, Chief Nursing Officer and Chief Operating Officer from the executive team and senior representatives from governance, finance and performance.

During 2024/25 the committee met on eight occasions. The committee held an extraordinary meeting in December 2024 to receive an update on financial position, intervention, and recovery.

Finance and Performance Committee Performance

The Finance and Performance Committee has undertaken a role to scrutinise arrangements for the delivery of the ICB's statutory duties in line with sections 2223GB to 223N of the National Health Service Act 2006 (as amended). Monthly financial performance has been scrutinised by the Finance and Performance Committee and reported to the Board. The committee has received the minutes from the Lancashire and South Cumbria Provider Collaboration Board and the System Finance Group.

Significant items that were discussed are shown below:

- Financial performance of the ICB and financial performance of the NHS provider organisations within the ICB footprint.
- ICB performance monitoring and mitigation against mandated national and regional metrics as well as locally agreed indicators
- 2023/24 Annual Accounts Going Concern Assessment
- Planning updates 2024/25
- System recovery and transformation updates
- Contract review and monitoring updates
- Urgent and emergency care winter update
- Investigation and intervention updates

- Risk management updates
- Improvement and Assurance Group Triple A reports

Minutes and attendance at the Finance and Performance Committee meetings are published on the ICB's website via the Board meeting papers at: https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/Board/meetings-and-papers

The terms of reference including the membership of the Finance and Performance Committee can be accessed via the following link:

https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook

Committee effectiveness

Membership and quoracy of the committee were reviewed at the June 2024 meeting in light of changes within the executive management team and associated portfolios, and to ensure consistency with other committees. The amended terms of reference were approved by the Board when it met in July 2024.

The terms of reference have been further reviewed during the year as part of the committee review and recommendations were approved by the Board at the March 2025 meeting. A Finance and Contracting Committee will be established for 2025/26 to focus on scrutiny on the ICB and system's financial performance, the effectiveness of ICB activities and the performance of commissioned services against contracted activity.

People Committee

The People Committee is a formal committee of the ICB and is a non-executive chaired committee. The People Committee provides a strategic oversight and direction of workforce matters across the Integrated Care System in line with the delivery of the People Plan and People Promise and our mandated obligations. The committee also has a role to ensure that the ICB delivers its workforce responsibilities as an employer.

The People Committee has met on a quarterly basis throughout the year with four meetings taking place during 2024/25.

People Committee Performance

Significant items received during 2024/25 include:

- Five-year workforce strategy
- Staff survey findings
- Culture and inclusion system updates
- Freedom to Speak Up
- 2024/25 operational plan updates
- VCSFE workforce training and development

- People Promise Exemplar programme
- Workforce insights
- Organisational development and education
- Work well Integrated Care Partnership update
- NHSE intervention update
- ICB culture, values, and behaviours re-set
- Gender pay-gap report 2024

The current terms of reference including the membership can be accessed via the following link: LSC Integrated Care Board :: Corporate Governance Handbook (icb.nhs.uk).

Minutes and attendance at the People Committee meetings are published on the ICB's website via the Board meeting papers at: LSC Integrated Care Board :Meetings and papers

Committee effectiveness

The committee (formerly the People Board) undertook a review of its effectiveness in quarter 4 2023/24 which informed changes to the terms of reference in order to clarify the responsibilities of the committee and align these to the membership. The amended terms of reference were agreed by the committee in April 2024 and approved by the Board in May 2024.

The terms of reference have been further reviewed during the year as part of the committee review and recommendations were approved by the Board at the March 2025 meeting. The

committee will become the People and Culture Committee from 01 April 2025 and have an increased focus on its system role in the committee business as well as ICB culture and research and innovation.

Public Involvement and Engagement Advisory Committee

The Public Involvement and Engagement Advisory Committee (PIEAC) supports the ICB in ensuring the voice of local people and residents is actively embedded and valued in decision making of the ICB and at all levels of the system, particularly in relation to inequalities and those who are seldom heard.

The committee has provided regular assurance updates to the Board in relation to activities and items within its remit. The committee usually meets quarterly and during 2024/25 the committee met on four occasions.

The committee is chaired by a Non-Executive Member of the Board. Membership of the committee includes one additional Non-Executive Member, the Chief Nurse or representative from the quality committee, and senior representatives from Place, communications and engagement, primary care and local authority.

The committee has supported the Board in ensuring the principles for working with people and communities are intrinsically in place across all parts of the organisation and wider integrated care system. The committee defines best practice in terms of public engagement, involvement and communications and support other committees

and parts of system in how the local voice is embedded and valued in all aspects of the ICB at different levels of the system including within place-based partnerships.

Public Involvement and Engagement Advisory Committee Performance

During the year, the committee received a regular assurance report which described how we deliver engagement across the health and care system, and an insight report, which shares the findings of engagement, learning and action agreed as a result of engagement.

Further significant items that were discussed and supported during 2024/25 are shown below:

- Involvement and engagement process and outcomes to support urgent and emergency care strategy
- Strategy for working in partnership with people and communities progress review
- Shaping Care Together: engagement on case for change
- Public engagement and pre-consultation engagement programme 2024/25
- Winter communications and engagement strategy and plan
- Your health. Your future. Your say. engagement programme and insights
- Engagement in priority wards – population health improvement

Information on the committee members and attendees, terms of reference, agendas and papers and approved minutes can be accessed at:

https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/sub-committees/public-involvement-and-engagement-advisory-committee

Committee effectiveness

The committee held a workshop in April 2024 with involvement from committee members, participants and members of the citizens health reference group. The outputs from this workshop were presented to the committee at the June 2024 meeting and a series of recommendations were endorsed by the committee and can be summarised as follows:

- Establish an ICB consultation working group which is able to report into the Public Involvement and Engagement Advisory Committee to provide assurance on programmes which are going through the NHSE change process.
- Reporting content presented to the committee should be concise and focused, with separate reports provided by local Healthwatch.
- detailed updates for engagement and involvement in places should be undertaken in a more informal setting and open to wider groups of staff and partners via the delivery of webinar sessions.

All of these recommendations have been embedded during 2024/25.

The advisory committee was within the scope of the full committee review. The review highlighted that involvement and engagement have become more mature and embedded within the ICB. This includes successfully developing a range of mechanisms for the way the ICB engages and involves local people including establishing:

- an active Virtual Citizen's Panel of actively engaged residents who contribute their views and insight to support decision making
- a cohort of citizen advisors who volunteer with the ICB to influence transformation and reconfiguration programmes and improvements to services
- a programme of capturing lived experience and patient experiences which contribute to service improvement and transformation
- place and neighbourhood-based engagement, involvement and outreach with communities
- engagement, involvement and communications approaches which support transformation and reconfiguration of service

The review recommended to disestablish the advisory committee from 1 April 2025 and that the ICB Board will have full oversight of this agenda and receive regular insight reports in relation to engagement, involvement and communication.

Primary Care Commissioning Committee

The Primary Care Commissioning Committee (PCCC) is a formal committee that reports to the Board. The committee enables collective decision-making on the review, planning and procurement of primary care services in relation to primary medical services, community pharmacy, primary dental and primary ophthalmic services and as part of the ICB's statutory commissioning responsibilities across Lancashire and South Cumbria under delegated authority from NHSE.

The committee provides oversight and assurance of effective primary care services across the ICB's four places and provides regular assurance updates to the Board in relation to activities and items within its remit.

The committee has been supported by four contracting sub groups covering primary medical, pharmaceutical, dental, and eye health services. All the groups operate within a decision-making matrix which outlines where decisions must be submitted to the committee for approval and the sub groups provide an Alert, Assure, Advise report to the committee to ensure that members are sighted on activity and any assurance or risks.

The committee has also been supported by a capital working group which has provided expert advice and recommendations on all capital matters and investment plans relating to primary care services.

The committee is chaired by a Non-Executive Member of the Board. Other membership of the committee includes the ICB Partner Member for Primary Medical Services, Chief Operating Officer, Medical Director, and senior representatives from primary care, communications and engagement, quality and safety, medicines management and finance.

Primary Care Commissioning Committee Performance

The committee has met eight times in public during 2024/25. The committee received regular reports on risk management and finance. Significant items that were considered in this time period :

- Procurement Evaluation Strategies

- Primary Care Capital report 2024/25
- Local Enhanced Services
- GP Quality Contract updates
- Local Pharmaceutical Services uplifts
- Primary care assurance framework annual submission
- Dental referral management service procurement
- Pharmacy access programme
- Branch closure/relocation applications
- Special allocation scheme
- General practice improvement grants
- Primary care contract extensions
- Primary care performance

The terms of reference can be accessed via the following link:

https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook

Information on the committee members and attendees, terms of reference, upcoming meeting dates, agendas and papers and approved minutes can be accessed at: LSC Integrated Care Board :: Primary Care Commissioning Committee.

Committee effectiveness

The committee was within the scope of the committee review. The review proposed for the ICB to disestablish the Primary Care Commissioning Committee with establishment of a Primary Care Contracts Sub-Committee from 1 April 2025 to oversee the review, planning and procurement of primary care services with financial and contracting assurance reported to the new Finance and Contracting committee, assurance of patient experience, access and outcomes reported to the new quality and outcomes committee, and decisions recommended to an Executive Committee for approval where required in line with the SORD. The Board agreed this proposal in March 2025.

Joint Committees

Under s65Z5 of the act the ICB is able to jointly exercise its functions with other relevant bodies and in 2024.25 the ICB Board has established two joint Committees.

North-West Specialised Services Joint Committee

Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. The North-West is one of three regions in England where NHSE approved plans to delegate the commissioning of a number of specialised services, to ICBs from 1 April 2024. These arrangements are underpinned by a Delegation Agreement.

These services consist of ‘delegate 1’ services which are planned at a single-ICB level with decision being taken by the ICB, and ‘delegate 2’ services which are planned and commissioned jointly at a multi-ICB level.

In order to facilitate the delegate 2 decision making a Specialised Services Joint Committee has been established between the three North West ICBs (Lancashire and South Cumbria, Cheshire and Merseyside, and Greater Manchester).

The role of the Joint Committee is to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified Delegated Services as set out in the NHSE Delegation Agreement.

As a Joint Committee of the three ICBs, the Joint Committee is accountable to the respective Boards of NHS Lancashire and South Cumbria ICB, NHS Cheshire and Merseyside ICB and NHS Greater Manchester ICB.

The Lancashire and South Cumbria ICB representatives at this committee are made up of one non executive member and one executive director.

The terms of reference for this joint committee were ratified by the Lancashire and South Cumbria ICB Board in April 2024 and can be viewed here.

Delegate 1 Services (single ICB)

The ICB has established a Specialised Commissioning Oversight Group to oversee the commissioning and delivery of the single-ICB Specialised services that have been delegated from NHSE to LSC ICB from 1 April 2024.

The group brings together the leadership of LSC ICB with the North West hub and subject matter experts with a commitment to ensure that we commission effective, high-quality care in relation to delegated specialised commissioning functions within the resources available.

Shaping Care Together Joint Committee

The Shaping Care Together (SCT) programme is a health and care transformation programme operating across Southport, Formby and West Lancashire. Its aim is to improve the quality of care for local residents by exploring new ways of delivering services and utilising staff, money and buildings to maximum effect.

A Case for Change detailing the current and future needs of the local population, the provision of local services and the key challenges facing the health and care system was approved by the ICB Board in July 2024.

As the commissioners for the programme, NHS Cheshire and Merseyside Integrated Care Board (C&M ICB) and NHS Lancashire and South Cumbria ICB will be required to consider this Pre-Consultation Business Case for approval in 2025 and to enable effective decision making, both Boards agreed to form a Joint Committee for future decisions for the SCT programme. The ICB Board approved the joint committee terms of reference in November 2024. The terms of reference can be viewed here.

As a Joint Committee of the two ICBs, the Joint Committee is ultimately accountable to the respective Boards of NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB. It is to be noted that C&M ICB are the lead commissioner.

The Joint Committee is authorised to:

- receive and approve on behalf of both ICBs, any case for change for services within scope of the Shaping Care Together programme
- receive and approve on behalf of both ICBs, any Pre-consultation business cases and any associated capital strategic outline case for services within scope of the Shaping Care Together programme
- receive and approve on behalf of both ICBs any Outline Business Case or Full Business Case for services within scope of the Shaping Care Together programme
- receive and approve on behalf of both ICBs the associated materials involved with and the initiation of any engagement or formal consultations with the public, patients, carers and stakeholders, in respect of the services within the scope of the Shaping Care Together Programme
- receive, consider and decide on any further next steps after receiving the outcomes of any engagement or formal consultations with the public, patients, carers and stakeholders, in respect of the services within the scope of the Shaping Care Together Programme

The Lancashire and South Cumbria ICB representatives at this committee are made up of one non executive member and two executive directors.

Special Lead Roles

To support the ICB in discharging its statutory duties there are several special lead roles that require named individuals to undertake responsibility on behalf of the Board for the oversight of specific areas. Additionally, there are several roles for which it is considered best practice to have named individuals aligned to. The ICB has the following appointment to these roles:

Senior Independent Risk Owner (SIRO)

The SIRO has overall responsibility for the organisation's information risk policy. They are accountable and responsible for information risk across the organisation, ensuring awareness across the organisation for the need for good judgment to be used to safeguard information and share it appropriately. All statutory NHS organisations are required to have a SIRO.

Asim Patel, Chief Digital Officer, undertakes this role on behalf of the ICB.

Caldicott Guardian

A Caldicott Guardian is the senior individual within the organisation with responsibility for protecting the confidentiality of people's health and care information and ensuring that information is used ethically and legally. All statutory NHS organisations are required to have a Caldicott Guardian.

Dr David Levy, Medical Director, has undertaken this role on behalf of the ICB up until 28 February 2025 and Professor Sarah O'Brien Chief Nurse has undertaken the role since.

Freedom to Speak up (FtSU) Executive Lead and Non-Executive Champion

The role of the FtSU lead is to oversee the systems and processes in place for ICB staff to raise concerns and ensure these are fit for purpose; enabling the organisation to be open and transparent and create a culture of learning.

Dr David Levy, Medical Director has undertaken the executive lead role on behalf of the ICB up until 28 February 2025 and Asim Patel Chief Digital Officer has undertaken the role since.

Professor Jane O'Brien undertakes the role of Non-Executive Champion on behalf of the ICB.

Equality, Diversity and Inclusion (EDI) Lead

It is important that the ICB ensure that its services and employment practices are fair, accessible, and inclusive for the diverse communities it serves and the workforce it employs.

In recognition of this, the ICB has sought to have a named Executive and Non-Executive Lead for EDI.

The acting CPO/s undertook this role until Debbie Eyitayo joined the organisation in October 2024 as substantive Chief People Officer.

Conflicts of Interest Guardian

It is important that in discharging its duties the ICB has appropriate measures in places to manage circumstances that may arise whereby those with decision making powers is, or could be, influences or impaired in their decision making as a consequence of other interests they hold.

The role of the Conflicts of Interest Guardian is to strengthen the scrutiny and transparency of the organisation's decision-making processes. It is commonly considered best practice for the Conflicts of Interest Guardian to be the Audit Chair, and James Birrell, Audit Chair, undertakes this role on behalf of the ICB.

Senior Independent Non-Executive Director

The role of the Senior Independent Non-Executive Director is to be available to members of the ICB should they have concerns they wish to raise but for which contact through the usual channels via the ICB Chair or Chief Executive is either inappropriate or has failed to resolve the issue. Other aspects of this individual's role relate to the annual appraisal process for the ICB Chair.

Sheena Cumiskey, Non-Executive Member of the Board undertakes the role of Senior Independent Non-Executive Director on behalf of the ICB.

Health and Wellbeing Guardian

Ensuring the health and wellbeing of our workforce is a fundamental priority of the ICB. Creating a culture that enables colleagues to be happy and healthy at work will contribute to improved patient and care and health and wellbeing in our population.

The role of the Health and Wellbeing Guardian is to support with oversight of the organisational culture to ensure that the health and wellbeing of the workforce is considered routinely across all organisational activities.

Professor Jane O Brien, Non-Executive Member of the Board undertakes this role on behalf of the ICB.

Other Population Groups and Functions

The ICB must identify members of its Board who have explicit responsibility for the following population groups and functions:

- Children and young people (aged 0 to 25)
- Children and young people with special educational needs and disabilities (SEND)
- Safeguarding (all-age), including looked after children and care leavers
- Learning disability and autism (all-age).
- Down syndrome (all-age)

These roles ensure visible and effective Board-level leadership for addressing issues faced by the groups outlined above, and to ensure that statutory duties related to safeguarding and SEND receive sufficient focus. Professor Sarah O'Brien, Chief Nurse is the named Board member with responsibility for these areas.

The guidance also includes the requirement of at least one member of the Board who has knowledge and experience in connection with services relating to the prevention, diagnosis, and treatment of mental illness. Mental Health Lead Board members for the ICB are Dr David Levy Medical Director and Chris Oliver, Partner Member for Mental Health.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance

Discharge of Statutory Functions

NHS Lancashire and South Cumbria ICB has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICBs is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Executive Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

Risk management arrangements and effectiveness

A fundamental aspect of the ICB's governance framework is the implementation and operation of sound risk management arrangements. The ICB's strategic risk management processes are centred around the Board Assurance Framework (BAF). The BAF provides a structured way of identifying the principal risks to the achievement of the strategic objectives of the ICB. It captures the control measures established to mitigate those risks and describes the key sources of assurance that support the achievement of the ICB's core aims and agreed strategic objectives.

The ICB has agreed six strategic objectives in order to define its strategic intent, with any risks to the achievement of these objectives held and monitored on the Board Assurance Framework:

- Improve quality, including safety, clinical outcomes, and patient experience
- To equalise opportunities and clinical outcomes across the area
- Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees
- Meet financial targets and deliver improved productivity
- Meet national and locally determined performance standards and targets
- To develop and implement ambitious, deliverable strategies

Throughout the reporting period the ICB has continued to build on the work undertaken during 2023/24 to strengthen and embed these arrangements, including embedding the ICB's Risk Management Strategy and Policy which was presented to the Board for approval in March 2024. This sets out the arrangements for the management and oversight of risks linked to the ICB's strategic aims and objectives and clearly describes the processes established to support the systematic identification, assessment, evaluation and control of risks, at different levels across the organisation. Following the risk management policy and strategy being approved by the Board, two Board Seminars were held during quarter 1 to review the ICB's Strategic Objectives, the principal risks held on the BAF and to agree alignment of risk appetite statements and tolerances to each principal risk.

A fully revised BAF was approved by the Board in July 2024; this included the re-aligned principal risks to the delivery of the ICB's strategic objectives, the alignment and embedding of its agreed risk appetite and tolerance and the actions to support delivery of the key priority programmes of work.

At an operational level, risks identified as having the potential to impact on the delivery of the ICB's plans and priorities are held on the ICB's Operational Risk Register (ORR). Operational risks which are categorised as "high" receive corporate oversight through the Executive Management Team (EMT) and the relevant assuring committee. Risks held on the ORR which are assessed as a "medium" (or lower) level, with the potential to impact on the delivery of team plans and priorities, are monitored at functional level with named Senior Responsible Officer (SRO) oversight.

The ICB's Risk Management Policy also explicitly identifies the responsibilities of the Board, its committees, and individuals for managing risks associated with meeting its strategic objectives. It provides the framework to achieve the desired risk culture and encourages staff to:

- Identify and control risks which may adversely affect the operational ability of the ICB and the achievement of its strategic objectives;
- Score risks consistently using an agreed grading matrix;
- Where possible, eliminate or transfer risks, or reduce them to an acceptable level (otherwise ensure the organisation openly accepts the remaining risk);
- Identify risks which are common across functions and explore the management of these collectively.

Risks are identified from a number of sources, including the Board, its committees, staff at all levels, and internal and external sources. They can also arise from the development or implementation of strategies and plans, therefore the ICB has embedded its risk management arrangements throughout the operation of the ICB's activities to ensure risk management is integral to decision making within the ICB.

This can be demonstrated in a number of ways e.g. when planning or commissioning health services, the ICB must take into consideration the risks arising from the potential impact of those decisions on the population served, the ICB also has a duty to consider the environmental impact of its plans, these risks are assessed through the completion of Equality and Health Inequalities Impact and Risk Assessments (EHIIRA) and sustainability impact assessments. These are undertaken before new services are commissioned, or when policies, plans, proposals or decisions are being considered which could have the potential to impact on health or widen health inequalities. The governance of the sustainability agenda can be found in the performance report under 'Environmental matters and Sustainability'.

To support the above, a defined risk management reporting cycle has been in place throughout the reporting period. Monthly risk updates and exception reports are presented to the EMT which includes risks held on the BAF and those operational risks which meet which meet the threshold for corporate oversight. These are also reported through the relevant assuring committees, to ensure full visibility and oversight of all risks held on the BAF and ORR.

One of the roles of the Audit Committee is to review the adequacy and effectiveness of the ICB's risk management arrangements. To enable this, the committee has received a full update in July and December 2024 on risks being managed within the organisation and the development of risk management arrangements. The committee also received the findings of the internal audit reviews of those arrangements undertaken by Mersey Internal Audit Agency (MIAA) which provided 'substantial assurance' .

In addition to the reports described above, and to support the ongoing review of the ICB's risk management arrangements, an Assurance Mapping exercise was undertaken and the findings presented to the Audit Committee in July 2024. This built on an independent review previously undertaken during 2023/24, commissioned by the Audit Committee in relation to assurances held on the BAF. The reviews focused on aligning assurances within the BAF to the "three lines of defence" model and highlighted where previously identified gaps in assurance had been addressed, or, where gaps remained, that plans that were in place to address these. A further follow-up report was presented to the Audit Committee at its meeting in December 2024 to assure the committee that the assurances provided in relation to the principal risks to the achievement of the ICB's strategic objectives were robust.

A copy of the ICB's Risk Management Policy can be found here.

Capacity to Handle Risk

The ICB's capacity to handle risk is demonstrated through the Board's risk appetite statement and is integral to the ICB's policy for risk management. During 2024/25 the overall risk profile has reflected the impact of the main risks facing the organisation including the impact of the financial challenges, and risks to the delivery of the financial plan and associated efficiency programmes for 2024/25. In response to this, additional governance arrangements were established in September 2024 through the implementation of an Incident Management Team (IMT) approach. This included the establishment of six delivery units to operationally manage the financial risks to the

delivery of the 2024/25 QIPP targets and planning for the 2025/26 QIPP delivery programmes.

The responsibility for risk management is clearly defined at all levels within the organisation through the ICB's Risk Management Strategy and Policy. This outlines the roles and responsibilities of the Board, its committees, the Chief Executive Officer, the Chief Finance Officer and other staff within the ICB. Committee terms of reference include the review and monitoring of those risks on the BAF and ORR which relate to each committee (and if relevant, risks have been overseen by more than one committee). Throughout 2024/25 the risk management cycle has operated effectively including a monthly "gateway" cycle for exception reports into the EMT. Risk dashboards have supported reporting into the Executive, and wider Senior Leadership Team, the Board and its committees. The Board has received updates for those risks held on the BAF, with a particular focus on the impact of those risks that could affect the delivery of the strategic objectives and where there are opportunities to achieve delivery. In addition, any risks which have met the threshold for corporate oversight with a score of "20" or higher have also been included within the Board assurance framework update reports.

The ICB's Executive Management Team (EMT) determine whether risks have the potential to impact the delivery of the ICB's strategic objectives and consequently reported on the BAF, or whether they are managed as operational risks and reported through the ORR.

The committees of the ICB all present timely Escalation and Assurance (Advise, Alert and Assure) reports into the Board. From a risk perspective, these reports are used by committees to assure the Board that risks are being effectively managed and to formally 'alert' the Board to areas of concern.

The ICB has established effective arrangements to support the committees to work and oversee risks in a cohesive and methodical way, with risk reporting being centrally coordinated by the Corporate Governance Team which is underpinned by regular monthly risk reviews being undertaken by SROs/ Risks Leads.

Staff training has been provided to support the implementation of the revised systems and processes for risk management. A series of communications were cascaded across the ICB including the provision of dedicated training and awareness sessions, facilitated drop-in sessions, and a dedicated risk management intranet page has been developed to enable all staff to have the information they need to adhere to the revised policy and processes. Furthermore, a series of interactive virtual training sessions on Equality and Health Inequalities Impact and Risk Assessments (EHIIRA) have also been delivered during the reporting period.

Risk Assessment

Risks are assessed in accordance with the ICB's Risk Management Policy to determine their significance to the delivery of the ICB's plans and priorities. Where risks are assessed as having the potential to impact on the achievement of a strategic objective, they are held on the BAF; where new risks are assessed as having the potential to impact on the delivery of the ICB's operational plans and meet the threshold for corporate oversight they are held on the ORR.

This approach enables the appropriate level of oversight, constructive challenge, and scrutiny to be undertaken. It also enables assurance to be sought that the appropriate control measures and mitigations have been put in place.

Throughout the reporting period the executive team has reviewed all new and existing risks, and made recommendations where further re-assessment, or support has been required to ensure that risks have been managed both strategically and operationally with appropriate Board and committee level oversight.

The risk profile of the ICB has remained consistent throughout the reporting year with the focus on its statutory duties and delivery of the ICB's strategic objectives whilst reflecting the financial challenges described in the section (capacity to handle risk) above.

Below are the principal risks to the achievement of the ICB's strategic objectives and a summary of the key actions and controls:

Risk Area	Status Update (including key actions/ controls)
Quality: Delivery of safe and effective healthcare services Reducing health inequalities	• Quality Impact Assessment process embedded within Programme Management Office (PMO) to support recovery and transformation. • Regular quality assurance visits established and held throughout the year. • Continued focus on performance reporting and performance related data requirements to enable wider operational performance to be monitored. • Key performance indicators included in refreshed Joint Forward Plan. • Governance arrangements strengthened through Prevention and Health Inequalities Steering Group.
People: Recruiting and retaining stable workforce in fragile services	• Continued challenges with recruitment and retention of stable workforce within a number of fragile services. People Committee re-established and 5-year multi-workforce strategy approved. • Focus on Integrated Neighbourhood Teams through Transforming Community Care Programme Board. • Monitoring of bank and agency spend through IAGs
Financial: Meeting statutory financial duties	• Risk fully reviewed and updated at the end of Quarter 3 to reflect the enhanced controls implemented through the establishment of the weekly IMT meetings chaired by the ICB's CEO. • Six delivery units established to focus on QIPP delivery for 2024/25 and planning for 2025/26. • Resource management group oversight of staff redeployment/exceptional requests for staff recruitment. • Re-focus of the Recovery and Transformation Board to Recovery and Supplier Oversight.

Risk Area	Status Update (including key actions/ controls)
All Age Continuing Healthcare overspend and disproportionated packages of care	• Enhanced cap commissioning strategy implemented. • Personal Health Budget and Choice and Equity Policies reviewed • Fast track reviews undertaken for individual patient activity fully funded places. • Additional support into AACC team
Infrastructure transformation	• Strategic Infrastructure Groups at Place+ established. • Strategic planning workshops held to support development of clinical services reconfiguration.
Performance: Cyber-security threats	• Digital and data strategy approved. • EPRR Programme Board established with focus on Business Continuity Planning.
Recovery of Elective and Urgent and Emergency Care	• UEC Strategy approved and 1-year UEC improvement plans and de-escalation plans established. • UEC Collaborative Improvement Board and local UEC Delivery Boards overseeing delivery.
Strategy: Clinical and Community Services Transformation including Place	• Transforming Community Care Board established; Clinical Services Programme Board established. • TCC Programme mobilised with one year plan linked to UEC de-escalation plans in place. • Development of overarching Acute Services Clinical blueprint and three-year system transformation road map in development.

Research and Innovation

The Health and Care Act 2022 set out the legal duties and roles of ICBs to facilitate, co-ordinate and promote research across the Integrated Care System (ICS). The ICB has been undertaking this duty through the Research and Innovation Collaborative which was established in September 2023. Biannual reports are submitted to the Board to provide assurance against this duty.

The Research and Innovation Collaborative meets monthly and brings together a wide range of stakeholders from across the ICS including all four HEIs (Higher Education Institutes), all five NHS Trusts, primary care, local authority representation and VCFSE colleagues. It is a vibrant forum and has worked to identify a small number of system research and innovation priorities and these were presented as a ‘Plan on a Page’ to the Board in May 2024 and approved for implementation. The development of the Plan on a Page has fostered collaborative system working and it is intended that a focus on four key priorities will support LSC to deliver on the aim of key national research strategies to develop a culture of research and improve population health and outcomes.

Two subgroups have been established in year; a medical sub-group and a Health Creation sub-group both will support delivery of the Plan on a Page.

REN (Research Engagement Networks) have been funded nationally to support improving health inequalities through research by bridging the gap and building trust with communities that are underrepresented by research. It is widely recognised that communities with health inequalities are often excluded from participating in research and have less opportunity to contribute their lived experience to the studies created.

REN projects are progressing well and starting to build capacity and capability for research within the VCFSE sector to build relationships and develop opportunities. For example, the ICB has supported a National Institute for Health and Care Research (NIHR) Rapid Conversion of Evidence Summaries (RaCES) project for the Respiratory Health and Wellbeing Champions Service. Furthermore, the lead research social worker at LSCFT and Professor of the University of Central Lancashire have completed their research skills training with the organisation Early Break (which supports families who have experienced substance or alcohol abuse). They have presented a toolkit together nationally around how to work with these communities and are now planning to develop their own research study soon. Building on this work, three new social workers are being trained in a similar model to work with three new VCFSE's across Lancashire and South Cumbria: The Foxton Centre, The Deaf Village and East meet West.

It is essential that the ICB and ICS have an effective and embedded approach to innovation. There is a vibrant innovation sub-group to the Research and Innovation Collaborative led by the Director of Public Health at Lancashire County Council in collaboration with Health Innovation North West Coast. There have been strategic co-design events exploring with system partners how we establish an Innovation Ecosystem across the ICS and with the aim of agreeing our innovation ambitions for LSC.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the NHS Lancashire and South Cumbria ICB, to ensure it delivers its policies, aims and objectives. It is designed, to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The ICB's Accountable Officer is responsible for the system of Internal Control within the ICB. Responsibility for specific elements of the Internal Control framework is delegated to individual members of the Executive team, who have established the controls relevant to the key business functions, in line with the risks implicit in those functions.

The ICB's Internal and External Auditors provide assurance on the adequacy of those controls both in their design and their performance. The Audit Committee is charged with receiving reports on the operation of key controls and ensuring that risks identified are appropriately mitigated and that actions are completed.

In addition, the Board Assurance Framework is the key document which provides an overview of the controls and assurances in place to ensure that the ICB can achieve its strategic objectives and manage the principal risks identified. All reports presented to the ICB Board include identified risks.

Control mechanisms are embedded within all aspects of the ICB's governance, with the oversight of risk management within the organisation being one of them.

The Constitution describes how we organise ourselves to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and populations we serve. The Constitution is underpinned by the duty that requires NHS bodies to consider the effects of their decisions on the health and wellbeing of the people of England, the quality of services and the sustainable and efficient use of resources.

The Governance Handbook includes key documents that underpin our Constitution and governance framework, including our Scheme of Reservation and Delegation (SoRD). The SoRD sets out those decisions that are reserved to the Board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. It clearly sets out the financial delegated limited for individual officers and functions.

Furthermore, the organisation has a suite of organisational policies and documents ensuring that the ICB is compliant with national and legal standards such as policies for Health and Safety Act, Standards of Business Conduct, Freedom to Speak Up, Conflicts of Interest and Fit and Proper Persons.

The Standards of Business Conduct policy was updated and approved by the Board in May 2024. A full review was undertaken to align this policy to:

- Fit and Proper Person's Test Policy and Framework
- Freedom to Speak Up Policy
- Updated guidance for Anti-Fraud Bribery and Corruption
- Updated and approved Joint Working with Pharmaceutical Industry policy (which also relates to commercial sponsorship)
- Reference to the approved Information Governance Handbook
- The updated Seven Principles of Public Life (NOLAN principles).

The Freedom to Speak Up policy was updated to reflect minor internal amendments such as the alignment of the role of medical director as executive lead and systems implemented to refer concerns to the speaking up service. The policy is in line with the NHSE national template, and a full review of this policy is scheduled for 2025/26.

The ICB has a Fit and Proper Persons Test policy and framework in place which was approved by the Remuneration Committee in February 2024. The ICB met the requirements of this policy with the annual submission made to NHSE regional director

by 30 June 2024 confirming that assurance had been received that all checks had been undertaken. The ICB is part way through the assurance cycle in this area for 2024/25 with submission to region due in June 2025.

The ICB has an overarching Health and Safety Policy which was updated and approved by the Health and Safety Oversight Group (HSOG) in October 2024; there are an additional seven specialist policies in place to ensure the health and safety of ICB's employees. Midlands and Lancashire Commissioning Support Unit provide subject matter expertise and guidance for ICB health and safety systems and procedures. All health and safety business is overseen by the HSOG which is chaired by the ICB Chief Executive Officer.

The ICB has implemented systems and processes which have supported a proactive approach to the review of declarations of interests and the maintenance of the ICB's registers of interests including gifts and hospitality. The ICB has also mandated NHSEs Conflict of Interested training module for all staff.

There is a clear process for reporting, management, investigation and learning from incidents. The ICB has a Senior Information Risk Owner (SIRO) to support the arrangements for managing and controlling risks relating to information/ data security. The Medical Director is the Caldicott Guardian to ensure that patient confidentiality is protected.

The ICB engages the services of a counter fraud specialist, the work undertaken by this specialist in liaison with the ICB is described at section 'Counter Fraud Arrangements' section of this report.

Management of Conflicts of Interest

The Health and Care Act 2022 places responsibility on ICBs to manage conflicts of interest and publish a Conflicts of Interest Policy within its Governance Handbook. In September 2024, NHSE updated its published guidance following which the ICB reviewed and revised its policy which can be located on the ICB's website and is contained in the governance handbook:

LSCICB_Corp34_Conflicts_of_Interest_Policy_V3.pdf

The updated policy re-affirms the guiding principles for managing conflicts of interests and includes the requirement for those defined as decision makers within the policy to declare all directorships regardless of their nature. The policy has also been updated to include the requirements of the Provider Selection Regime and references the ICB's new Contracting and Procurement Policy. In addition, the policy will be further reviewed to take into account the additional training modules provided by NHSE aimed at decision making staff and ICB chairs. While all staff were mandated to complete module 1 in 2024/25, role specific requirements will be considered to support the implementation of the additional modules from April 2025 onwards.

Data Quality

The ICB recognises that good quality data is essential for the effective commissioning of services and that data quality is crucial. The availability of complete, relevant, accurate and accessible and timely data is important in supporting patient care, clinical

governance, management and service agreements for healthcare planning and accountability. Information is generated, and processed, for a broad variety of uses, and therefore the ICB employs varied techniques in assuring data quality across those different contexts. Where the ICB receives datasets from its service providers or external parties, a culture of routine data validation is promoted. The ICB and its data processors endeavour to both ensure that timescales for submission of information are adhered to, and that the quality and accuracy of such submissions is monitored and any issues fed back to relevant forums as appropriate. To support this, the ICB developed a Data Quality Policy during 2024-25 to clarify responsibilities for ensuring data quality, validation and the escalation routes for any identified data quality issues.

The Board has received an Integrated Performance Report at each of its meetings and nationally published data is used to ensure accurate information is provided and offer a benchmarked position. In instances where data is provided to offer a more real-time position, a caveat is provided that the data is subject to validation. The Board also approved a Digital and Data Strategy at the May 2024 meeting. Work continues on the refinement and presentation of the data utilised by the ICB to provide greater assurance to the Board and that actions are underway to improve performance where necessary.

The Finance and Performance Committee receives a performance report at every meeting. Reporting is continuously under review to provide greater assurance to the Board that actions are underway to improve performance where necessary.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The ICB places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. A comprehensive suite of information governance policies has been embedded that outline the mechanisms in place to ensure that risks to confidentiality and data security are effectively managed and controlled. This includes a Data Protection and Security Policy, Information Governance Handbook, and Information Governance Code of Conduct. These documents have been updated and approved by the Audit Committee at the December 2024 meeting to reflect the latest developments on use of information both personal and non-personal.

The ICB's Chief Digital Officer, who is the Senior Information Risk Officer is responsible for ensuring information governance processes are fully embedded. A governance structure for the management and oversight of delivery of the information governance agenda has been developed which includes the establishment of an Information Governance Operational Group to support the delivery of the Data Security and Protection Toolkit (DSPT) and provides oversight on the policies and any incidents that may occur. This Group reports into a quarterly Information Governance Oversight Group which ultimately provides assurance to the Audit Committee and the ICB on all aspects of information governance; including the implementation of the requirements

within the Data Security Protection Toolkit (DSPT) including the review of information governance policies and national standards as well as being responsible for any improvements required to provide additional assurance.

The ICB met all the standards within the DSPT submission in 2024/25 and is expecting to meet the requirements of the DPST submission for 2025/26 by the deadline 30 June 2025. There are DSPT requirements that relate to larger programmes of work where engagement from ICB staff is key when collating evidence required for the mandatory assertions. This includes areas such as, training on information governance, oversight and assurance on information assets and software and data flow mapping. Evidence continues to be gathered in this regard.

Annual information governance training and a new starter induction programme is in place to ensure that all staff recognise the importance of protecting personal information and ensuring that data protection is embedded in the organisation in all processes, both by design and default.

Further there are robust processes in place to ensure that all personal data breaches are reported and investigated by the Information Governance team and reported where appropriate to the internal information governance groups and the Audit Committee as well as the Information Commissioners Office (ICO). All data breaches result in an in-depth review of what went wrong in order to establish changes to processes to mitigate the risk of them re-occurring.

To date this year, the ICB has reported two internal information governance breaches to the Information Commissioners Office (ICO) which related to one individual sharing personal information of a staff member on two occasions. The Root Cause Analysis (RCA), initiated as part of the ICB incident response process, identified the primary contributory factor as human error. The staff member received targeted one to one personal training. To prevent recurrence the lessons learned from the RCA informed the updated policies and procedures which were approved by the Audit Committee at the December 2024 meeting. Any non-reportable incidents are also managed and investigated appropriately by undertaking low level root cause analysis and subsequent action plans to mitigate any further risk.

The Information Governance Code of Conduct, the Information Governance Data Security and Protection policies and the Information Governance Handbook have been revised in 2024/25 and are available on the ICB Intranet and detail the standards and expectations of the organisation and its staff in relation to information governance.

The ICB believes it has made significant improvements in information governance awareness and oversight in 2024/25 and continues to acknowledge the importance of this agenda for its staff and the population of Lancashire and South Cumbria.

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, I can confirm that an appropriate framework and environment is in place to provide quality assurance of business critical models.

A business continuity plan is in place for the ICB, and development of business impact analyses is underway. A full review of the plan has been undertaken to address any

gaps and incorporate the risks and mitigations associated with the loss of critical information systems. This has been reported through the Emergency Preparedness Resilience and Response (EPRR) Co-ordinating Group, chaired by the Chief Operating Officer who is the Accountable Emergency Officer (for EPRR).

A business continuity exercise was developed to test the Integrated Care System Annual Cyber Incident Resilience and this took place on the 31st March. Outputs from this exercise and any proposed actions will be presented to a future Audit Committee.

Third party assurances

The ICB currently contracts with a number of external organisations for the provision of back-office services and functions. Assurances on the effectiveness of the controls in place for these services are received from a Service Auditor Report from the relevant service sent upon request.

The organisations concerned are:

Service	Provider
Finance and Accounting Services	NHS Shared Business Services
Payroll Management	Lancashire Teaching Hospitals
IT Services	Blackpool Teaching Hospital
HR Services	East Lancashire NHS Trust
Various	MLCSU

In addition, internal and external audit provide assurance to the ICB.

Control Issues

The month nine governance statement return in January 2025 reported control issues under the following categories. Control issues in each of these categories could prejudice the not resolved and could put at risk delivery of the standards expected of the Accountable Officer. Achievement of priorities or undermine the integrity or reputation of the ICB and wider NHS if these control issues have no bearing on fraud or national security of data.

Quality and Performance – Regulators

The ICB reported control issues under this category under a series of themes; safeguarding, National Oversight Framework, Never Events, Prevention of Future Death notices (Regulation 28), and independent investigations. Mitigation plans are in place for these areas.

Quality and Performance - Accident and Emergency

The ICB reported control issues under this category due to difficulties in meeting the 4-hour target, reducing 12 hour waits, and the number of patients not meeting the criteria to reside having remained high for a period of time. A range of strategies and approaches are being utilised to try to tackle the identified challenges.

Urgent and emergency care is described in further detail in the performance report.

Quality and Performance - Referral to treatment/ 52 week wait

The ICB reported control issues under this category due to difficulties in meeting the referral to treatment targets. To maximise and optimise elective capacity and undertake a system wide approach to delivery, the Lancashire and South Cumbria Elective Recovery Programme has been focused on six clear pillars of work; Referral Optimisation, Waiting List Management, Outpatient Transformation, Theatre Transformation, Surgical Hubs and Use of the Independent Sector.

Diagnostic and elective care is described in further detail in the performance report.

Quality and Performance - Ambulance services

The ICB reported control issues under this category due to difficulties in meeting the response and handover targets. Across the North West there are ICB level improvement groups to aid reducing hospital handover times, within Lancashire and South Cumbria this meets fortnightly. To increase ambulance availability, reduce pressures on Emergency Departments (EDs), and give better outcomes and more appropriate care, North West Ambulance Service (NWAS) also strive to reduce conveyance to ED for patients calling 999 where possible.

Urgent and emergency care is described in further detail in the performance report.

Quality and Performance - Mental Health and Dementia

The ICB reported control issues under this category due to issues with inappropriate out of area placements, although these were significantly reduced in comparison to last year. 14 patients remained in out of area placements as at March 2025 and a mitigation plan is in place to further reduce this number during 2025/26.

Mental Health is described in further detail in the performance report.

Quality and Performance – Cancer

The ICB reported control issues under this category due to breaches in referral and treatment times. There has been a robust and wide-ranging cancer improvement plan for 2024/25 with detailed actions aiming to improve performance by:

- Reducing the 62-day backlog
- Improving performance against the faster diagnosis standard
- Reducing diagnostic delays
- Increasing surgical capacity

Cancer waiting times are described in further detail in the performance report.

Quality and Performance – Infection Prevention and Control

The ICB reported control issues under this category due to healthcare associated Infections, and in particular Clostridioides difficile (C. difficile) rates have been an ongoing cause of concern within the providers. The ICB in working with the providers has a series of improvement mechanisms in place to mitigate this risk.

Infection Prevention and Control is described in further detail in the performance report.

Quality and Performance – Maternity

The ICB reported control issues under this category due to two providers remaining on the Maternity Safety Support Programme (MSSP). Both have improvement plans in

place and formal review meetings are undertaken on a 6-montly basis. The Local Maternity and Neonatal System (LMNS) continue with the programme of quality assurance visits for Maternity Incentive Scheme (MIS) and Saving Babies Lives (SBL).

Maternity services are described in further detail in the performance report.

Quality and Performance – Continuing Healthcare

The ICB reported control issues under this category due to challenges with:

- CHC conversion
- Fast Track conversion
- Overspend on budget allocation
- Spend per 50,000 of population
- Backlog of overdue reviews

The ICB has a series of improvement plans in place against each of these challenges.

Quality and Performance – Children's services

The ICB reported control issues under this category due to challenges in 52-week position with regards to community waits for Speech and Language Therapy (SALT) and Occupational Therapy (OT) specifically, with waits for community paediatrics across the system being an area of concern. Namely, community dentistry is subject to long waits for children and young people who require sedation and general anaesthetic, and paediatric audiology is also under additional scrutiny relating to the Paediatric Hearing Service Improvement Programme. The ICB in working with the providers has a series of improvement mechanisms in place to mitigate this risk.

Children's services are described in further detail in the performance report.

Quality and Performance – Workforce

The ICB reported control issues under this category due to challenges within maternity workforce. Detailed work has been undertaken with all maternity providers regarding their midwifery workforce figures and deployment.

Supporting our current and future workforce is described in further detail throughout the performance report.

Quality and Performance – Diagnostics

The ICB reported control issues under this category namely due to challenges in performance for the 6 weeks diagnostic target. Recovery plans are in place with associated trajectories which continue to be monitored.

Diagnostic and elective care is described in further detail in the performance report.

Finance, Governance and Control - Information Governance

The ICB reported a control issue under this category due to two data breaches taking place which were reported to the Information Commissioners Office. These were closed following satisfactory submission of corrective actions taken by the ICB.

More information regarding information governance can be found in the statement at the 'Information Governance' section.

Finance Governance and Control – Finance and Procurement

During the reporting period up to month 9, there were two instances of the control environment being breached in relation to the ICB's standing financial instructions (SFI) and 1 breach in relation to year-to-date deficit. The SFI breaches were reported to Audit Committee at its meeting in September 2024. The breaches related to the continuation of agency spend beyond the approved timeframe for All Age Continuing Care team and incomplete procurement documentation to commission support for a mandatory assessment for outstanding CHC cases (phase 1 and 2) undertaken during 2023. To mitigate the issues identified from the breaches, the ICB's establishment control processes have now been strengthened. Also, a Procurement and Contracting Policy has been developed and approved by the Finance and Performance committee in December 2024.

With regards to the year-to-date deficit reported at Month 8, it was reported to NHSE in the month 9 governance statement that the month 8 forecast outturn would be in line with the ICB's plan of breakeven. This was after receiving £87.5m deficit support funding from NHSE, which was the ICB's share of the agreed system Control Total of £175m. This control issue was mitigated by year-end with a break-even position being achieved. The year-end position is described in more detail at the 'Introduction and Context' section of the statement.

Review of economy, efficiency & effectiveness of the use of resources

The ICB is charged with ensuring that it achieves economy, efficiency and effectiveness in its use of resources, and continues to develop and strengthen the system of internal controls. The Chief Finance Officer has worked with the Internal and External Auditors to ensure that the ICB receives assurance in relation to the use of resources and that this is reported to the Board.

The ICB has a strategic objective to 'meet financial targets and deliver improved productivity', and there are three risks on the Board Assurance Framework in this regard related to; All Age Continuing Care (AACC) in terms of referrals per head of population and cost per head of the population and that quality targets are not sustained, failing to deliver against financial plan to ensure recurrent financial balance over a three-year period, failure to deliver infrastructure transformation as set out in LSC system-wide estates plan and LSC infrastructure strategy. Further details on these risks and the controls can be found in the 'risk management' section of this report.

Monthly financial performance has been scrutinised by the Finance and Performance Committee and reported to the Board. Internal and External Audit arrangements give a view to the Audit Committee on the delivery of the ICB's statutory financial responsibilities and the achievement of value for money.

The enforcement undertakings issued to the ICB by NHS England as described in the 'Introduction and Context' and 'Financial Review' sections of this statement, outline the mitigations the ICB is required to meet in the areas of financial planning and leadership and governance in order to ensure the ICB can discharge its functions properly.

Assurance reporting against these mitigations will continue throughout 2025/26 utilising the mechanisms which have been previously described in this statement, namely: the Improvement and Assurance Groups, Incident Management Team function and

oversight from the nominated system financial turnaround director, and will be reported via the committee structure and onward to the board.

Commissioning of delegated specialised services

The ICB signed a delegation agreement (DA) with NHSE and has held full commissioning responsibilities for delegated services during the 2024/25 reporting period.

To the best of ICB leadership's knowledge, the commissioning of all delegated services has been compliant with the 10 core commissioning requirements – as set out in the 2024/25 Delegated Commissioning Assurance Guidance, published by NHS England – including the requirement that all conditions set out in the DA are being met.

Where there were known compliance issues, the ICB leadership, collectively with other ICBs through multi-ICB working arrangements, has engaged with NHS England's regional leadership to notify and address such issues in a timely manner.

The ICB leadership is able to provide the necessary evidence of core commissioning requirements compliance should NHS England or a third party (e.g. external auditors) ask for such evidence.

Delegation of ICB functions

The ICB keeps its governance structures under constant review with the aim of delegating decision-making responsibility where this enables the ICB Board to devote more time to strategy and optimises the use of clinical leadership. All such arrangements are set out in the SORD.

The ICB has the following delegated functions from NHSE:

- Primary Medical Care
- Primary Pharmacy Services
- Optometry Services
- Primary and Secondary Dental Services; and
- Specialised commissioning

The decision making of delegated services is described in further detail in the 'Committees of the Board' section of this statement, and the performance of primary care is described in the annual report at 'Primary Care'.

In line with NHSE Statutory Guidance, the ICB has not delegated any of its functions during 2024/25.

Counter fraud arrangements

The ICB Chief Finance Officer is responsible for ensuring appropriate arrangements are in place to comply with the Government Functional Standard 013: Counter Fraud within the NHS. An accredited Counter Fraud Specialist is contracted to undertake counter fraud work proportionate to identified risks via the contract the ICB holds with Mersey Internal Audit Agency.

The ICB Audit Committee receives quarterly progress reports against each of the Standards for Commissioners and a final one within an annual report. The Chief Finance Officer (CFO) provides executive oversight, and a proactive work plan is in place to address identified risks. The CFO is proactively and demonstrably responsible for tackling fraud, bribery and corruption. Regular meetings are held with the Anti-Fraud Specialist and the CFO throughout the year.

Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations via alerts, Fraud Prevention Notices or Local Proactive Exercises, which are cascaded to the relevant departments within the ICB.

In the year to date the Anti-Fraud Specialist has received a total of 30 fraud referral queries. 1 has been converted into a formal fraud investigation and is ongoing. The remaining 29 have been closed, as no fraud was identified after further checks conducted by the ICB.

The anti-fraud annual work plan, which is approved by the Audit Committee, is risk based. The Anti-Fraud Specialist provides regular updates on the progress of the anti-fraud plan to the Audit Committee via Progress Reports, which details the ongoing self-assessment against the 12 components of the Government Functional Standard 013 Counter Fraud.

The Government Counter Fraud Standards has 12 components which are regularly monitored and scored by the Anti-Fraud Specialist within the year and an update is provided to the Audit Committee on the current scoring via anti-fraud progress reports. For the year to date, the ICB assessed itself as being ‘Green’ (with all 12 components scoring ‘green’ individually). The return is due to be provided to NHS Counter Fraud Authority by the end of May 2025.

Freedom to Speak Up

Freedom to speak up (FtSU) is an important part of creating a safe and open culture within the ICB and wider ICS and of ensuring staff feel listened to and valued in order to confidently share concerns where patient safety or quality of care is below the standards the ICB expect, or when behaviours or working practices do not reflect the values of the organisation. The ICB has two FtSU Guardians, a lead executive and a named non-executive champion. The speaking up service has developed robust processes that are fit for purpose and promote an open culture. The guardians have conducted a series of proactive sessions with a range of staff groups to encourage accessing the FtSU service including via organisation wide briefings and regular attendance at corporate induction.

The Board received an annual FtSU report when it met in November 2024 and the People Committee has received quarterly updates at each meeting.

Between April 2024 and March 2025, 25 concerns eligible for reporting were raised with the ICB speaking up service, 4 of which were from Primary Care Providers. This compares with a total of 14 reported in the 2023/24 annual report. Each concern is considered in line with the ICB’s Freedom to Speak Up Policy and for each concern raised the guardian will ensure that the concern is heard, and that positive actions, support and signposting are agreed where appropriate.

ICBs also hold a system role for speaking up. The ICB has received assurance from its acute providers that each has a provision in place for speaking up, including awareness raising of this provision, recording and reporting of themes and trends. A key aim for the ICB service for the future is to build on the links with the providers to facilitate a more system-wide approach to this agenda and for the ICB to build on its assurance role.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2024 to 31 March 2025 for the ICB to date, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control.

The Head of Internal Audit concluded that there is a split opinion for the for the period 1st April 2024 to 31st March 2025 as follows:

- **Moderate Assurance,** can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk. This opinion rating relates to the outcomes from the internal audit coverage focusing upon internal controls, risk management and governance and excluding CHC.
- **Limited Assurance,** can be given that there is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls impacts on the overall system of internal control and puts the achievement of the organisation's objectives at risk. This opinion rating specifically relates to the CHC internal control environment.

This opinion is provided in the context that the ICB like other organisations across the NHS is continuing to face a number of challenging issues and wider organisational factors particularly with regards to the recently announced changes to national bodies and the corresponding uncertainty this causes, workforce challenges, financial challenges and increasing collaboration across organisations and systems.

During 2024/25, the ICB has been placed into NHS Oversight Framework (NOF) Segment 4 and has been receiving intensive support from the National Recovery Support Programme (RSP). It has been evident from the internal audit work undertaken, that there has been a lack of robust controls, specifically in relation to the management and oversight of Continuing Healthcare which has significantly impacted on the ICB's financial position and its internal control framework. The ICB's expenditure on All Age Continuing Care which has continued to grow throughout the year, in total the budget is £500m but the likely year end outturn is £564m, a deficit of £64m or 12.8% overspend against the budget significantly impacting on the ICB's financial position (as reported in March 25).

We have proposed a split opinion for 24/25. It is recognised that the ICB have utilised internal audit by directing them to the areas of greatest risk, specifically CHC. MIAA's continuous work on CHC during the year has identified significant internal control weaknesses across a range of areas including governance, financial reporting, budgetary management and data quality. Recommendations have been raised during the course of the year but the progress regarding implementation of these has not been

of a sufficient pace to address the risks. As such, a limited assurance opinion has been provided in relation to the internal control environment operating with regard to CHC.

We acknowledged that the ICB has continued to maintain the core internal controls around transactional financial processing controls and wider risk management. There has also been reasonable progress with the implementation of audit recommendations. As such, for the other elements of our internal audit coverage during the year, a moderate assurance opinion has been provided.

During the period, Internal Audit issued the following audit reports:

(*denotes further information can be found at 'Further Details on Limited Assurance Audits')

Area of Audit	Level of Assurance Given
Assurance Framework Phase 1 & Phase 2	NA
Risk Management	Substantial Assurance
Data Security & Protection Toolkit	Substantial Assurance: Veracity Self-Assessment Moderate Assurance: National Data Guardian Standards
Key Financial Transactional Processing Controls	Substantial Assurance
Workforce controls – Employment Checks	Substantial Assurance
Safeguarding	Moderate Assurance
Health Inequalities	Moderate Assurance
Quality of Commissioned Services – Maternity & Neonatal	Moderate Assurance
Performance Reporting	Moderate Assurance
Mandatory Training	Moderate Assurance
Patient Safety Incident Response Framework	Moderate Assurance

CHC Adam System* - IT Controls	Limited Assurance
Continuing Healthcare*	Limited Assurance

Further Details on Limited Assurance Audits

*The IT review - Continuing Healthcare (CHC) Adam System audit received limited assurance. The audit identified that there was a compromised system of internal control in respect of the ADAM system due to weaknesses in the design and inconsistent application of controls. Two high and two medium priority recommendations were agreed in order to mitigate these issues. These were for the ICB to; develop a business continuity plan, develop a user management process in respect of accessing the ADAM system, develop a training plan focusing on correct operation of the ADAM system and to ensure data inputting is being undertaken accurately, and ensure the workshop with ADAM will include the right to audit and the requirement for the supplier to provide assurance on an annual basis. The high priority action regarding developing a user management process has been completed, and the high priority action regarding the development of a business continuity plan is in progress with the plan drafted and due to be completed by June 2025. The medium priority actions relating to developing a training plan and assurance of data input have both been completed. Monitoring will continue until the business continuity plan has been fully implemented.

*The Continuing Healthcare review received limited assurance. The audit identified 19 high priority actions with implementation dates between April and September 2025. These actions will be collated into one action plan and monitored until completion. Operational progress against the plan will be submitted to the Finance and Contracting Committee and Quality and Outcomes Committee with Audit Committee for overall plan and arrangements.

Review of the effectiveness of governance, risk management and internal control and conclusion of statement

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our Board Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

Whilst the Board, its committees and the executive team have had good oversight of the principal risks and issues impacting on the ICB's ability to deliver and achieve its objectives, and the financial risks have been reported to the Board thorough the year, the ICB has faced significant risk in controlling its expenditure to stay within its allocated resource limit. This has resulted in the ICB receiving deficit support funding; being placed in segment four of the NHSE's national oversight framework (NOF4) and issued enforcement undertakings by NHSE in relation to financial governance.

The focus for the coming financial year is to address the underlying financial position for the ICB and the Lancashire and South Cumbria System and continue to work with the NHSE system financial turnaround Director and delivery partners.

This is vital to ensure the future financial sustainability of the Lancashire & South Cumbria system and to allow for transformation of services and delivery of the Integrated Care System's joint aim to improve the health and wellbeing of the population we serve.

Sam Proffitt

Accountable Officer

16th June 2025

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

Details of the ICB's Remuneration Committee can be found in the Governance Statement.

Percentage change in remuneration of highest paid director – subject to audit

Reporting bodies are required to disclose the percentage change from the previous financial year in respect of the highest paid member and the average percentage change from the previous financial year in respect of employees of the reporting body, taken as a whole:

2024/25	Salary and allowances	Total Remuneration
The percentage change from the previous financial year in respect of the highest paid director	4%	4%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	5%	5%

The average percentage change for employees of the entity broadly reflects the effect of the 2024/2025 pay award and the government decision to add intermediate pay points in each of pay bands 8a and above with effect from 1 April 2024.

The prior year comparatives in respect of the above percentage changes are as follows:

2023/24	Salary and allowances	Total Remuneration
The percentage change from the previous financial year in respect of the highest paid director	6%	6%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	-10%	-11%

In 2023/24 the average employee salary reduced from the previous year due to changes in staff composition following the transfer of staff into the ICB in respect of All Age Continuing Care staff.

Fair Pay Information – subject to audit

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in NHS Lancashire and South Cumbria ICB in the reporting period 1 April 2024 to 31 March 2025 was £280,000 - £285,000 (prior year £270,000 – £275,000).

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2024/25	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	£37,338	£48,526	£62,215
Salary component of total remuneration (£)	£37,338	£48,526	£62,215
Pay ratio information	7.57:1	5.82:1	4.54:1

2023/24	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	£34,581	£45,996	£58,972
Salary component of total remuneration (£)	£34,581	£45,996	£58,972
Pay ratio information	7.88:1	5.92:1	4.62:1

The calculations for the above figures include the costs of any agency staff engaged by the ICB in the financial period.

The reduction in the pay ratios is a reflection of the increase in the number of Band 7 to Band 8d posts, mainly as a result of the transfer into the ICB, and associated recruitment of, the Medicines Optimisation team from Midlands and Lancashire CSU.

During the reporting period 2024/25, no employees received remuneration in excess of the highest-paid director/member (2023/24: nil). Remuneration ranged from £15,000 - £20,000 to £280,000 - £285,000 (2023/24 £20,000 - £25,000 to £270,000 - £275,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers

Remuneration of senior managers, up to and including Band 9, is undertaken in accordance with Agenda for Change, and guided and advised by the ICB's HR function.

Remuneration of Very Senior Managers

We are obliged to review the remuneration of all our Senior Executives (non-agenda for change) on an annual basis and in accordance with NHS England's (NHSE) Guidance on ICB Executive Director pay. NHSE has ranked all Integrated Care Systems in size order according to weighted population, with four categories, A,B,C and D, with A being the smallest and D the largest. This pay framework determines the pay range for the Chief Executive, and the proportionate minimum and operational maximum of statutory executive Board roles and other Board level executives. LSC ICB is ranked as band D, meaning that the Remuneration Committee can make decisions on Board level executive pay, subject to this remaining under £170,000 per annum or the operational maximum, whichever is the lower. Pay proposals exceeding £170k or the operational maximum is subject to NHSE and Department of Health and Social Care approval. The ICB has also adopted a local pay framework for other VSM roles, and all VSM pay is considered and agreed by the ICB's Remuneration Committee

Senior manager remuneration (including salary and pension entitlements) – subject to audit

Name and Title	1 April 2024 to 31 March 2025					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Kevin Lavery* *Chief Executive Officer*	280 – 285	1,700	0	0	67.5 – 70	350 – 355
Samantha Proffitt *Chief Finance Officer*	190 – 195	0	0	0	22.5 – 25	215 – 220
David Levy *Chief Medical Officer – from 01/04/2024 to 28/02/2025*	155 – 160	100	0	0	0	155 – 160
Sarah O'Brien *Chief Nursing Officer*	175 – 180	0	0	0	40 – 42.5	215 – 220
Debbie Eyitayo *Chief People Officer – from 18/09/2024 to 31/03/2025*	85 – 90	0	0	0	100 – 102.5	190 - 195
Asim Patel	155 – 160	1,200	0	0	25 – 27.5	180 – 185

Name and Title	1 April 2024 to 31 March 2025					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Chief Digital Officer						
Craig Harris *Chief Operating Officer*	170 – 175	0	0	0	32.5 – 35	205 – 210
Emma Woollett *Chair – from 01/09/2024 to 31/03/2025*	40 – 45	0	0	0	0	40 – 45
Debbie Corcoran *Non-Executive Member*	10 – 15	0	0	0	0	10 – 15
Geoff Jolliffe *Partner Member – Primary Medical Services – from 01/04/2024 to 30/06/2024*	0 – 5	0	0	0	0	0 – 5
Jim Birrell *Non-Executive Member*	15 – 20	100	0	0	0	15 – 20
Sheena Cumiskey *Non-Executive Member*	15 – 20	0	0	0	0	15 – 20

Name and Title	1 April 2024 to 31 March 2025					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Roy Fisher *Acting Chair – from 01/04/2024 to 31/08/2024* *Non-Executive Member – from 01/09/2024 to 31/03/2025*	40 – 45	100	0	0	0	40 – 45
Jane O'Brien *Non-Executive Member*	10 - 15	100	0	0	0	10 – 15
Julie Colclough Partner Member – Primary Medical Services – from 01/07/2024 to 31/03/2025	20 - 25	0	0	0	0	20 – 25

**Note: Kevin Lavery stepped down from the position of Chief Executive Officer of the ICB in April 2025. His last working day was 30/04/25.*

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

Notes:

1. David Levy was seconded into NHS England from 1 March 2025 but continued to be paid in full by the ICB and therefore the costs shown above relate to the period 1 April 2024 to 31 March 2025.
2. Expense payments (taxable) to the nearest £100 relate to the net taxable benefit of the use of lease cars. In addition, the table above includes the taxable benefit relating to payments in respect of mileage claims where the payment is above the HMRC allowable rate of £0.45 per mile.

3. The ICB does not have a performance-related pay scheme; the performance of staff is measured through the ICB's annual appraisal process. There is therefore no reference to performance-related bonuses.

4. Pension-related benefits are calculated as follows:

((20 x PE) + LSE) – ((20 x PB) + LSB) – Employee contribution

Where:

PE = the annual rate of unreduced pension that would be payable to the senior manager if they became entitled to it at the end of the financial year.

LSE = the amount of unreduced lump sum that would be payable to the senior manager if they became entitled to it at the end of the financial year.

PB = the annual rate of unreduced pension, adjusted for inflation, that would be payable to the senior manager if they became entitled to it at the beginning of the financial year.

LSB = the amount of unreduced lump sum, adjusted for inflation, that would be payable to the senior manager if they became entitled to it at the beginning of the financial year.

Ees cont = employee pension contributions for the financial year.

To adjust PB and LSB for inflation the Consumer Prices Index (CPI) of 6.7% has been used.

In summary, the value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

The following page includes 2023/2024 comparative figures:

Name and Title	2023/24 (for the reporting period 1 April 2023 to 31 March 2024)					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Kevin Lavery *Chief Executive Officer*	270 – 275	1,800	0	0	60 – 62.5	330 – 335
Samantha Proffitt *Chief Finance Officer*	180 – 185	0	0	0	0 – 2.5	180 – 185
David Levy *Chief Medical Officer*	150 – 155	100	0	0	0	150 – 155
Sarah O'Brien *Chief Nursing Officer*	165 – 170	0	0	0	0 – 2.5	165 – 170
Maggie Oldham *Chief Planning, Performance and Strategy Officer*	210 – 215	0	0	0	0	205 – 210
James Fleet *Chief People Officer*	165 – 170	3,100	0	0	35 – 37.5	205 – 210
Asim Patel *Chief Digital Officer*	145 – 150	1,200	0	0	0 – 2.5	150 - 155
Craig Harris *Chief Operating Officer*	160 – 165	100	0	0	0 – 2.5	165 - 170
Geoff Jolliffe *Partner Member – Primary Medical Services*	15 – 20	500	0	0	0	15 – 20
David Flory	65 – 70	0	0	0	0	65 – 70

Name and Title	2023/24 (for the reporting period 1 April 2023 to 31 March 2024)					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Chair – from 01/04/2023 to 29/02/2024						
Ebrahim Adia *Non-Executive Member – from 01/04/2023 to 31/10/2023*	5 – 10	0	0	0	0	5 – 10
Jim Birrell *Non-Executive Member*	15 – 20	300	0	0	0	15 – 20
Sheena Cumiskey *Non-Executive Member*	15 – 20	0	0	0	0	15 – 20
Roy Fisher *Non-Executive Member – from 01/04/2023 to 29/02/2024 Acting Chair – from 01/03/2024 to 31/03/2024*	20 – 25	200	0	0	0	20 – 25
Jane O'Brien *Non-Executive Member*	10 - 15	200	0	0	0	10 – 15
Debbie Corcoran *Non-Executive Member*	10 - 15	100	0	0	0	10 - 15

Notes:

- Maggie Oldham is on secondment from Isle of Wight NHS Trust from 11th September 2022.

- Expense payments (taxable) to the nearest £100 relate to the net taxable benefit of the use of lease cars. In addition, the table above includes the taxable benefit relating to payments in respect of mileage claims where the payment is above the HMRC allowable rate of £0.45 per mile.
- The ICB does not have a performance-related pay scheme; the performance of staff is measured through the ICB's annual appraisal process. There is therefore no reference to performance-related bonuses.
- James Fleet was seconded to Sandwell and West Birmingham Hospitals NHS Trust from 2 October 2023.

Pension-related benefits are calculated as follows:

((20 x PE) + LSE) – ((20 x PB) + LSB) – Employee contribution

Where:

PE = the annual rate of unreduced pension that would be payable to the senior manager if they became entitled to it at the end of the financial year.

LSE = the amount of unreduced lump sum that would be payable to the senior manager if they became entitled to it at the end of the financial year.

PB = the annual rate of unreduced pension, adjusted for inflation, that would be payable to the senior manager if they became entitled to it at the beginning of the financial year.

LSB = the amount of unreduced lump sum, adjusted for inflation, that would be payable to the senior manager if they became entitled to it at the beginning of the financial year.

Ees cont = employee pension contributions for the financial year.

To adjust PB and LSB for inflation the Consumer Prices Index (CPI) of 10.1% has been used.

In summary, the value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Pension benefits – subject to audit

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 31 March 2025	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2025	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Kevin Lavery *Chief Executive Officer*	5 – 7.5	0 – 2.5	10 – 15	0 - 5	114	63	211	0
Samantha Proffitt *Chief Finance Officer*	2.5 – 5	0 – 2.5	75 – 80	195 – 200	1,709	32	1,765	0
Sarah O'Brien *Chief Nursing Officer*	2.5 – 5	0 – 2.5	65 – 70	170 – 175	1,433	47	1,502	0
Debbie Eyitayo *Chief People Officer – from 18/09/2024 – 31/03/2025*	2.5 - 5	10 – 12.5	35 – 40	95 – 100	0	107	908	0
Asim Patel *Chief Digital Officer*	0 – 2.5	0 – 2.5	45 – 50	120 – 125	945	23	987	0
Craig Harris *Chief Operating Officer*	2.5 – 5	0 – 2.5	50 – 55	125 – 130	995	27	1,044	0

Notes:

The payments made to the Lay Members do not include pension contributions. These persons have therefore been excluded from the above table.

Any Officers who are not members of the pension scheme have been excluded from the above table.

For comparative purposes the CETV figures at 31 March 2024 have been inflated by 6.7%. The real increase in CETV is calculated as follows:

CETV at 31/03/2025 – (CETV at 31/03/2024 + 6.7%) - 2024/2025 Employee superannuation contributions

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office – subject to audit

The ICB made no payments for early retirement or for loss of office during the financial year (zero, 2023/24).

Payments to past directors – subject to audit

The ICB has made no payments to past Directors in the period 1 April 2024 to 31 March 2025 (zero, 2023/24).

Staff Report

Number of senior managers

The following table details the breakdown of ICB-employed staffing by pay band as at 31 March 2025, including the number of senior managers (represented as 'very senior managers'):

Pay Band	Headcount	2023/24 Headcount
Apprentice	0	0
Band 1	0	0
Band 2	1	1
Band 3	30	27
Band 4	86	88
Band 5	116	104
Band 6	161	128
Band 7	144	138
Band 8 – Range A	143	116
Band 8 – Range B	73	70
Band 8 – Range C	47	34
Band 8 – Range D	36	34
Band 9	26	26
Medical	46	41
Very Senior Managers	26 (includes NEDs: 6)	28 (includes NEDs: 8)
Grand Total	935	837

Staff numbers and costs

Number of people (average whole time equivalent) employed by NHS Lancashire and South Cumbria ICB (subject to audit):

	Total number	Permanently employed number	Other number	2023/24 total number
Total	**776.62**	**755.88**	**20.74**	615.63
Costs:	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and wages	43,248	41,243	2,004	34,881
Social security cost	4,783	4,783	0	3,770
NHS pension cost	9,240	9,240	0	5,989
Other pension cost	0	0	0	0
Apprenticeship levy	202	202	0	150
Recoveries in respect of employee benefits	0	0	0	0
Termination benefits	65	65	0	309
Total costs	**57,538**	**55,534**	**2,004**	45,099
Of the above, number of whole time equivalent people engaged on capital projects	0	0	0	0

There has been an increase in permanent whole-time equivalents employed by the ICB in 2024/25. The increase is due to movement of staff into the ICB under the Transfer of Undertakings (Protection of Employment) regulations (TUPE), for a number of service areas, including Medicines Management, System Co-ordination Centre and Governance Compliance. There has also been additional recruitment in some service areas in year, including Continuing Healthcare and Medicines Management.

Staff composition

As an ICB, we recognise the need for our workforce to be representative of our resident population. Furthermore, we recognise that we need to do far more to attract and retain a workforce that is representative of the communities we serve, retain the existing diversity within our workforce, and improve the experiences of our diverse staff.

Throughout 2024/25, our internal workforce has grown – rising from 842 people in March 2024 to 922 people as of 31 March 2025. However, while we have seen some improvements, there are still significant issues with under-representation of specific

protected characteristics and under-reporting of diversity monitoring data via the national NHS Electronic Staff Record (ESR). This means we need to make further efforts to ensure that our people are comfortable with, and understand the importance of, sharing their personal information with us so that we are better able to understand their needs and the challenges they may face, and improve the workplace experience for all employees regardless of their background or protected characteristics. This need is reflected in our refreshed Equality Objectives 2024-2027.

The following sections provide an overview of diversity within our existing ICB workforce as at 31 March 2025. Please note – due to relatively low workforce numbers, we are unable to report on pregnancy and maternity, or marriage and civil partnership as there is a risk of identifying individual members of staff through the publication of this data. Furthermore, we are unable to report on gender reassignment as this data is not routinely collected via the national NHS Electronic Staff Record.

Gender

In Lancashire and South Cumbria, the population has nearly the same number of males (49.2%) as females (50.8%). As of 31 March 2025, Lancashire and South Cumbria ICB's full time equivalent (FTE) workforce comprises of 20.7% male staff and 79.3% female staff.

The following table details the breakdown of total ICB staffing by gender as at the 31st March 2025:

Gender	FTE	Headcount
Female	667.76	731
Male	170.76	191
Grand Total	**837.98**	**922**

The following table details the gender split of the ICB Executive Director team (those who are directly employed by the ICB) as at the 31st March 2025:

Gender	FTE	Headcount
Female	3.00	3
Male	3.80	4
Grand Total	**6.80**	**7**

Disability

Census 2021 data tells us that 19.7% of the total resident population of Lancashire and South Cumbria are disabled under the Equality Act, and 8.8 per cent of those individuals, report that their disability limits their day-to-day activities. In total, 7.3 per cent of Lancashire and South Cumbria ICB's workforce has declared that they are disabled. However, 42.3 per cent of the workforce has not declared their disability status which means that the actual number of disabled staff is likely to be higher. This is further supported by the fact that there are a significantly higher number of staff members who have required reasonable adjustments in the workplace due to a disability or long-term condition. Staff are also encouraged to discuss any needs or requests for reasonable adjustments as part of their health and wellbeing conversations with line managers.

Ethnicity

The proportion of Lancashire and South Cumbria's resident population who are from an ethnically diverse background (i.e., non-White British) is currently 12.3 per cent. In comparison, 7.5 per cent of Lancashire and South Cumbria ICB's combined workforce self reported as coming from ethnically diverse backgrounds. However, it should be noted that 5.5 per cent of the workforce has not stated their ethnicity.

Religion and Belief

The following table provides an overview of the most prevalent religions and beliefs within the ICB workforce compared to our resident populations in Lancashire and South Cumbria. Please note that it has not been possible to report on the religion of some of our people due to the risk of identifying individual members of staff.

Religion & Belief	% ICB Workforce	% Population of Lancashire and South Cumbria
Atheism	11.0%	32%
Christianity	41.2%	52.8%
Islam	4.0%	8.3%
Other	5.1%	1.4%
Unspecified	5.2%	
Not declared	33.5%	5.4%

Sexual Orientation

The following table provides an overview of sexual orientation within our workforce compared to our resident populations in Lancashire and South Cumbria.

Sexual Orientation	% ICB Workforce	% Population of Lancashire and South Cumbria
Bisexual	0.7%	
Gay or Lesbian	2.6%	1.5%
Heterosexual or straight	62.3%	90.2%
Other	0.3%	1.4%
Unspecified	5.0%	
Not declared	29.2%	6.9%

Sickness absence data

The following table details the monthly ICB sickness absence rate between 1st April 2024 and 31st March 2025 including a 12-month cumulative percentage:

Month	Absence FTE %	Rolling Abs FTE %
April-24	3.51%	2.96%
May-24	3.61%	3.13%
June-24	3.61%	3.27%
July-24	3.78%	3.55%
August-24	2.49%	2.93%
September-24	2.87%	3.63%
October-24	4.21%	3.78%
November-24	5.05%	3.93%
December-24	5.74%	4.18%
January-25	4.82%	4.28%
February-25	4.68%	4.39%
March-25	4.58%	4.53%

Staff turnover percentages

The staff turnover rate across the ICB between 1st April 2024 and 31st March 2025 was 5.53%. There were 60 leavers in that time, two of which were compulsory redundancies, both at the end of March 2025.

Staff engagement percentages

The ICB took the decision not to participate in the NHS annual staff survey during 2024 to focus on its organisational development and cultural reset plan. The executive and senior leadership team considered it important to focus on taking action in response to detailed staff feedback that had already been received and that which was captured following an all staff away day in October 2024. The cultural reset included a revised set of ICB values and behaviour standards which were co-design and development by. staff. This has formed the foundation needed to build a positive culture.

The ICB newly launched values of Compassion, Integrity, Respect and Inclusion underpin the ICB's commitment to foster a culture that is ambitious, appreciative and resilient. The ICB aspires to develop an organisational culture that has a "can do" attitude, where every challenge is an opportunity for growth and improvement. The ICB's intent is to deliver its plans effectively and efficiently, ensuring that it become an organisation that serves its communities with excellence.

A full values and behaviours toolkit has been developed from our workshops and session that took place between October 2024 and February 2025, establishing our core values and behaviours to help us foster a positive organisational culture and create a great place to work, delivering high quality, safe and effective health and care. The next stage, currently in progress, is beginning roadshows across the organisation to gain support from leaders and colleagues to embed the values to make a positive shift in the organisations culture.

The ICB has continued to invite staff to complete the national quarterly pulse surveys (NQPS) in April 2024, July 2024 and January 2025. Recommendations and actions from analysis presented to the executive teams are added to the ICB staff experience improvement plan and implemented. These actions are monitored and progress and achievement is reported back to all staff via the ICB you said we did intranet page and internal communication.

The work on the values development and staff experience improvements from the NQPS insights demonstrates the ICB's commitment to continuous improvement and employee engagement.

Staff policies

The following staff policies have been applied during the financial year.

Policies are reviewed and Equality Impact Assessed in line with the policy schedule

- Absence Management Policy
- Adoption Policy
- Annual Leave Policy
- Career Break Policy
- Disciplinary Policy
- Domestic Abuse and the Workplace Policy
- Equality and Inclusion Policy
- Flexible Working
- Grievance Policy
- Harassment and Bullying at Work Policy
- Induction Policy
- Agenda for Change Job Evaluation and Re-banding Policy
- Managing Work Performance Policy
- Maternity Policy
- Appraisal objectives and performance review (including pay progression) policy
- Organisational Change Policy
- Special Leave
- Parental Leave Policy
- Paternity Leave Policy
- Professional Registration Policy
- Recruiting Ex-Offenders Policy
- Recruitment and Selection Policy
- Retirement Policy
- Shared Parental Leave Policy
- Substance Misuse Policy
- Training and Development Policy
- Secondment Policy
- Temporary Promotion Policy
- Freedom to Speak up Policy (Whistleblowing / Raising Concerns)
- Human Rights Policy
- Lone Worker Policy and Procedure

Trade Union Facility Time Reporting Requirements

The number of employees who were relevant Trade Union officials during the relevant period is 1. Facility time for accredited trade union representatives is supported by the ICB as well as regular staff side engagements.

Other employee matters

We are fully committed to providing a safe working environment that values wellbeing and diversity. We recognise our wider legal and moral obligation to provide a safe and healthy working environment for our employees, visitors and members of the public that may be affected by our activities. We have adapted a Health and Safety Management System based on the HSG65 model and are adopting a positive, proactive stance on health and safety. We aim to promote an accountable culture which is just and fair to its employees and enables us to learn from incident reports and risk assessments in order to continuously improve our health and safety management, and, where necessary, change policies/procedures to enable this to happen.

It is a statutory requirement to keep a record of all accidents, incidents and near misses that occur out of work activities. There were no RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reportable accidents relevant to our organisation during the reporting period.

Expenditure on consultancy

During the 2024/25 financial year we have spent £3,628k on external consultancy services (2023/24 £619k). The majority of this expenditure is in connection with the ICB's external enhanced intervention and turnaround support, along with costs relating to work undertaken to assist the ICB in recovering continuing healthcare costs.

Off-payroll engagements

There is a Treasury requirement for public sector bodies to report arrangements whereby individuals are paid through their own companies and so are responsible for their own tax and National Insurance arrangements.

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2025, for more than £245[(1)] per day:

	Number
Number of existing engagements as of 31 March 2025	**4**
Of which, the number that have existed:	
for less than one year at the time of reporting	**4**
for between one and two years at the time of reporting	**0**
for between 2 and 3 years at the time of reporting	**0**
for between 3 and 4 years at the time of reporting	**0**
for 4 or more years at the time of reporting	**0**

Notes:

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

(2) All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual pays the right amount of Income Tax and National Insurance and, where necessary, that assurance has been sought.

(3) Of the 4 individuals outlined above, the individuals are employed by and on the payroll of an agency and therefore the off-payroll legislation does not apply.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2024 to 31 March 2025, for more than £245(1) per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2024 to 31 March 2025	4
Of which:	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35(2)	0
No. subject to off-payroll legislation and determined as out of scope of IR35(2)	4
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

Notes:

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

(2) A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2024 to 31 March 2025:

Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during reporting period	0
Total no. of individuals on payroll and off-payroll that have been deemed “Board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements.	7

Exit packages, including special (non-contractual) payments – subject to audit

Table 1: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	1	9,716	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	1	55,056	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 –£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	2	64,772	0	0	2	0	0	0

Redundancy and other departure cost have been paid in accordance with the provisions of NHS Business Services Authority. Exit costs in this note are accounted for in full in the year of departure. Where the NHS Lancashire and South Cumbria ICB has agreed early retirements, the additional costs are met by the NHS Lancashire and South Cumbria ICB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

As the above table indicates, there are no other (non-compulsory) departures agreed in 2024/25 and no departures where special payments have been made

Sam Proffitt

Accountable Officer

16th June 2025

Parliamentary Accountability and Audit Report

NHS Lancashire and South Cumbria is not required to produce a Parliamentary Accountability and Audit Report

Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report.

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF NHS LANCASHIRE & SOUTH CUMBRIA INTEGRATED CARE BOARD

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Lancashire & South Cumbria Integrated Care Board ("the ICB") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2025 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 23 April 2025 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the ICB in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis, as they have not been informed by the relevant national body of the intention to either cease the ICB's services or dissolve the ICB without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the ICB will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal as to the ICB's high-level policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the ICB by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls, in particular the risk that ICB management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. We therefore assessed that there was limited opportunity for the ICB to manipulate the income that was reported.

We did not identify any additional fraud risks.

In determining the audit procedures, we took into account the results of our evaluation of some of the ICB-wide fraud risk management controls.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual double entries to cash account codes and journals that reduced the reported accrued non-NHS expenditure.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board and other management (as required by auditing standards), and from inspection of the ICB's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the ICB is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of

compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the ICB is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the nature of the ICB's activities and its legal form. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management and inspection of regulatory and legal correspondence, if any. Therefore, if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2024/25.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 98, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the ICB or dissolve the ICB without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

The Accountable Officer is responsible for ensuring the regularity of expenditure and income.

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Basis for opinion on regularity

We conducted our work on regularity in accordance with Statement of Recommended Practice - Practice Note 10: *Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022)* issued by the FRC. We planned and performed procedures to obtain sufficient appropriate evidence to give an opinion over whether the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. The procedures selected depend on our judgement, including the assessment of the risks of material irregular transactions. We are required to obtain sufficient appropriate evidence on which to base our opinion.

Report on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

Significant weakness – financial sustainability

We have identified a significant weakness in arrangements to secure value for money in respect of financial sustainability due to the £64m overspend to the 2024/25 budget for All Age Continuing Care due to a variety of factors such as operational inefficiencies resulting in inappropriate referrals and misalignment between financial, operational wider management information which impeded effective forecasting of expected packages in the year. This has led to the ICB being a national outlier on several key metrics such as fast track referrals and conversion rates, and also having unclear funding arrangements with local authorities, leading to financial disputes.

Recommendation

We recommend that the ICB continues its work to ensure that it is not a national outlier on fast-track referrals and conversion rates, through a stricter screening process at the clinical level for referrals, as well as working to reduce inappropriate referrals. We also recommend the ICB clarifies its statutory responsibilities regarding packages of care and reaches robust agreement with local authorities to ensure it can appropriately forecast costs.

Significant weakness – governance

The ICB has been issued undertakings by NHS England ("NHSE") in relation to financial governance. This was in respect of the ICB's duties to manage the wider Lancashire and South Cumbria system ("LSC system") given the significant LSC system wide deficit and the significant further deterioration in the year, and concerns over the ICB's governance arrangements over provider financial plans. As a result, we have identified a significant weakness in respect of governance.

Recommendation

We recommend that the culture of system wide working and accountability is further embedded, to help ensure that providers are fully held accountable for delivery of savings programmes and any deterioration of financial position. Additionally, we recommend that the ICB fully captures the actions required and stakeholders to be engaged to ensure compliance with the NHSE issued undertakings.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 98, the Accountable Officer is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the ICB has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the ICB had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the ICB under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS Lancashire & South Cumbria Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, those matters we are required to state to them in

an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the ICB's accounts consolidation template for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of NHS Lancashire & South Cumbria Integrated Care Board for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.

Timothy Cutler
for and on behalf of KPMG LLP
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE
19 June 2025

ANNUAL ACCOUNTS

Data entered below will be used throughout the workbook:

Entity name:	NHS Lancashire and South Cumbria Integrated Care Board
This year	2024-25
Last year	2023-24
This year ended *	31 March 2025
Last year ended	31-March-2024
This year commencing:	01-April-2024
Last year commencing:	01-April-2023

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Income from sale of goods and services	3	(52,550)	(52,672)
Other operating income	3	(2,461)	(1,856)
Total operating income		**(55,011)**	**(54,528)**
Staff costs	5	57,538	45,099
Purchase of goods and services	6	5,354,455	4,606,539
Depreciation and impairment charges	6	362	362
Other operating expenditure	6	23,567	1,924
Total operating expenditure		**5,435,922**	**4,653,924**
Net Operating Expenditure		**5,380,911**	**4,599,396**
Finance expense	8	27	30
Net expenditure for the Year		**5,380,938**	**4,599,426**
Comprehensive Expenditure for the year		**5,380,938**	**4,599,426**

Statement of Financial Position as at 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Non-current assets:			
Right-of-use assets	9	2,659	3,021
Total non-current assets		**2,659**	3,021
Current assets:			
Inventories	11	7,669	7,302
Trade and other receivables	12	59,174	116,371
Cash and cash equivalents	13	1,089	1,605
Total current assets		**67,932**	**125,278**
Total assets		**70,591**	128,299
Current liabilities			
Trade and other payables	14	(225,140)	(259,331)
Lease liabilities	9	(346)	(356)
Total current liabilities		**(225,486)**	(259,687)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(154,895)**	(131,388)
Non-current liabilities			
Lease liabilities	9	(2,332)	(2,678)
Total non-current liabilities		**(2,332)**	**(2,678)**
Assets less Liabilities		**(157,227)**	(134,066)
Financed by Taxpayers' Equity			
General fund		(157,227)	(134,066)
Total taxpayers' equity:		**(157,227)**	(134,066)

The notes on pages 5 to 29 form part of this statement

The financial statements on pages 1 to 4 have been approved by the Board on 16 June 2025 and signed on its behalf by:

Sam Proffitt
Acting Chief Executive Officer

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2025

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 01 April 2024	(134,066)	(134,066)
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25		
Net operating expenditure for the financial year	(5,380,938)	**(5,380,938)**
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	**(5,380,938)**	**(5,380,938)**
Net funding	5,357,777	**5,357,777**
Balance at 31 March 2025	**(157,227)**	**(157,227)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2023-24		
Balance at 01 April 2023	(145,282)	**(145,282)**
Changes in NHS Integrated Care Board taxpayers' equity for 2023-24		
Net operating costs for the financial year	(4,599,426)	(4,599,426)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	**(4,599,426)**	**(4,599,426)**
Net funding	4,610,642	4,610,642
Balance at 31 March 2024	**(134,066)**	**(134,066)**

The notes on pages 5 to 29 form part of this statement

Statement of Cash Flows for the year ended 31 March 2025

	Note	**2024-25 £'000**	2023-24 £'000
Cash Flows from Operating Activities			
Total net expenditure for the financial year		(5,380,938)	(4,599,426)
Depreciation and amortisation	6	362	362
Interest paid / received		27	30
(Increase)/decrease in inventories	11	(367)	(1,010)
(Increase)/decrease in trade & other receivables	12	57,197	(58,574)
Increase/(decrease) in trade & other payables	14	(34,191)	49,384
Net Cash Inflow (Outflow) from Operating Activities		**(5,357,910)**	(4,609,234)
Net Cash Inflow (Outflow) before Financing		**(5,357,910)**	(4,609,234)
Cash Flows from Financing Activities			
Drawdown Funding Received		5,357,777	4,610,642
Repayment of lease liabilities		(383)	(383)
Net Cash Inflow (Outflow) from Financing Activities		**5,357,394**	4,610,259
Net Increase (Decrease) in Cash & Cash Equivalents	13	**(516)**	1,025
Cash & Cash Equivalents at the Beginning of the Financial Year		**1,605**	580
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**1,089**	1,605

The notes on pages 5 to 29 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Integrated Care Boards (ICBS) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Joint arrangements**

Arrangements over which the ICB has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the ICB is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

The ICB's pooled budget arrangements are considered to fall under the provisions of a joint operation.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

The ICB does not consider itself to be involved in any joint ventures.

1.5 **Pooled Budgets**

The ICB has entered into pooled budget arrangements with local authorities in Lancashire and Cumbria. Under the arrangements, funds are pooled in respect of services for adults with learning disabilities, services to support integrated hospital discharges and the Better Care Fund (BCF) initiative. The BCF is designed to create a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

Note 17 to the accounts provides details of the ICB's share of the assets, liabilities, income and expenditure for the ICB's pooled fund arrangements.

1.6 **Operating Segments**

The ICB considers itself to have one operating segment which is healthcare for its population.

1.7 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard, the ICB will not disclose information regarding the performance obligations part of a contract that has an original expected duration of one year or less,

• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICB is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Notes to the financial statements

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 **Other Expenses**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.10 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Notes to the financial statements

1.12 **Intangible Assets**

1.12.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.12.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.13 **Donated Assets**

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 **Non-current Assets Held For Sale**

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

Notes to the financial statements

1.16 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.16.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.16.2 **The ICB as Lessor**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases
When the group is an intermediate lessor, it accounts for the head lease and the sub-lease as two separate contracts. The sub-lease classification is assessed with reference to the right-of-use asset arising from the head lease.

Amounts due from lessees under finance leases are recognised as receivables at the amount of the ICB's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the net investment in the lease.

Rental income from operating leases is recognised on a straight-line basis over the term of the relevant lease.

1.17 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

1.18 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.19 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 4.03% (2023-24: 4.26%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 4.07% (2023-24: 4.03%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 4.81% (2023-24: 4.72%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 4.55% (2023-24: 4.40%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.20 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the ICB.

Notes to the financial statements

1.21 **Non-clinical Risk Pooling**

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.22 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.23 **Financial Assets**

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.23.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.23.2 **Financial assets at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

1.23.3 **Financial assets at fair value through profit and loss**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.23.4 **Impairment of financial assets**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 months expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.24 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.24.1 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.24.2 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Notes to the financial statements

1.25 **Value Added Tax**
Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.26 **Foreign Currencies**
The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB's surplus/deficit in the period in which they arise.

1.27 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the ICB has no beneficial interest in them.

1.28 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.29 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.29.1 **Critical accounting judgements in applying accounting policies**
There are no critical accounting judgements that management has made in the process of applying the ICB's accounting policies that would have a significant effect on the amounts recognised in the financial statements.

1.29.2 **Sources of estimation uncertainty**
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.
There are a number of accruals within the Statement of Financial Position where estimation techniques are applied. This is because the outturn information is not available at the time of preparation of the financial statements. Examples of significant accruals in the ICB's accounts involving estimates are prescribing and dental costs and all age continuing care costs.

1.30 **Gifts**
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.31 **New and revised IFRS Standards in issue but not yet effective**

● IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted. It is not expected that adoption of this standard would have a material impact on the ICB accounts.
● IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted
● IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.
● Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:
• Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
• Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.
These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:
• A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
• Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.
The impact of applying these changes in future periods has not yet been assessed. The ICB's right-of-use assets have a total book value of £2.658m as at 31 March 2025 and as such, any changes are not expected to be material to these financial statements.

2 Financial performance targets

The Integrated Care Board has a number of financial duties under the NHS Act 2006 (as amended).
Performance against those duties was as follows:

	2024-25 Target	2024-25 Performance	Target Achieved
	£000s	£000s	
Expenditure not to exceed income	5,435,949	5,435,949	Yes
Revenue resource use does not exceed the amount specified in Directions	5,380,938	5,380,938	Yes
Revenue administration resource use does not exceed the amount specified in Directions	32,922	29,720	Yes

There was no capital resource allocated to the ICB for its own capital projects in 2024-25.

	2023-24 Target	2023-24 Performance	Target Achieved
	£000s	£000s	
Expenditure not to exceed income	4,565,008	4,653,954	No
Revenue resource use does not exceed the amount specified in Directions	4,510,480	4,599,426	No
Revenue administration resource use does not exceed the amount specified in Directions	36,090	26,816	Yes

There was no capital resource allocated to the ICB for its own capital projects in 2023-24.

In 2023-24, the ICB, in line with the financial position discussed with NHS England, delivered a deficit position of £89m and therefore utilsed more resource in year than was allocated to it. This was a breach of the ICB's financial duty to spend within its revenue resource limit and resulted in the ICB's external auditors issuing both a qualified regularity opinion and a referral to the Secretary of State under Section 30(b) of the Local Audit and Accountability Act 2014.

3 Other Operating Revenue

	2024-25 Total £'000	2023-24 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**0**	742
Non-patient care services to other bodies	**1,041**	2,789
Prescription fees and charges	**25,643**	24,706
Dental fees and charges	**25,702**	24,331
Other Contract income	**164**	104
Total Income from sale of goods and services	**52,550**	52,672
Other operating income		
Other non contract revenue	**2,461**	1,856
Total Other operating income	**2,461**	1,856
Total Operating Income	**55,011**	54,528

4.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
Source of Revenue				
NHS	0	0	0	150
Non NHS	1,041	25,643	25,702	15
Total	**1,041**	**25,643**	**25,702**	**165**

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
Timing of Revenue				
Point in time	1,041	25,643	25,702	165
Total	**1,041**	**25,643**	**25,702**	**165**

4.2 Fees and Charges

NHS England certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. The following table provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

2024/25	Note	Income £000	Full Cost £000	Surplus/ (deficit) £000
Dental	3 & 6	25,702	(135,528)	(109,826)
Prescription	3 & 6	25,643	(420,182)	(394,539)
Total fees and charges		**51,345**	**(555,710)**	**(504,365)**

2023/24	Note	Income £000	Full Cost £000	Surplus/ (deficit) £000
Dental	3 & 6	24,331	(109,826)	(85,495)
Prescription	3 & 6	24,706	(411,512)	(386,806)
Total fees and charges		**49,037**	**(521,338)**	**(472,301)**

The fees and charges information in this note is provided in accordance with the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for International Financial Reporting Standards (IFRS) 8 purposes.

The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. From 1 May 2024, the NHS prescription charge for each medicine or appliance dispensed increased to £9.90 (2023/24 and up until 30 April 2024, £9.65). However, around 90% of prescription items are dispensed free each year where patients are exempt from charges*. In addition, patients who were eligible to pay charges could purchase pre-payment certificates from 1 May 2024 at £32.05 (2023/24 and up until 30 April 2024, £31.25) for 3 months or £114.50 (2023/24 and up until 30 April 2024, £111.60) for a year. A number of other charges were payable for wigs and fabric supports.

Those who are not eligible for exemption are required to pay NHS dental charges which fall into 3 bands depending on the level and complexity of care provided. In 2024/25, the charge for Band 1 treatments was £26.80 (2023/24 £25.80), for Band 2 was £73.50 (2023/24 £70.70) and for Band 3 was £319.10 (2023/24 £306.80).

** Prescriptions Dispensed in the Community - Statistics for England, 2007 - 2017*
https://digital.nhs.uk/data-and-information/publications/statistical/prescriptions-dispensed-in-the-community

5. Employee benefits and staff numbers

5.1 Employee benefits

	2024-25		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	41,244	2,004	**43,248**
Social security costs	4,783	-	**4,783**
Employer Contributions to NHS Pension scheme	9,240	-	**9,240**
Apprenticeship Levy	202	-	**202**
Termination benefits	65	-	**65**
Employee benefits expenditure	**55,534**	**2,004**	**57,538**

	2023-24		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	30,614	4,267	**34,881**
Social security costs	3,770	-	**3,770**
Employer Contributions to NHS Pension scheme	5,989	-	**5,989**
Apprenticeship Levy	150	-	**150**
Termination benefits	309	-	**309**
Employee benefits expenditure	40,832	4,267	**45,099**

5.2 Average number of people employed

	Permanently employed Number	Other Number	Total Number
2024-25 Total	**755.88**	**20.74**	**776.62**
2023-24 Total	**572.97**	**42.76**	**615.73**

There has been an increase in permanent whole-time equivalents employed by the ICB in 2024/25 and a reduction of whole-time equivalent staff not employed on permanent contracts, classified as 'Other'. Some of the staff classified as 'Other' in 2023/24 have become permanent in 2024/25. The increase in permanent whole time equivalents is also due to movement of staff into the ICB under the Transfer of Undertakings (Protection of Employment) regulations (TUPE), for a number of service areas, including Medicines Management, Governance and Compliance and System Resilience/Gold Command teams.

5.3 Exit packages agreed in the financial year

	2024-25 Compulsory redundancies		**2024-25 Other agreed departures**		**2024-25 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	1	9,716	0	0	1	9,716
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	1	55,056	0	0	1	55,056
£100,001 to £150,000	0	0	0	0	0	0
Total	**2**	**64,772**	**0**	**0**	**2**	**64,772**

	2023-24 Compulsory redundancies		2023-24 Other agreed departures		2023-24 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	2	3,700	2	3,700
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	1	42,329	1	42,329
£50,001 to £100,000	0	0	2	140,000	2	140,000
£100,001 to £150,000	1	122,801	0	0	1	122,801
Total	**1**	**122,801**	**5**	**186,029**	**6**	**308,830**

Analysis of Other Agreed Departures

	2024-25 Other agreed departures		2023-24 Other agreed departures	
	Number	**£**	Number	£
Mutually agreed resignations (MARS) contractual costs	0	0	4	184,629
Contractual payments in lieu of notice	0	0	1	1,400
Total	**0**	**0**	**5**	**186,029**

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change.

Exit costs are accounted for in accordance with relevant accounting standards and in full in the year of departure.

Where entities have agreed early retirements, the additional costs are met by NHS Entities and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.
The ICB has had no early retirements on the grounds of ill-health during 2024-25 (one, 2023-24). The estimated resulting additional pension liability borne by the NHS Pension Scheme is nil (£32k, 2023-24).

5.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.
An outline of these follows:

5.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

5.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

6. Operating expenses

	2024-25 Total £'000	2023-24 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	19,734	17,007
Services from foundation trusts	2,461,988	2,000,551
Services from other NHS trusts	961,812	857,082
Purchase of healthcare from non-NHS bodies	784,491	683,253
Purchase of social care	107,948	94,750
General Dental services and personal dental services	135,528	109,826
Prescribing costs	346,149	344,114
Pharmaceutical services	74,033	67,398
General Ophthalmic services	18,931	17,986
GPMS/APMS and PCTMS	404,066	375,879
Supplies and services – clinical	(1,466)	402
Supplies and services – general	7,342	9,126
Consultancy services	3,601	619
Establishment	6,836	6,441
Transport	119	(6)
Premises	18,198	17,691
Audit fees	247	241
Other non statutory audit expenditure		
· Internal audit services	148	115
· Other services	50	50
Other professional fees	3,332	3,005
Legal fees	1,153	798
Education, training and conferences	215	211
Total Purchase of goods and services	**5,354,455**	**4,606,539**
Depreciation and impairment charges		
Depreciation	362	362
Total Depreciation and impairment charges	**362**	**362**
Other Operating Expenditure		
Chair and Non Executive Members	213	218
Grants to Other bodies	357	1,705
Expected credit loss on receivables	22,936	0
Other expenditure	61	1
Total Other Operating Expenditure	**23,567**	**1,924**
Total operating expenditure	**5,378,384**	**4,608,825**

The Integrated Care Board's contract with its external auditors (KPMG LLP) provides for a limitation of the auditor's liability. The principal terms of this limitation are as follows:
Liability for all defaults resulting in direct loss or damage to the property of the other party shall be subject to a limit of £1M. In respect of all other defaults, claims, losses or damages the liability shall not exceed £1M.

7 Payment Compliance Reporting

7.1 Better Payment Practice Code

Measure of compliance	2024-25 Number	2024-25 £'000	2023-24 Number	2023-24 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	130,933	1,640,543	144,970	1,339,247
Total Non-NHS Trade Invoices paid within target	129,765	1,596,999	144,334	1,299,531
Percentage of Non-NHS Trade invoices paid within target	**99.11%**	**97.35%**	**99.56%**	**97.03%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,792	3,760,394	4,400	2,886,150
Total NHS Trade Invoices Paid within target	4,669	3,719,996	4,275	2,873,853
Percentage of NHS Trade Invoices paid within target	**97.43%**	**98.93%**	**97.16%**	**99.57%**

8 Finance costs

	2024-25 £'000	2023-24 £'000
Interest		
Interest on lease liabilities	27	30
Total interest	**27**	**30**
Total finance costs	**27**	**30**

9 Leases

The ICB's right-of-use assets and associated lease liabilities reflect lease arrangements associated with ICB headquarters accommodation.

All right-of-use assets and associated lease liabilities are with external counterparties i.e. outside of the NHS and DHSC group.

9.1 Right-of-use assets

2024-25	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2024	3,385	3,385
Accumulated depreciation at 01 April 2024	364	364
Net Book Value at 01 April 2024	**3,021**	**3,021**
Depreciation charged during the year	**362**	**362**
Accumulated depreciation at 31 March 2025	726	726
Net Book Value at 31 March 2025	**2,659**	**2,659**

9.2 Lease liabilities

	2024-25 £'000	2023-24 £'000
Lease liabilities at 01 April 2024	(3,034)	(3,387)
Interest expense relating to lease liabilities	(27)	(30)
Repayment of lease liabilities (including interest)	383	383
Lease liabilities at 31 March 2025	**(2,678)**	**(3,034)**

9.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2024-25 £'000	2023-24 £'000
Within one year	(368)	(384)
Between one and five years	(1,427)	(1,440)
After five years	(1,083)	(1,440)
Balance at 31 March 2025	**(2,878)**	**(3,264)**

9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2024-25 £'000	2023-24 £'000
Depreciation expense on right-of-use assets	362	362
Interest expense on lease liabilities	27	30

9.5 Amounts recognised in Statement of Cash Flows

	2024-25 £'000	2023-24 £'000
Total cash outflow on leases under IFRS 16	383	383

10 Intangible non-current assets

2024-25	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2024	**188**	**188**
Disposals other than by sale	(188)	(188)
Cost / Valuation At 31 March 2025	**0**	**0**
Amortisation 01 April 2024	**188**	**188**
Disposals other than by sale	(188)	(188)
Amortisation At 31 March 2025	**0**	**0**
Net Book Value at 31 March 2025	**0**	**0**

11 Inventories

	Loan Equipment £'000	Total £'000
Balance at 01 April 2024	7,302	**7,302**
Additions	367	**367**
Balance at 31 March 2025	**7,669**	**7,669**

12.1 Trade and other receivables

	Current 2024-25 £'000	Current 2023-24 £'000
NHS receivables: Revenue	8,044	2,314
NHS prepayments	345	260
NHS accrued income	1,016	161
Non-NHS and Other WGA receivables: Revenue	50,030	78,014
Non-NHS and Other WGA prepayments	894	560
Non-NHS and Other WGA accrued income	20,956	20,545
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	249	14,095
Expected credit loss allowance-receivables	(22,912)	0
VAT	538	415
Other receivables and accruals	14	7
Total Trade & other receivables	**59,174**	**116,371**

12.2 Receivables past their due date but not impaired

	2024-25 DHSC Group Bodies £'000	**2024-25 Non DHSC Group Bodies £'000**	2023-24 DHSC Group Bodies £'000	2023-24 Non DHSC Group Bodies £'000
By up to three months	329	7,587	3,444	30,080
By three to six months	931	1,537	69	8,008
By more than six months	62	39,383	39	23,227
Total	**1,322**	**48,507**	**3,552**	**61,315**

12.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	**Total**
	£'000	**£'000**
Balance at 01 April 2024	0	0
Lifetime expected credit losses on trade and other receivables-Stage 2	(22,912)	**(22,912)**
Lifetime expected credit losses on trade and other receivables-Stage 3	(25)	**(25)**
Amounts written off	25	**25**
Total	**(22,912)**	**(22,912)**

13 Cash and cash equivalents

	2024-25	2023-24
	£'000	£'000
Balance at 01 April 2024	1,605	580
Net change in year	(516)	1,025
Balance at 31 March 2025	**1,089**	**1,605**
Made up of:		
Cash with the Government Banking Service	1,089	1,605
Cash and cash equivalents as in statement of financial position	**1,089**	**1,605**
Balance at 31 March 2025	**1,089**	**1,605**

14 Trade and other payables	**Current 2024-25 £'000**	Current 2023-24 £'000
NHS payables: Revenue	22,738	40,610
NHS accruals	11,182	11,116
Non-NHS and Other WGA payables: Revenue	76,741	81,149
Non-NHS and Other WGA accruals	102,212	116,270
Social security costs	596	536
Tax	668	569
Other payables and accruals	11,003	9,081
Total Trade & Other Payables	**225,140**	**259,331**

Other payables include £2,996k outstanding pension contributions at 31 March 2025 (31 March 2024: £2,658k).

15 Contingencies

15.1 Contingent Liabilities

As at 31 March 2025, the ICB has a legal claim against it in respect of a multi-ICB procurement for the provision of healthcare waste collection and disposal services for primary care settings.

Any potential obligation or liability that may arise following legal proceedings is not yet confirmed.

The ICB had no contingent liabilities as at 31 March 2024.

16 Financial instruments

16.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the Integrated Care Board's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the Integrated Care Board and internal auditors.

16.1.1 Currency risk

The Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Integrated Care Board has no overseas operations and therefore has low exposure to currency rate fluctuations.

16.1.2 Interest rate risk

The Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Integrated Care Board therefore has low exposure to interest rate fluctuations.

16.1.3 Credit risk

Because the majority of the Integrated Care Board revenue comes from parliamentary funding, the Integrated Care Board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

16.1.4 Liquidity risk

The Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The Integrated Care Board draws down cash to cover expenditure, as the need arises. The Integrated Care Board is not, therefore, exposed to significant liquidity risks.

16.1.5 Financial Instruments

As the cash requirements of the Integrated Care Board are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the Integrated Care Board's expected purchase and usage requirements and the Integrated Care Board is therefore exposed to little credit, liquidity or market risk.

16 Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost 2024-25 £'000	**Total 2024-25 £'000**	Total 2023-24 £'000
Trade and other receivables with NHSE bodies	4,481	4,481	292
Trade and other receivables with other DHSC group bodies	5,147	5,147	23,810
Trade and other receivables with external bodies	70,682	70,682	91,034
Cash and cash equivalents	1,089	1,089	1,605
Total at 31 March 2025	**81,399**	**81,399**	116,741

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2024-25 £'000	**Total 2024-25 £'000**	Total 2023-24 £'000
Trade and other payables with NHSE bodies	2,034	**2,034**	702
Trade and other payables with other DHSC group bodies	31,917	**31,917**	51,384
Trade and other payables with external bodies	192,602	**192,602**	209,175
Total at 31 March 2025	**226,553**	**226,553**	261,261

17 Joint arrangements - interests in joint operations

The ICB has entered into pooled budget arrangements for services for adults with learning disabilities, services to support integrated hospital discharges and Better Care Fund (BCF). The BCF is an integrated commissioning approach between local authorities and the ICB to help jointly plan and deliver local services.

The ICB's share of the assets, liabilities, income and expenditure handled by the pooled budget in the accounting period were:

			Amounts recognised in Entities books ONLY 2024-25				Amounts recognised in Entities books ONLY 2023-24			
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	*Assets*	*Liabilities*	*Income*	*Expenditure*	*Assets*	*Liabilities*	*Income*	*Expenditure*
			£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Learning Disabilities Pool	Lancashire County Council NHS Lancashire and South Cumbria Integrated Care Board	Services for Adults with Learning Disabilities	0	0	(480)	2,313	0	0	(2,112)	9,458
Better Care Fund	Lancashire County Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Lancashire County Council	0	0	(77,759)	113,768	0	0	(73,594)	117,572
Better Care Fund	Blackpool Borough Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Blackpool Borough Council	0	0	(8,695)	36,512	0	0	(18,098)	35,647
Better Care Fund	Blackburn with Darwen Borough Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Blackburn with Darwen Borough Council	(600)	0	(6,973)	17,151	0	(2,050)	(5,566)	15,171
Hospital Discharge Fund	Lancashire County Council NHS Lancashire and South Cumbria Integrated Care Board	Services to support integrated hospital discharges	(11,167)	11,167	(11,167)	11,167	(5,351)	6,065	(5,351)	6,065
Hospital Discharge Fund	Blackpool Borough Council NHS Lancashire and South Cumbria Integrated Care Board	Services to support integrated hospital discharges	0	0	(1,572)	1,572	0	0	(837)	837
Hospital Discharge Fund	Blackburn with Darwen Borough Council NHS Lancashire and South Cumbria Integrated Care Board	Services to support integrated hospital discharges	(1,153)	1,153	(1,153)	1,153	(353)	353	(353)	353
Learning Disabilities Pool	Westmorland and Furness Council NHS Lancashire and South Cumbria Integrated Care Board	Services for Adults with Learning Disabilities	0	0	0	0	0	0	0	2,078
Hospital Discharge Fund	Westmorland and Furness Council NHS Lancashire and South Cumbria Integrated Care Board	Services to support integrated hospital discharges	(2,198)	2,198	(2,198)	2,198	(1,923)	1,923	(1,923)	1,923
Better Care Fund	Cumberland Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Cumberland Council	0	0	0	603	0	0	0	571
Better Care Fund	Westmorland and Furness Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Westmorland and Furness Council	0	0	0	9,333	0	0	0	8,727

18 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Emma Woollett - Non-Executive Member - NHS Confederation	33	0	0	0
Sheena Cumiskey - Non-Executive Member - NHS Confederation	33	0	0	0
Sheena Cumiskey - Non-Executive Member - The Value Circle	58	0	0	0
Professor Jane O'Brien - Non-Executive Member - Lancaster University	266	0	0	0
Dr Julie Colclou - Partner Member for Primary Care - General Practice Cartmel Surgery	989	0	28	0
Dr Julie Colclou - Partner Member for Primary Care - Grange and Lakes Primary Care Centre	1,547	0	0	(6)
Aaron Cummins - Partner Member for NHS Trust/Foundation Trust - Chief Executive Officer of University Hospitals Morecambe Bay NHS Foundation Trust	506,472	0	5,546	(374)
Chris Oliver - Partner Member Mental Health - Chief Executive Officer of Lancashire and South Cumbria NHS Foundation Trust	472,699	(64)	8,529	(729)

The above table identifies the interests and related transactions of individuals who have been ICB Board Members during 2024-25, where a financial transaction has been identified between the ICB and the organisation identified as an interest.

Please note that the above figures represent the total value of transactions between the ICB and the organisations identified as an interest. The values do not represent transactions with the individuals named.

18 Related party transactions continued

The Department of Health and Social Care is regarded as a related party.
During the period the ICB had a significant number of material transactions with entities for which the Department is regarded as the parent Department.
Those bodies not already included in the previous table with transactions greater than £1 million are:

NHS North East and North Cumbria ICB
NHS Cheshire and Merseyside ICB
NHS Midlands and Lancashire CSU
East Lancashire Hospitals NHS Trust
The Leeds Teaching Hospitals NHS Trust
North West Ambulance Service NHS Trust
Mersey and West Lancashire Teaching Hospitals NHS Trust
Airedale NHS Foundation Trust
Alder Hey Children's NHS Foundation Trust
Ashford & St Peter's Hospitals NHS Foundation Trust
Blackpool Teaching Hospitals NHS Foundation Trust
Bolton NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
North Cumbria Integrated Care NHS Foundation Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Liverpool Heart & Chest Hospital NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
Manchester University NHS Foundation Trust
Mersey Care NHS Foundation Trust
Northern Care Alliance NHS Foundation Trust
The Christie NHS Foundation Trust
The Clatterbridge Cancer Centre NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
The Walton Centre NHS Foundation Trust
Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust
Community Health Partnerships

In addition, the ICB has had a number of transactions with other government departments and other central and local government bodies. Government bodies with transactions greater than £1 million that are not already included in the previous table are:

Lancashire County Council
Blackburn with Darwen Borough Council
Blackpool Borough Council
Cumberland Council
Westmorland and Furness Council
Home Office

19 Events after the end of the reporting period

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged but they have been tasked with significant reductions in their cost base.

Discussions are ongoing on the impact of these and the impact of staffing reductions, together with the costs and approvals of any exit arrangements. ICBs are currently being asked to implement any plans during quarter 3 of the 2025/26 financial year.

20 Losses and special payments

Losses

The total number of NHS integrated care board losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2024-25 Number	**Total Value of Cases 2024-25 £'000**	Total Number of Cases 2023-24 Number	Total Value of Cases 2023-24 £'000
Administrative write-offs	15	25	0	0
Fruitless payments	2	0	0	0
Cash losses	2	55	0	0
Total	**19**	**80**	**0**	**0**

Special payments

	Total Number of Cases 2024-25 Number	**Total Value of Cases 2024-25 £'000**	Total Number of Cases 2023-24 Number	Total Value of Cases 2023-24 £'000
Compensation payments	0	0	1	1
Ex Gratia Payments	2	5	0	0
Total	**2**	**5**	**1**	**1**