NHS
Lancashire and South Cumbria
Integrated Care Board

Subject to approval at the next meeting

Minutes of a Meeting of the Integrated Care Board Held in Public on Thursday, 25 September 2025 at 1.00pm in the Lune Meeting Room, ICB Offices, Level 3 Christ Church Precinct, County Hall, Preston, PR1 8XB

Part 1

	Name	Job Title
Members	Emma Woollett	Chair
	Sheena Cumiskey	Deputy Chair/Non-Executive Member
	Roy Fisher	Non-Executive Member
	Jim Birrell	Non-Executive Member
	Debbie Corcoran	Non-Executive Member
	Sam Proffitt	Acting Chief Executive
	Stephen Downs	Acting Chief Finance Officer
	Dr Andy Knox	Acting Medical Director
	Dr Julie Colclough	Partner Member – Primary Care
	Chris Oliver	Partner Member – Trust/Foundation Trust – Mental Health
Regular Participants	Debbie Eyitayo	Chief People Officer
	Professor Craig Harris	Chief Operating Officer & Chief Commissioner
	Asim Patel	Chief Digital Officer
	Debra Atkinson	Company Secretary/Director of Corporate Governance
	Neil Greaves	Director of Communications and Engagement
	David Blacklock	Healthwatch
	Tracy Hopkins	Voluntary, Community, Faith and Social Enterprise Sector
	Dr Sakthi Karunanithi	Director of Public Health (Lancashire County Council)
	Cath Whalley	Director of Adult Services (Blackpool)
In attendance	Mark Bakewell	Interim Chief Finance Officer (wef 1 October 2025)
	Davina Upson	Board Secretary and Governance Manager
	Jennifer Riley	ICB Associate Director Population Health and Place Delivery (Blackpool)
	Amy Butler	Healthwatch Blackpool

Ref	Item
114/25	*Prior to the commencement of the meeting, five colleagues involved in the NWAS UNISON pay dispute approached the Chair to discuss their position and express their concerns. During this engagement, they provided a letter outlining their stance on the matter, which the Chair received and agreed to review the content to better understand their position.* **<u>Welcome and Introductions</u>** The Chair, Emma Woollett, opened the meeting and welcomed everyone, thanking the members of the public who were observing the Board meeting either in person or through the live stream.

	The Chair noted that this meeting marked the final attendance at the ICB Board held in Public for S Proffitt, Acting Chief Executive Officer, who was due to leave the ICB on 31 October 2025. The Chair took the opportunity to publicly express appreciation for S Proffitt's leadership, highlighting the integrity and compassion with which she had guided the system and acknowledged that she would leave the ICB in a stronger position due to the positive impact of her leadership. The Chair also extended her thanks to S Downs for stepping into the role of Acting Chief Finance Officer and commended him for guiding the organisation with clarity and integrity, expressing appreciation for his contributions to the Board and the wider system. The Chair welcomed M Bakewell, who would formally commence as Interim Chief Finance Officer with effect from 1 October 2025 and was in attendance as an observer at today's meeting. In addition, she noted that J Scattergood had taken up post as Acting Chief Nurse and S Nicholls would join the Board as the Partner Member for Acute Trusts, further to the departure of A Cummins, who stepped down as Partner Member ahead of commencing in post as the ICB Chief Executive Officer from 1 November 2025. Jennifer Riley, ICB Associate Director Population Health and Place Delivery (Blackpool) and Amy Butler, Manager for Healthwatch Blackpool were also welcomed to the meeting noting that they were in attendance for the agenda item on the community experience. The Chair advised that, due to the Integrated Care Board's Annual General Meeting scheduled to commence at 4:30pm, the Board meeting must conclude promptly at the agreed time of 4:00pm.
115/25	**<u>Apologies for Absence/Quoracy of Meeting</u>** Apologies for absence had been received from Non-executive Members S Igoe and J O'Brien; J Scattergood, Acting Chief Nurse; Regular Participant D Park, Partner Member – Local Authorities and regular participants V Gent, Director of Children's Services (Blackpool) and Steve Spill, Associate Non-Executive. The meeting was quorate.
116/25	**<u>Declarations of Interest</u>** **RESOLVED: That no declarations were noted which related to the business items on the agenda. The Chair would be advised of any conflicts that arise during the meeting as appropriate.** **Board Register of Interests -** Noted.
117/25	**a) <u>Minutes of the Board Meeting Held on 24 July 2025, Matters Arising and Action Log</u>** J Birrell requested that an alteration was made to minute reference 102/25 to include *12-hour trolley waits* in addition to virtual wards. **RESOLVED: That the minutes of the meeting held on 24 July 2025 be approved as a correct record with the above amendment.**

	Matters Arising and Action Log Reference 16: Board papers to reflect the voice of communities With the update provided that a revised reporting template had been devised to include a specific section relating to public and stakeholder engagement it was agreed to close the action. Reference 17: ICB Values The Chair commented that there were two parts to this action: a) That a one-year review to assess how the values were being upheld would take place through the People and Culture Committee with the OD plan being presented at the October 2025 meeting. b) Consideration to be given to incorporating values and reflections at the end of each Board meeting against the decisions taken. The Chair proposed that this formed the discussion which all Board members undertook via the Board debrief session. Members agreed to close the action with this update. Reference 18: Performance Metrics to articulate improved health outcomes Members agreed to close the action, noting that the new integrated performance report was presented to the Quality and Outcomes Committee which integrated performance with quality and inequalities data. **RESOLVED: That the action log be updated accordingly.**
118/25	**Community Experience /Story** A Knox introduced the item which focused on an initial pilot that had been undertaken in the Claremont Ward in Blackpool. He commented that the work undertaken highlighted how the ICB was prioritising patient and resident experiences to inform decision-making and improve health and wellbeing across Lancashire and South Cumbria. Jennifer Riley and Amy Butler presented the work of the pilot noting that this approach had been supported through proactive outreach and highlighted: - That the Claremont Ward faced significant socio-economic challenges, including low life expectancy, high disability rates, and elevated levels of preventable deaths and unemployment. - The work was a partnership between the ICB, local government, NHS, voluntary sector, and the community, and was integral to addressing health inequalities and shaping commissioning intentions. - A 16-week pilot in Claremont introduced a proactive, outreach-based population health approach, with Healthwatch leading door-knocking and engagement. Which had led to: • Improved collaboration between services, • Better understanding of community needs and barriers, • Direct support for residents previously not accessing services. • Work and support undertaken through a multi-disciplinary team (MDT) approach which had equal roles to providing support to the community. - Early results: 576 doors knocked, 55 people received ongoing support, and 40% of targeted individuals were, as a result of the intervention, now accessing new services. - The approach was being expanded to other areas, with lessons learned informing the wider Neighbourhood Health Implementation Programme. The Chair reflected on the value of sharing stories at the start of Board meetings, noting that they served as a powerful reminder of the purpose of the Board. She expressed appreciation

	for the update and particularly referenced the use of MDTs and the emphasis on equal roles within those teams. She acknowledged that assessing the impact of the pilots was essential and recognised that these approaches could be scaled and adapted to meet the diverse needs of different communities. J Birrell welcomed the detail which had been shared and commented on the value in illustrating the delivery of care. He was encouraged to hear about the proposed wider rollout. He observed that resource implications were not mentioned within the presentation, and therefore he queried whether this had been a factor in the initiative. It was confirmed that funding had been received from the core population health budget to support a 12-week test of change programme and this was currently being delivered within existing budgets, however it was noted that future programmes may require a review related to how they were resourced. R Fisher commented that Claremont Ward was one of the seven wards participating in the Better Start scheme and he acknowledged the importance of understanding the impact of this initiative on Children and Young People and their families within the ward specifically related to deprivation. D Eyitayo expressed an interest in the team and organisational culture, noting that the current approach was a strong example of an integrated workforce operating across organisational boundaries and queried how this model had been made to work effectively. A Butler advised that one of the support officers involved in the project was a resident in Claremont and provided 'lived experience' which had been highly valued and had helped shape the culture from the outset. T Hopkins reflected on the success of the project which she attributed to the enthusiasm shown by the team. She recognised that the success of this project highlighted how challenges often related to how services were organised and emphasised that true integration required empowerment to break down barriers and foster a more responsive and person-centred approach. T Hopkins further commented that future resource planning should be informed by a deeper understanding of how services were designed to meet people's needs, ensuring that investment decisions were aligned with community priorities. C Oliver advised of the resource available with the Initial Response Service (IRS) and suggested exploring opportunities to join up teams and services to improve visibility and access. C Whalley also expressed her interest in having a conversation linked to opportunities for joint initiatives. **RESOLVED: That the ICB Board noted the presentation.** *A Butler and J Riley left the meeting.*
119/25	**<u>Chair's Report</u>** The report provided an update for the Board on the engagement and work undertaken by the Chair. The Chair acknowledged that the past few months had been a very challenging time for everyone, as the ICB had to address the issues raised in the Undertakings and through the Recovery and Support Programme (RSP) as well as dealing with the uncertainties associated with the transition to the Model ICB and ensuring all 'day jobs' were undertaken. She expressed pride in the way the Executive Team and staff across the organisation had responded to these pressures, demonstrating resilience, commitment, and a clear focus on the ICB's purpose.

	She noted that this dedication was beginning to pay dividends. The Chair commented that despite the ongoing risks the ICB remained on track to delivering the plan it had committed to, and feedback from the RSP team and Region was very positive regarding the improvements in governance and delivery. She was mindful that uncertainties remained about the ICB transition, particularly in relation to timing, but noted that significant progress had been achieved related to understanding the different functions required and how these would interact. She noted that continued evolution of this understanding would take place through the engagement processes that were currently underway. The Chair noted that the engagement with staff over the next month was critical to allow an explanation of the thinking and to gather insights from front line colleagues, which would help shape an organisation that delivered for the population and provided a meaningful and enjoyable working environment for all staff. She noted the importance of the values which were committed to as a Board in a previous meeting and commended the improving position as a testament to collective commitment. **RESOLVED: That the ICB Board note the report.**
120/25	**<u>Report of the Chief Executive</u>** S Proffitt expressed her thanks for the support which she had received from providers, partners, and the Executive Team whilst she had been in the Acting CEO position. She extended a warm welcome to M Bakewell as the Interim Chief Finance Officer and offered her best wishes to S Downs for his future role. S Proffitt spoke to the circulated report and highlighted key pieces of work which had been undertaken during the reporting period, acknowledging that the current change process represented a significant reset across the NHS. She commented on the positive momentum generated by the 10-Year health plan and associated regional blueprints and that these developments were helping to shape the future direction of the ICB as it evolved into a strategic commissioner. S Proffitt noted the impact these changes were having on staff and expressed her sincere thanks to all colleagues for their continued commitment in maintaining focus and driving improvement. She recognised that tangible progress was being seen, with delivery remaining on plan and a strong emphasis being placed on the prevention agenda. She shared her reflections further to her recent visit to Derian House and expressed how the experience underscored the vital role of the hospice community and the profound impact of the work they undertook. She encouraged colleagues to watch a film titled “The Little Things”, created by Paul Woodward, which captured the essence of hospice care and its importance to individuals and families. Dr S Karunanithi expressed his thanks to S Proffitt for the work she had undertaken with partners and leading the ICB. **RESOLVED: That the ICB Board note the report.**
121/25	**<u>Reporting from People and Culture Committee</u>** Due to apologies being received from J O’Brien, R Fisher provided an update from the People and Culture Committee held on 16 July 2025 and highlighted: **Alert: Risk SO3/BAF ICB 003 to recruit and retain a stable workforce** - The committee

	had recognised this as a risk across the system with widening conversations around the fragility and how L&SC determined work and future work around this. This had been escalated to NHSE and the Board noted that the committee would monitor the risk with the changes to the ICB and roles. **Alert: Research and Innovation –** The Board noted that collaboration was being discussed with Greater Manchester and Cheshire and Mersey ICBs further to the committee recognising the importance of research, which needed to be driven by the ICB Board and Executive team by empowering teams to work more with academia. **Alert: Transition Plan –** Noted that the committee received an update to the transition position. There was a delay due to NHSE confirming a number of matters. 47% reduction would mean approximately circa 400 wte reduction, undertaken in phases. R Fisher advised that the immediate priorities for the People and Culture Committee were to support staff morale, health and well-being as the ICB transitioned to a new model ICB and to be assured that the transition was well-managed and there was an effective transfer of system responsibilities to region. He commented that the lack of certainty on the transition implications, which was a situation outside ICB control, was having a negative impact against a background of already low morale. It was noted that the committee would receive a deep dive on health and well-being to be assured of implementation of the improvement plan. Similarly, he advised the committee awaited clarity on which ICB workforce responsibilities would transfer to region and highlighted the need to ensure system-wide working continued and relationships were maintained. R Fisher advised that the committee had identified a risk that the short-term focus on restructuring may divert the ICB from thinking longer term about strategic objectives related to workforce across the system, which would include recruitment and retention challenges in key services. **Assure:** The EDI annual report was recommended for approval at the last Board meeting and the committee would receive an EDI action plan as well as an update on the People plan at the next meeting. **RESOLVED: That the ICB Board note the update from the ICB People and Culture Committee meeting held on 16 July 2025.**
122/25	**<u>Working with People and Communities - Insight Report</u>** N Greaves presented the report which described the proactive engagement and involvement activity. He highlighted: - On Friday 4 July, the Shaping Care Together joint committee, led by NHS Lancashire and South Cumbria ICB and NHS Cheshire and Merseyside ICB, kickstarted a 13-week consultation on the location of A&E services across Southport, Formby and West Lancashire to allow members of the public and stakeholders views to be heard. The communications team had visited more than 42 different venues or services across West Lancashire including family hubs, community centres, libraries, NHS venues and GP practices. - A petition had been received regarding provision of critical care at Furness General Hospital (FGH) signed by 13,000 individuals who opposed the proposals to permanently suspend Level 3 intensive care at FGH and to treat and transfer level 3 patients to the site at Lancaster. The ICB had committed to an eight-week period of engagement to reassure people in South Cumbria about the safety and sustainability of services. - At the last Board meeting a question was posed regarding links between patient experience teams and it was noted that the section relating to learning from patient

	experiences and complaints linked to this. During the period 1 April to 31 August 2025, the ICB received 891 complaints and MP letters which was an increase of 18% on the previous period 2024/25. Assurances were provided that significant work was being undertaken to ensure that lessons were learnt. - Feedback received from the ICB's group of citizen advisors had been that Patient Participation Groups (PPGs) were valuable in supporting involvement at a local level to support general practice and work in neighbourhoods. T Hopkins welcomed the broader remit of the work being undertaken, noting that it extended beyond patient-focused concerns. She expressed support for the inclusive approach, highlighting the value of engaging through alternative routes, which she felt would significantly enhance the consultation process. S Proffitt reflected on the community experience presentation earlier in the agenda and noted its relevance to the development of a new operating model for the ICB as a strategic commissioner. She recognised the proposed new model required a clear understanding of the population health needs to enable services to be commissioned accordingly and emphasised the importance of gathering intelligence through the engagement processes. N Greaves commented on the importance of identifying trends across the system and advised that the commissioning intentions this year had been informed by the public voice through the engagement work which had been undertaken. He also acknowledged that collaborative work had improved which allowed for genuine outreach with teams including the cancer team and women's health who were actively engaging with communities. D Blacklock raised a query, which had been a barrier for a number of years, regarding the availability of patient information to be shared and accessed across agencies. A Patel acknowledged that this remained a challenge to the system and advised that discussions had taken place with the voluntary sector to explore solutions. He commented that the Lancashire and South Cumbria System Intelligence Service currently provided the infrastructure for the NHS element and advised of the commitment and capabilities to incorporate the voluntary sector data. He noted that the governance element posed a barrier which would need to be addressed. A Knox further advised that he had, along with A Patel, co-hosted a digital roundtable last week, which focused on improving information sharing with partner organisations as part of the data and digital strategy. He noted that this was a significant component of the broader ICB strategic goals. He provided an example of a stream of work called 'Friendly Faces', where information was shared though multidisciplinary teams and fed into the GP record. He recognised that not all parties were able to see the record and access the system at the same time and advised that much of the work required centred around governance and information governance, explaining that work was being undertaken through One LSC to refine the steps required to progress this initiative. A timeline would be developed to support more effective team operations within neighbourhood areas. **RESOLVED: That the ICB Board note the contents of the report and the insight captured from engagement and involvement activities.** The chair advised that the meeting agenda had been revised since the last Board meeting to prioritise performance discussions, which would be followed by the strategic elements of the agenda.
123/25	**Quality and Outcomes Committee Escalation and Assurance Report - 6 August and 3 September 2025** S Cumiskey provided an update from the Quality and Outcomes Committee held on 6 August

	and 3 September 2025 and highlighted: <u>6 August 2025</u> **Alert: All Age Continuing Care (AACC) and Individual Patient Activity (IPA) – monthly update** - The committee had received a report on progress made and the plans which were in place to improve the quality of the AACC & IPA service alongside improved performance. They were also informed about work that has been commissioned to consider further indications of quality in relation to complaints and MP letters. It was noted that a deep dive had been commissioned of which the fundings would be reported through the committee. **Advise: Presentation on the NHS Performance Assessment Framework** - The committee received a presentation on the new approach to NHS oversight and assessment, which aided understanding of how the new segmentation would be developed. **Assure: Provider Annual Quality Accounts 2024/25 -** The report assured the committee that the annual quality accounts cycle was completed, and providers were compliant with the obligations around uploading quality accounts. <u>3 September 2025</u> **Alert: Biochemistry blood process at ELHT -** Key issues continued to be raised particularly across East Lancashire regarding workforce and transportation. It was noted that this was having an impact on General Practice time and patient experience. It was also generating potential harm by delaying diagnosis. Members were advised that an update would be brought to the next meeting of the committee. **Alert: Quarterly risk management update** - *New risk ICB-033: ICB and community pharmacy readiness for NHS commissioned services with prescribing*. It was unclear who would be undertaking the oversight and development of independent prescribing in pharmacies in the future, therefore this was out of the control of the ICB, and mitigations could not be put in place. The risk is in terms of a lack of clarity on the responsibility for broader workforce development as the NHS reorganisation and the left shift to community occurs, which posed a risk not just for pharmacy but for the whole system. **Assure: ICB Integrated Performance Report -** The first iteration of the ICB Integrated Performance and Quality Report (bringing together performance, quality (including outcomes, safety and experience) and Population Health) had been reported to the committee. S Cumiskey thanked the team for producing this report which was well received. She commented that this report would support the work of the committee considerably both now and in the future. D Blacklock requested that the deep dive into AACC had a focus on understanding the experience of individuals who may become ineligible for support and therefore understanding and exploring appropriate follow-up support mechanisms. S Cumiskey acknowledged the importance of this and advised this would be incorporated in discussion at the Quality and Outcomes Committee. C Whalley highlighted the conversations which had been taking place between Directors of Adult Services and J Scattergood, ICB Acting Chief Nurse in relation to AACC and advised that she felt reassured by the progress and direction of the work being undertaken. She emphasised the importance of ensuring that the population were at the heart of all activities. **RESOLVED: That the ICB Board:** • **Note the Alert, Advise and Assure within the committee report and**

	approve any recommendations as listed • **Note the summary of items or issues referred to other committees of the Board over the reporting period** • **Note the ratified minutes of the committee meetings.**
124/25	**Integrated Performance Report** A Patel advised that the report circulated was a summary of the full report which had been presented to the Quality and Outcomes Committee. He noted the report addressed the metrics in the NHS Oversight Framework, which included the introduction of health inequality metrics and commented on the significance of the metrics given the high levels of deprivation in Lancashire and South Cumbria. He highlighted the following domains which reflected some movement and required focus: <u>Elective Recovery</u> ➢ Over 85% of relevant procedures were being delivered as a day case, and therefore resources were utilised appropriately. ➢ Lancashire & South Cumbria ICB latest performance (13 July 2025) related to theatre capped utilisation was 85.6% which was within the upper quartile of performance and above the national and regional average ➢ Pre-referral diversion rates for specialist advice in June 2025 was 35.8%, which was higher than the national diversion rate, whilst the utilisation rate was also higher and was increasing. However, post referral diversions (9.1%) were lower than regional and national averages despite higher levels of utilisation. ➢ The demand for services continued to increase with the waiting list remaining at a static position for the last 8 months at 244,000. ➢ 52+ week waiting list was above trajectory particularly in specialties such as Gynaecology, Oral Surgery and Gastroenterology and there continued to be a focus on backlog reduction and exploring expansion of community alternatives. <u>Diagnostics</u> ➢ There had been an improvement in performance against the 6 weeks diagnostic target in June 2025 to 78.6% on the previous month for the four main Lancashire & South Cumbria providers. ➢ Latest performance for the ICB showed that 79.1% of people waited less than 6 weeks for a diagnostic test. ➢ East Lancashire were noted to be in the top quartile for performance, however variation was noted across providers. ➢ Community Diagnostic Centres were not running at capacity and A Patel advised that targeted recruitment would take place to address this and enable the services to support elective recovery. C Harris would provide an update on Urgent and Emergency Care as part of the update later in the agenda and therefore A Patel did not focus on this domain. <u>Cancer</u> A Patel emphasised the importance of understanding the local context when reviewing cancer performance and commented that these factors must also be considered when evaluating performance. He advised that Lancashire and South Cumbria had a higher incidence and prevalence of cancer compared to the England average and commented that premature mortality rates were elevated, with cancer diagnosis being closely linked to deprivation and lifestyle factors. He highlighted that avoidable deaths due to cancer were at the highest levels in Blackpool, which correlated with higher smoking rates in deprived areas. A Patel provided an overview of the ambition outlined in the NHS Long Term Plan regarding

	early cancer diagnosis and noted that the target was for 75% of people with cancer to be diagnosed at an early stage by 2032. He was mindful that historically performance in this area had been in the bottom quartile, but that recent data indicated an improving trend. He highlighted several initiatives led by the Cancer Alliance, which included the lung cancer screening programme which had shown significant impact, with 41% of lung cancers diagnosed at an early stage, which was slightly above the national average. He further advised that the programme had led to a 12% increase in early-stage diagnoses, with 82% of lung cancer cases now being identified early. Since its inception two years ago, the programme had resulted in 400 early-stage diagnoses, which would contribute to better outcomes for patients and their families. He commented on the positive feedback which had been received related to the screening programme and advised that this had been recognised as one of the best performing programmes in the country, particularly due to its use of mobile screening scanners located in deprived and disadvantaged communities. A Patel provided an update on the Pharmacy First service and advised this service enabled patients to be referred into community pharmacies for services such as urgent repeat medicine supply, minor ailments consultations and designated minor illnesses. He advised that consultation activity was currently running well above planned levels, with approximately 5,000 referrals for consultations and an additional 4,000–5,000 referrals for medicine supply. He commented that this service was designed to alleviate pressure on primary care services and also support a “shift left” approach focused on prevention and promotion of care closer to home. Dr S Karunanithi commented that the circulated performance scorecard differed to what had been presented at the last Board meeting, particularly noting that the key prevention indicators, such as smoking at the time of delivery and childhood vaccination rates, were not included in the current report. He considered these to be strategically important metrics and key performance measures for monitoring population health outcomes. A Patel advised that there had been discussions prior to submission of the report regarding the inclusion of appendices and confirmed that these sections would be reintroduced in future iterations, with content more closely aligned to strategic priorities, allowing for focused reporting on specific areas at appropriate times. D Corcoran expressed her support for the Pharmacy First service and noted the encouraging level of demand and use of the service. She queried from an equity perspective, whether the service was equally accessible across all communities, particularly in areas where individuals may be less likely to visit a GP, also whether the service would be evaluated to inform future rollout. A Patel confirmed the intention to evaluate the service using metrics on geography and demographics to better understand the effectiveness and advised that this would be incorporated within the performance report, which is presented to the ICB Quality and Outcomes Committee N Greaves advised that a series of reports which captured public feedback and engagement around community pharmacy services, including the Pharmacy First programme were available on the ICB Internet page. A Knox expressed appreciation to the Digital and Business Intelligence teams for their support in producing a comprehensive report, which provided rich data and would enable the Board to answer the “so what” questions and supported decision-making. He highlighted the following key points: • The report provided a valuable opportunity to adopt a system improvement approach, celebrating what was working well and using an appreciative inquiry model to explore quality and learning. • The data demonstrated that targeted interventions were effective, noting the lung health checks screening programme, an example with the identification of 400 patients with early-stage lung cancer would have a profound impact on survival rates.

	• These outcomes represented real-life changes for communities and underscored the importance of early detection. • The value of a proactive, targeted approach, particularly in disadvantaged communities, and requested the Board consider how such approaches could be scaled and spread with the evidence which is readily available. J Birrell welcomed the improvements made to the report which had been reviewed through the ICB Quality and Outcomes Committee, noting that the discussions which were being held were crucial to the ICB's strategic direction. He emphasised the importance of including volume metric data in reports, which would by assigning numerical values to performance indicators help to bring the detail to life and therefore make the data more tangible and impactful. A Patel advised this was part of the contracting report which was presented to the ICB Finance and Contracting Committee. **RESOLVED: That the ICB Board note achievement against key performance indicators for Lancashire and South Cumbria and support the actions being undertaken to improve performance against metrics in this report.**
125/25	**Finance and Contracting Committee Escalation and Assurance Report - 17 July and 27 August** The Chair expressed her thanks to D Corcoran for presenting the report from the Finance and Contracting Committee due to apologies received from S Igoe. D Corcoran advised that the circulated report related to the last two meetings held on 17 July 2025 and 27 August 2025 and noted that whilst not included in the report the committee had met on Monday 22 September 2025. She noted that the report tended to fall within three main areas which included AACC, Waste Reduction Programme (WRP) and an update against the ICB financial position. She highlighted: <u>27 August 2025</u> **Alert: All Age Continuing Care:** Good progress continued to be made on waste reduction targets. In relation to AACC WRP, YTD was £15.2m vs target of £12.1m. However, there were significant overspends in M4 as a result of inaccurate accruing in 24/25. This was £10m to date and there may be a further £20m outstanding, hence the substantial cost pressure. The committee noted concerns around delivery/execution rather than plan, as evidenced by the high-risk assessment of the schemes. The committee was concerned as to recent reports of increasing complaints, again indicating the high-risk element of delivery. **Assure: All Age Continuing Care** - The turnaround arrangements continued to demonstrate grip and control over AACC payments. The committee was fully engaged with the detail within the report from the Turnaround Director and had requested further amendments to reporting to highlight specific matters that the committee would continue to seek assurance on. The committee supported the ongoing risk mitigation and detailed validation of pipeline schemes. **Alert: Waste Reduction Programme:** Discussion of the current position in relation to WRP's and mitigations took place. Whilst the WRP total continued to increase, so too did the risk to delivery. Mitigations were already being used and whilst there was confidence that there was sufficient coverage for the current position on paper, there was an increasing concern amongst committee members as to the potential for downside risk, particularly in relation to the need for actual delivery to start to increase substantially if the planned outcomes were to be achieved. Once mitigations were reduced, the impact of the redundancy programme excluded alongside the use of finance mitigations this left c: £107m of cost saving compared to an ask of £142.7m recurrently. The bulk of this being required from AACC and prescribing - two high risk areas in terms of delivery.

	Assure: Waste Reduction Programme: The committee discussed the current position in relation to the WRP programme and mitigations. The programme was showing WRP's of £183m and mitigations of £47m. The ICB was actively managing these issues and was clear on the position, although as noted substantial risk still existed in relation to delivery as the ICB progressed throughout the rest of the financial year. The committee was less assured on delivering on these plans as each month passed. **Assure: UEC and Winter Planning:** The committee received a positive report on winter planning in the system and preparedness. A review of UEC governance was being undertaken with a view to being concluded by end October 2025. Submitted winter plans were assessed by NHS England who concluded that they were not fully assured and therefore revised plans are being developed for return. D Corcoran advised that at the meeting of the Finance and Performance Committee held on 22 September 2025 there was an update on both AACC and WRP with a focus predominantly on the forecast outturn for month 5. Members looked at a sensitivity analysis of the year end budget position and it was noted that this would be covered in the finance paper later in the agenda. She advised that the committee had received sufficient assurance levels to have confidence in the M5 position and the year end forecast position for the ICB. **RESOLVED: That the ICB Board:** • **Note the Alert, Advise and Assure within the committee report and approve any recommendations as listed** • **Note the summary of items or issues referred to other committees of the Board over the reporting period** • **Note the ratified minutes of the committee meetings.**
126/25	**<u>Finance Report Month 5 and 2025/26 Plan Position</u>** S Downs advised the report provided an overview of the Month 5 financial position as 31 August 2025, which focused on the year to-date deficit position and delivery against the efficiency programme. S Downs advised that the reported position at month 5 was a £58.1m deficit against a planned year-to-date deficit of £35.1m, resulting in a £23.0m adverse variance, which was attributed to provider Trusts, whilst the ICB was a reporting a breakeven plan. He noted that the system was forecasted to deliver the full year planned position, however there was significant risk against this position with only 25% of the savings target having been delivered at 31 August 2025, which left 75% to be delivered in the remaining seven months of the year. He explained that when the plan was set there was a level of unidentified efficiencies which were phased in twelfths and were now therefore impacting the position. The risks were attributed to the WRP, the fact that the independent sector was overheating and the pressures aligned to AACC, however assurances were provided of the mitigations in place to address the risks. He advised that through the Improvement and Assurance Group meetings (IAGs) which were held with NHS England that there were plans to address this during the remainder of the year and therefore the achievement of the plan was being forecasted. S Downs advised that the provider operational capital envelope for 2025-26 was £118.5m and at month 5, provider Trusts had spent £24.5m, which was £7.0m behind plan and provided assurances that this would be addressed in year. **RESOLVED: That the ICB Board note the content of this report.**

127/25	**<u>Update on development of Commissioning Intentions 26/27</u>** C Harris advised that the paper provided an update on the process for developing the 2026/ 27 Commissioning Intentions within the system plan. It gave an update progress to date, including feedback from engagement and next key steps in delivery. C Harris advised that four engagement sessions had taken place in June/July 2025 with partners including the Local Authority and the voluntary sector, and feedback received from these sessions had been collated and circulated to attendees and commissioners for inclusion in the consideration of proposed commissioning intentions. He advised that as the commissioning intentions were developed, consideration would be given to the insights which had been received from the engagement sessions which were noted as: • Ensure continued and inclusive engagement with partners, moving towards shared outcomes. • Focus on system-wide, high-impact priorities that are commissioned and delivered consistently. • Prioritise community-based services, with an emphasis on prevention and early intervention. • Enable sustainable shifts in activity to release resources and support the “left shift” approach, aligned with planning guidance. • Provide clarity of vision for Integrated Neighbourhoods, including a defined core offer and flexibility to build on this at Place level to meet specific community needs. • Avoid commissioning in isolation or silos; promote integrated approaches. C Harris commented that the commissioning intentions would be aligned to the NHS planning guidance and emphasised that future planning would reflect a single integrated approach linked to the 10-year health plan. It was noted that engagement was scheduled for October and November 2025, with final sign-off at ICB Board, which would ensure that any contractual changes could be implemented in the final quarter of the financial year. Dr S Karunanithi noted it was helpful to see a definition included in the report outlining the criteria for what constituted a commissioning intention. However, he queried what the contractual changes would be to support the three strategic shifts (treatment to prevention; hospital to community and analogue to digital), how these changes would be overlaid within current commissioning frameworks and what practical implications they would have for provider contracts. He also acknowledged that this year’s earlier engagement timeline presented a valuable opportunity for partners to align their plans proactively. C Harris acknowledged the resource constraints often faced in implementation and emphasised the need to explore multiple approaches within the existing financial envelope. He referenced the upcoming engagement sessions during October 2025 and commented that these were an opportunity to develop the detail. He stressed that support from partners would be invaluable to shape and deliver the shared vision. S Cumiskey raised the importance of aligning the 10-Year health plan and broader strategy with a system-wide integrated approach and queried how commissioning intentions would evolve to reflect a population-based approach to be focused on integrated health outcomes. C Harris supported this view and highlighted the need for a joint needs analysis and a clear clinical strategy which would underpin the planning. He emphasised the importance of defining delivery models at neighbourhood level and provided assurances that the foundations were already in place and the focus should now move to implementation. He welcomed that the operating model and planning guidance had been published early enough to support this work. A Knox was mindful that local government reform, particularly in Lancashire, introduced an

	additional complexity in the commissioning and planning processes. He stressed the importance of the ICB and local authority partners being closely aligned to understand how commissioning would evolve within the changing landscape and emerging Place structures. T Hopkins shared her reflections from the Integrated Care Partnership (ICP) meeting held earlier in the week, where local government reform had been a key agenda item. She noted the government reform added complexity to commissioning intentions and highlighted the importance of overlaying strategic planning with broader system changes. She emphasised the importance of continued partnership working and the opportunity to build on the foundations laid by the ICP. C Whalley noted the complexity of working across two ICBs in Westmorland and Furness and emphasised that planning and commissioning must ensure equity of offer for residents. **RESOLVED: That the ICB Board:** • **Note the contents of the report** • **Note the further maturity in the preparation of Commissioning Intentions for 26/27** • **Note the proposal for Board to receive Commissioning Intentions 2026/27 for approval in December 2025 (subject to NHS Planning Round).**
128/25	**<u>NHS Draft Planning Framework</u>** C Harris advised that a new multi-year planning framework was published by NHS England (NHSE) on the 8 September 2025 which set out a new model of planning in response to the 10 Year Health Plan and was intended as a guide for local leaders responsible for shaping medium-term plans covering the period 2026/27 to 2030/31. The framework provided clarity on roles and responsibilities within the context of the new NHS operating model and set out core principles, key planning activities and indicative timescales. He noted that the paper brought together strategic and operational planning which dovetailed with both commissioning intentions and the Joint Forward Plan, whilst defining the different responsibilities and accountabilities and articulated some of the key risks and mitigations. It was noted that the planning framework was explicit in its expectations on the role of individual ICB Boards in the development and delivery of plans and that the paper described these responsibilities and set out proposals for ensuring that the Board was fully engaged in the planning process over the coming months. C Harris confirmed that weekly planning oversight groups were in place to ensure the ICB maintained progress and advised that this forum would monitor operational planning, including the development of neighbourhood health plans across the ICB footprint and would be developed through collaboration with partners including providers and the VCFSE sector. He also advised that the risks outlined within the paper would be further refined through the planning oversight group. C Harris raised concerns surrounding the tight timescales and the delay in allocations, which placed the system in a challenging position to meet the planning requirements, however he provided assurances that capacity would be reviewed to ensure that deadlines were achieved. The Chair commented that the planning framework guidance had been helpful in assessing the evolving role of the ICB, particularly in the context of strategic planning and commissioning, and would be valuable in identifying what more was required in terms of data, capacity and alignment of required structures. She noted that this would be critical in shaping a coherent and effective commissioning approach. S Proffitt recognised the risks which were identified in the paper, particularly around tight

	timescales and the current status of the operating model and asked partners to consider whether anything further could be undertaken to ensure a shared commitment. She encouraged partners to reflect on whether there were any additional actions or opportunities to strengthen collaboration and how engagement could be maximised during this critical planning phase. D Eyitayo stressed the importance of ensuring that workforce planning remained a central focus throughout the planning process and reminded members that having a sustainable workforce was a risk within the Board Assurance Framework and highlighted that this was key to delivering transformation and ensuring long-term system resilience. Dr S Karunanithi reflected on the importance of maintaining clarity between the Department of Health and Social Care's 10-Year Health Plan and the NHS planning framework and emphasised that while the 10-year health plan provided a broader system-wide vision, it was not solely an NHS plan, and the distinction must be made to ensure the system could leverage wider resources to improve health outcomes and reduce inequalities. Secondly, he referenced national guidance which indicated that neighbourhood health plans were jointly owned by partners, including local authorities, and should reflect the wider economy's role in enabling people to live well. He commented that the Health and Wellbeing Boards, as the upper-tier local authority governance structure, were the appropriate place to lead this work and noted that the relationship between the ICB board and Health and Well Being Boards was an increasingly important dynamic in laying out the foundations to inform the joint forward plan and commissioning intentions. A Knox supported the points raised by Dr S Karunanithi, particularly surrounding the role of Health and Wellbeing Boards in spreading learning and embedding it into planning. He proposed taking an appreciative inquiry approach to identify what was already working well in neighbourhoods and using that insight to inform future planning and delivery. He also emphasised the importance of building health inequalities into planning and that planning must be deliberate and targeted to ensure that communities experiencing inequalities were prioritised and supported. The Chair acknowledged the significant work which was underway and affirmed that the system was moving in the correct direction of travel and welcomed the interactive and collaborative conversations which were taking place with partners around the table, noting that such engagement was essential to shaping a shared and effective planning approach. **RESOLVED: That the ICB Board**: • **Note the requirements outlined in the NHS Planning Framework** • **Support the approach outlined in the paper** • **Receive monthly reports on progress and schedule deep dive sessions during October and November to review progress and provide constructive challenge to support plan developments**
129/25	**<u>Urgent and Emergency Care (UEC) Delivery and Winter Planning 2025/26</u>** C Harris spoke to the circulated report and advised that the report contained a request for approval of the ICB Board Assurance Statement as detailed within the appendix in readiness for submission to NHS England by 30 September 2025. He noted that NHS England required each ICB and Trust Board to formally approve their winter plans via a Board Assurance Statement and he provided assurance that all providers were undertaking the same process through their respective Boards. C Harris recognised that the paper contained significant detail which he advised was required to provide an update on the status and/or progress of several areas related to UEC and winter planning.

	He reminded members that the UEC plan 2025/26, which was published on 6 June 2025, outlined seven priority actions that would have the biggest impact on UEC improvement this coming winter, including: 1. Reduction of ambulance wait times for Category 2 patients by over 14% (from 35 to 30 minutes) 2. Eradicate last winter's lengthy ambulance handover delays by meeting the maximum 45-minute ambulance handover standard 3. Ensure a minimum of 78% of patients who attend A&E to be admitted, transferred or discharged within 4 hours 4. Reduction of the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time 5. Reduction of the number of patients who remain in an emergency department for longer than 24 hours while awaiting a mental health admission 6. Tackle the delays in patients waiting to be discharged – commencing with reducing patients staying 21 days over their discharge-ready-date 7. Increase the number of children within 4 hours, resulting in thousands of children receiving more timely care than in 2024/25 He advised that a range of winter planning arrangements and activities had been developed, to improve UEC, to support the delivery of safe, dignified, and high-quality care for patients this winter and noted that as a minimum the system would: • improve vaccination rates • increase the number of patients receiving care in primary, community and mental health settings • meet the maximum 45-minute ambulance handover time standard • improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on eliminating corridor care • set local performance targets by pathway to improve patient discharge times and eliminate internal discharge delays of more than 48 hours in all settings • reduce length of stay for patients who need an overnight emergency admission. It was noted that the plans outlined would be worked through collaboratively through the implementation of the UEC improvement plans, which would be actively managed by the UEC Delivery Boards, operating within defined geographical footprints and supported jointly between health and social care partners, ensuring a fully integrated approach. C Harris further noted that NHS England Northwest had organised a winter exercise, 'Exercise Aegis', to stress-test draft winter plans and advised the exercise took the form of a tabletop (desk-based) workshop discussion, with sessions aimed at assessing plan details against scenarios featuring increasing demand and unexpected challenges. He also advised that the System Coordination Centre (SCC) was outlining with all providers across the system an efficient and effective approach to daily monitoring of operations and identification of early warning of system pressures by utilising the OPEL framework, which would provide the central point of communication for the system and support the ICB with coordination of escalation responses. C Harris advised that risks were evident in relation to operational and financial pressures and he reminded members of the pressure related to winter when some performance was stretched. It was recognised that as part of planning for 2025/26 the NHS England North West had set aside £26m as a Regional Transformation Fund and the ICB had submitted five

	high priority bids, noting that the outcome of the bidding process was awaited. It was confirmed that the UEC Capacity Investment Funding for 2025/26 has been allocated to support initiatives aimed at hospital avoidance and timely discharge and C Harris advised that the impact of these investments would be monitored and reported through monthly updates to the Board. J Birrell commented on the ongoing consultation regarding the Shaping Care Together programme, noting that in addition to expressing views regarding the location of A&E services, attendees were concerned about the quality of patient experience within A&E settings. He suggested some reflection on how patient experience could be enhanced and incorporated into the winter planning arrangements. C Harris advised that the continuous improvement work led by Wendy Lewis was addressing many aspects of patient experience and confirmed that this worked linked closely with the communications team and he would be able to provide further detail in the next report to Board. **Action: C Harris** ***(emailed)*** C Whalley advised that the UEC Board had taken direction from the ICB and introduced the voice of the person which included incorporating lived experience, and she noted that this had brought a human perspective to what would otherwise be a data-driven discussion. A Knox commended the work which had been undertaken by Wendy Lewis and advised that she regularly attended Medical Directors forums, which had resulted in a joined-up approach with the commissioning team. S Cumiskey raised concerns about the cohort of individuals with mental health needs who frequently attended A&E and referenced a point previously raised by C Oliver regarding how well-connected these individuals were to appropriate support services. She also questioned what strategic focus had been given to this issue, particularly in terms of reducing waiting times for mental health needs. C Oliver advised that the system was performing well in terms of timely assessment within Emergency Departments and meeting the national standards, however, he recognised that there were challenges presented when an admission was required. He referenced the 10-Year health plan, which included an expectation for systems to develop dedicated mental health emergency departments and commented that this model had been trialled with mixed responses, although repiloting was underway at Blackburn and Blackpool, where purpose-built units were available to assess patients and facilitate onward referral or discharge. S Cumiskey emphasised that this area often lacked sufficient focus and requested that it be included in future reports to Board and provided her commitment to ensuring that the Quality and Outcomes Committee continued to provide oversight and progress monitoring. **Action: C Harris** ***(emailed)*** T Hopkins queried how the UEC plans were addressing preventative measures to reduce A&E attendances and highlighted the valuable contributions of the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, referencing a successful initiative in Blackpool last year that focused on respiratory conditions which was deemed as a key driver of A&E attendances. She advised this year, the scope had expanded to include cardiovascular disease and mental health, with a focus on implementing community-based interventions in collaboration with primary care with the aim to address the wider determinants of health, such as suitable housing and debt to help to mitigate mental health crises. She emphasised that greater community-based action was essential to prevent avoidable A&E attendances. S Proffitt shared that she had met with T Hopkins recently and reflected on the success of providing some UEC funding to the VCSFE sector to allow consideration to be provided as to how they could contribute to admission avoidance. T Hopkins added that a key takeaway was the VCFSE Alliance working collaboratively with Population Health Teams in Place to focus on identifying areas where the greatest impact could be made. She noted that through

	the sector-led approach there was an opportunity to push back on rigid metrics and agreeing on meaningful metrics, ultimately demonstrating 400 avoided admissions. She confirmed that a report would be presented to the ICB Board which would detail the approach taken which used a community and health inequalities lens to address longstanding issues. The Chair noted that the Board approved the ICB Board Assurance Statement for submission. Furthermore, the Chair requested that future monthly updates included broader contributions from system partners, in order to build on the richness of discussion and reflect the full scope of collaborative work underway. **RESOLVED: That the ICB Board**: • **Note the content of the report and the associated appendices** • **Approve the ICB Board Assurance Statement at Appendix A for submission to NHS England by 30 September 2025.**
130/25	**<u>Audit Committee Escalation and Assurance Report - 23 July 2025</u>** J Birrell provided an update from the Audit Committee held on 23 July 2025 and advised there had been a further meeting of the committee on 24 September, therefore he would incorporate discussions held at both meetings. **Alert: New ICB financial system -** A new financial management system was currently scheduled for implementation on 1 October 2025. The finance team was working hard to ensure that the process goes smoothly but there may be some short-term issues during the transition period. J Birrell advised that the risk had been assessed at 16, which suggested a high potential for issues to take place. He highlighted the potential for issues related to payments being made and raised awareness that this may impact on the financial reporting for several months and therefore may reflect in the accuracy of the reports. **Advise: All Age Continuing Care, (AACC), Turnaround Plan** - A presentation was made to the committee in respect of the AACC Turnaround Plan. Encouraging progress was reported although significant work was still required to deliver the Plan. It was agreed that the Chairs of the Quality & Outcomes, Finance & Contracting and Audit Committees would liaise around their respective oversight roles and responsibilities. From the audit committee perspective members would like to have a better understanding of the overall integrated action plan. **Advise: Completed internal audit reviews -** Two completed audits and one assurance report were considered by the Committee: - Continuing Healthcare – limited assurance - Patient Safety Incident Response Framework – moderate assurance - Data Security & Protection Toolkit (DSPT) - overall assurance of high risk J Birrell advised that whilst the overall assurance rating for DSPT was classified as 'high risk', he clarified that this was a result of the national scoring methodology, which automatically assigned a high-risk status if two or more outcome areas were not achieved and did not align to the veracity of the self-assessment which was rated as high confidence. J Birrell provided assurance that work was actively underway to address the identified issues, and that a detailed improvement action plan was being developed for submission to the Information Governance Oversight Group in the coming month. <u>24 September 2025</u> J Birrell provided verbal update from the discussion held at the Audit Committee on 24 September and highlighted:

	- The recent audit into SEND had provided a moderate assurance rating, however, it was noted that the audit raised questions regarding the extent to which the ICB was complying with its statutory responsibilities in this area. S Cumiskey confirmed that this matter would be discussed at the Quality and Outcomes Committee for further scrutiny and assurance. - The committee would review the effectiveness of the ICB arrangements for business continuity with a plan for an update to be received at the December 2025 meeting of the Audit Committee. - Noted the Information Governance annual report. - Received a paper related to the growing importance of Artificial Intelligence which outlined the current landscape of AI adoption across services. As part of this paper there was a recommendation which was supported related to foundation AI literacy to be provided to all staff. - Approve the updated Anti-Fraud, Bribery and Corruption Policy which included the new corporate fraud offence related to failure to prevent fraud. A Knox raised an important consideration regarding the environmental impact of Artificial Intelligence (AI), commenting that whilst AI presented significant opportunities for innovation and efficiency, it also required substantial power, which in turn consumed large amounts of non-renewable energy resources. He recognised the ICB's commitment to achieving net zero by 2040 and suggested that this would need to include an evaluation of AI's environmental footprint. S Proffitt advised that this concern would need to be fed into the work led by Alistair Rose as part of the ongoing development and implementation of the ICB's Green Plan. S Downs provided an update on the transition to the new financial ledger system, confirming that the ICB was currently in the 'cutover' period with the previous ledger, ISFE1, officially being closed as of 30 September 2025, and the new ledger scheduled to go live on 1 October 2025. He advised that during this period, emergency payments could be processed by NHS England and he acknowledged that the previously reported risk rating of 16 was assessed prior to the implementation of these contingency measures. **RESOLVED: That the ICB Board:** • **Note the Alert, Advise and Assure within the committee report and approve any recommendations as listed** • **Note the summary of items or issues referred to other committees of the Board over the reporting period** • **Note the ratified minutes of the committee meetings.**
131/25	**<u>ICB's Board Assurance Framework, Strategic Objectives and Risk Appetite</u>** S Proffitt advised that the report provided a refreshed update on the Board Assurance Framework (BAF) further to a facilitated Board seminar held in May 2025 and the extensive review undertaken since this seminar through the Executive Management Team throughout June 2025 – August 2025. She advised of the eight key risks to achieving the ICB's strategic objectives. These were identified on the BAF and should be used to drive the Board's agenda, as they represented the most critical areas requiring oversight and assurance. She commented that the report also outlined efforts to strengthen internal controls, including the use of cause-and-effect analysis to better articulate the meaning and implications of each risk. Additionally, the Board was asked to consider its risk appetite, with a risk statement included in the report to define the level of tolerance the Board was willing to accept. The Chair emphasised that the BAF was a fundamental document when used correctly, and

	commended the clarity of the report presented, further expressing her appreciation for the significant work undertaken by the ICB Executives, Audit Committee and particularly D Atkinson in developing and refining the framework. Dr Sakthi Karunanithi commented on the need to triangulate performance measures back to the BAF, specifically referencing that neurodevelopment pathways did not currently align with existing Key Performance Indicators. The Chair noted that if the BAF was used as intended then it would meaningful performance insights and strategic decision-making. **RESOLVED: That the ICB Board**: • **Support the recommendation that the strategic objectives for 2025/26 remain "as is" for the remainder of the financial year.** • **Approve the ICB's fully refreshed and revised BAF and eight principal risks to the achievement of the ICB's objectives 2025/26 (and any associate updates or realignment of the Risk Management Policy and Framework)** • **Note that during the review process, oversight of existing BAF risks remained in place, with routine risk management reporting through the Executive and relevant assuring committees.** • **Agree the board's overarching risk appetite statement and levels of risk appetite across each risk domain.** • **Support the approach that (where relevant) reports to the board or its committees clearly demonstrate appropriate consideration has been given to the board's risk appetite.**
132/25	**<u>Use of the ICB Seal</u>** D Atkinson advised that the report detailed the use of the corporate seal, noting that this had been used on one occasion to date during the financial year 2025/26 and related to the extension of the lease for 1 year for ICB staff at the Health Innovation Centre in Lancaster. **RESOLVED: That the ICB Board note the use of the ICB Seal.**
133/25	**<u>Report concerning matters considered in Private Board meetings held between 24 July and 6 August 2025 (inclusive)</u>** D Atkinson advised that the Board had met in private on two occasions since the last report to Board in July 2025 and the discussions from these meetings were summarised within the report. It was noted that all the discussions which had taken place through Private Boards had subsequently been captured within the updates provided to the Board meetings held in Public in July and September 2025. D Atkinson highlighted that whilst members had approved a voluntary redundancy scheme at the private meeting held on 6 August 2025, it was subsequently confirmed that the scheme had not yet been approved by NHS England. **RESOLVED: That the ICB Board note the contents of the report.**
134/25	**<u>Any Other Business</u>** There were no issues raised.

135/25	**<u>Items for the Risk Register</u>** **RESOLVED: That there were no items to be included on the ICB Risk Register.**
136/25	**<u>Closing Remarks</u>** The Chair thanked Board members for the discussions and challenges and for the public attending today. The meeting was closed.
137/25	**<u>Date, Time and Venue of Next Meeting</u>** The next meeting to be held in public would be on Thursday, 27 November 2025, 1.00pm - 4.00pm, Lune Meeting Room, ICB Offices, Level 3 Christ Church Precinct, County Hall, Preston, PR1 8XB The meeting closed.

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