NHS
Lancashire and South Cumbria
Integrated Care Board

Subject to approval at the next meeting

Minutes of a Meeting of the Integrated Care Board Held in Public on Thursday, 22 January 2026 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
	Steve Spill	Non-Executive Member
	Jane O'Brien	Non-Executive Member
	Steve Igoe	Non-Executive Member
	Debbie Corcoran	Non-Executive Member
	Aaron Cummins	Chief Executive
	Mark Bakewell	Interim Chief Finance Officer
	Dr Andy Knox	Acting Medical Director
	Jane Scattergood	Interim Chief Nursing Officer
	Dr Julie Colclough	Partner Member – Primary Care
	Chris Oliver	Partner Member – Trust/Foundation Trust – Mental Health
	Silas Nicholls	Partner Member – Trust/Foundation Trust – Acute and Community Services
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
In attendance	Kirsty Hollis	Associate Director and Business Partner to the Chief Executive
	Dr Nicola Finnigan (up to item 5)	Pendle West PCN Health Inequalities Lead
	Bimpe Kuti-Matekenya	Aspirant Non-Executive Member
	Jo Leeming	Committee and Governance Officer

Ref	Item
01/26	**Welcome and Introductions** The Chair 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.

	It was noted that this meeting was the first meeting for Steve Spill as a Non-Executive Board member and the new Chair of the ICB Audit Committee. The welcome was also extended to Bimpe Kuti-Matekenya, an aspiring Non-Executive Member who was being supported by the ICB Chair and to Dr N Finnigan, GP and Pendle West PCN Health Inequalities Lead who would be presenting the item on community experience. It was noted this would be the last meeting for Debbie Eyitayo, Chief People Officer as she would be leaving to commence a new role at the end of this month and the Chair formally thanked her on behalf of the Board for her contribution, particularly surrounding the leadership which she has provided through the transition period for the ICB and the support to all teams. One question had been received from a member of public pertaining to item 10, which would be covered at that item.
02/26	**<u>Apologies for Absence/Quoracy of Meeting</u>** Apologies for absence had been received from regular participants Cath Whalley, Vicky Gent and Dr Sakthi Karunanithi. The meeting was quorate.
03/26	**<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.
04/26	**a) <u>Minutes of the Board Meeting Held on 27 November 2025, Matters Arising and Action Log</u>** There were no matters arising that would not be picked up as part of the agenda and it was noted that there were no current outstanding actions for Board members on the action log. **RESOLVED: That the minutes of the meeting held on 27 November 2025 be approved as a correct record.**
05/26	**<u>Community Experience /Story</u>** A Knox introduced Dr Nicola Finnigan, GP in East Lancashire, who had undertaken work through the Population Health Leadership Academy and had been invited to present the community experience story. Dr N Finnigan provided the background on her role and advised that she worked in a deprived area with ethnic minorities. She described the learning she had gained about working effectively with communities and explained that local data, particularly relating to cervical smear uptake, the lowest rate in East Lancashire, was largely influenced by population characteristics. She advised that an outreach worker had been appointed to explore opportunities to improve engagement and had identified a group of Asian women interested in women's health, to whom she presented the data and discussed possible solutions. The group had explored barriers to accessing cervical screening and participated in educational sessions on the female reproductive system. Simple interventions were implemented, including proactively calling patients to book appointments and a video had been produced to capture women's stories and concerns; the video was being shared more widely and would be adapted for use on social media. A community bus offering cervical

	screening had been deployed the previous week, achieving excellent uptake and initiating conversations on previously taboo subjects. The video was presented to Board members. The Chair observed that the video had been very powerful and had demonstrated the importance of discussing women's health and tailoring approaches to specific groups. A Knox commended the work and the change being made in the community. He advised that the Quality and Outcomes Committee had also received this detail and he offered assurance that this was reflective of how learning was undertaken across the region. He further noted that a different approach had been taken to working with different groups, which had demonstrated the effectiveness of population health methodology in enabling communities to be part of the solution. It was recognised that whilst solutions were not the same in each place, the outcomes had shown increased uptake and the data continued to show that long-term outcomes improved when communities were engaged in this way. T Hopkins emphasised the power of the data and the importance of ensuring that it was translated into insights so that communities could understand and interpret it. A Patel agreed it was a powerful story and that the impact of peer support could not be underestimated. It was commented that the story should be considered in light of other agenda items for the meeting today, as this pertained to good engagement leading to improved performance, specifically in early cancer screening and early detection, which could then have an impact on gynaecology and cancer waiting lists. A Cummins advised he had visited communities in East Lancashire, but this was not a corporate initiative. There was a need for the Board to consider how greater autonomy could be devolved to communities to enable them to lead on outcomes. It was noted that further visits would be undertaken to discuss place and neighbourhood arrangements and to identify the factors required to embed this approach as standard practice. He commended the work undertaken and stressed the importance of ensuring initiatives were scalable and could become business as usual. Dr N Finnigan advised that the work required significant time, particularly in supporting women to develop confidence to discuss sensitive issues and participate in filmed materials. She explained that cultural factors within Asian communities made such conversations more challenging and that trust-building through informal community events had been essential. Small contributions for community gatherings had also supported engagement and identifying community champions was crucial, as people were more likely to respond to messages from trusted peers than from clinicians. ***Dr N Finnigan left the meeting.*** **RESOLVED: That the ICB Board note the video and discussion.**
06/26	**<u>Chair's Report</u>** The Chair reported that it had been extremely busy for providers and the ICB, with huge efforts focused on performance and finance, which would be discussed later in the meeting. There was also significant work underway to develop the clinical strategy and the 5-year commissioning plan incorporating stakeholder engagement, both of which would be brought to a future Board meeting. In addition, she recognised the substantial work on developing the ICB operating model for

	the future which included incorporating significant reductions in running costs, and alongside this was the voluntary redundancy programme. The Chair recognised that staff have waited too long for clarity around the voluntary redundancy scheme, which had caused enormous uncertainty and stress and she expressed thanks to all the executives and managers for their professionalism, efficiency and compassion in leading through this period of uncertainty and the voluntary redundancy process. She acknowledged that many colleagues would be leaving the ICB over the coming months and on behalf of the Board, the Chair wished them all the best in their future endeavours. **RESOLVED: That the ICB Board note the report.**
07/26	**<u>Report of the Chief Executive</u>** A Cummins noted his personal thanks to D Eyitayo for her advice, support and kindness, and wished her well in her future role. He reported that the ICB continued to face significant challenges in maintaining service and access standards within a severely constrained budget, alongside the voluntary redundancy process affecting nearly 200 colleagues. He commented that despite the pressures, staff remained compassionate and focussed on progressing priority work, with comprehensive support in place from the organisational development team for both departing and remaining colleagues. He highlighted sustained system pressures, particularly in urgent and emergency care, and commended providers and primary care for their collective efforts over the winter period. A new strategic narrative for the ICB had been tested with staff and stakeholders, with positive feedback, and the medium-term plan and commissioning intentions would be presented to the Board in due course. It was noted that recruitment to the new executive team was underway which had seen a strong calibre of applicants and he advised that stakeholder panels and interviews were planned for next week. He advised of recent visits across the system, where he had observed strong innovation and also heard that working with the ICB remained challenging. He emphasised the need for a more permissive, devolved approach as part of the future strategic commissioning framework and confirmed that several items had been progressed under the Executive Committee's mandate and were included in the accompanying papers. D Blacklock queried how the Board would understand the impact on patient safety arising from significant staff reductions. A Cummins advised that whilst changes must be delivered within budget, the ICB must remain effective in maintaining quality and safety. Strong information sources, provider intelligence and oversight through the Quality and Outcomes Committee would have a heightened sense of risk appetite to support early detection of issues. The operating model would be reviewed to test the effectiveness of changes, and contract priorities would be adjusted accordingly with some functions no longer being undertaken by the ICB. D Park expressed thanks to the Chair and A Cummins for their positive comments regarding recent visits to East Lancashire, noting that these demonstrated effective joint working with system partners and provided reassurance that, despite capacity pressures and organisational change, strengthening governance at neighbourhood and place level could significantly improve healthy life outcomes for local communities. D Corcoran sought clarification on the benefits of expanding the enhanced prior approval scheme for procedures of limited clinical value and how clinical and public engagement had informed the decision making. C Harris confirmed that clinical impact, equity considerations and multidisciplinary clinical input were built into the governance process to determine any

	adverse impact of decisions on communities. He confirmed that further data could be shared with D Corcoran for assurance regarding decision making should this be required. A Knox advised that as part of the governance process, whenever changes were made, a group of clinicians would consider the implications of decisions, which would also feed into the quality and safety group. A Cummins added that commissioning decisions were often driven by clinical evidence and feedback from clinicians. Therefore, this was about listening to clinical colleagues and creating a response that would allow delivery of the services that added the most value. J Colclough observed that while clinical effectiveness was important, communicating this to communities remained challenging. **RESOLVED: That the ICB Board note the report.**
08/26	**Quarterly Report of the Board Assurance Framework** D Atkinson summarised progress made in Quarter 3 on the 8 principal risks linked to the ICB's strategic objectives. The Board Assurance Framework (BAF) had been strengthened since September 2025 and incorporated the Board's risk appetite, updated assurances, gaps, controls and quarterly assurance mapping against the four lines of defence. Regular oversight had been maintained through the Executive Committee and relevant ICB committees, and MIAA's Phase 1 review had provided positive findings with a small number of improvement actions already addressed. The report set out updated narratives for each principal risk and included recommendations relating to target risk score dates and one reduced current risk score. High-scoring operational risks were also highlighted. Alongside wider strategic planning and transition work, a full refresh of the BAF, strategic objectives and risk appetite would take place in Quarter 1 of 2026/27. S Cumiskey noted that operational risks were captured through sub-committee escalation reports, providing assurance that these risks and their impacts were being monitored within committees rather than solely through the BAF report. D Atkinson advised that the MIAA assurance review had confirmed the BAF was highly visible across the ICB. She emphasised that the transition risk formed part of the wider articulation of the ICB's strategic objectives, the associated principal risks, and the mitigating actions, reinforcing the importance of the BAF as a core governance document. T Hopkins recognised that some of the mitigating actions were external to the ICB, which demonstrated that this was about listening and understanding people outside of the ICB. D Park acknowledged that affordability of All Age Continuing Care (AACC) was a significant risk for local authority partners and there was a need to ensure that risk was not transferred but managed collectively. **RESOLVED: That the ICB Board:** • **Note the contents of the report.** • **Note the progress made during Quarter 3 2025/26 to support the management of risks held on the BAF.** • **Approve the recommendations to BAF risk scores and target risk score dates as summarised in section 3.4 of the report.** • **Note the positive outcomes of MIAA's Phase 1 review of the ICB's Assurance Framework and the actions undertaken.** • **Note those risks held on the ORR (corporate oversight) which are held at a score of 20 or above.** • **Note the full review and refresh of the BAF, Strategic Objectives and Board risk appetite in Q1 of 2026/27.**

09/26	**<u>People and Culture Committee Escalation and Assurance Report – 14 January 2026</u>** J O'Brien provided a verbal update from the People and Culture Committee meeting held on 7 January 2026 and highlighted: • The workforce element (strategic transformation) of the medium-term plan submission was discussed and would be submitted to the private Board meeting being held on 9 February 2026 as part of the full submission. • There remained an alert to Board related to metrics on staff well-being and absence. • The committee received a report from providers concerning sickness absence and productivity in the system, which showed a high correlation between sickness absence of the workforce and population health in a geographical area. • The committee received information on the 'Get Lancashire Working' initiative about getting people back into work and contributing to their own wellbeing, wealth and the wider economy. • The committee continued to monitor the workforce implications of the transition and voluntary redundancy. **RESOLVED: That the ICB Board:** • **Note the Alert, Advise and Assure and approve any recommendations as listed.** • **Note any summary of items or issues referred to other committees of the Board over the reporting period.** • **Note the ratified minutes of the committee meetings.**
10/26	**<u>Working with People and Communities - Insight Report</u>** N Greaves advised that a public question had been submitted regarding assurance on engagement and involvement approaches, and how the ICB worked with patient and public representatives and confirmed he would meet with the individual. N Greaves responded to the public question by outline the ICB's approach to listening to communities, capturing insights and empowering teams to embed engagement with communities across all work programmes, and commented this was particularly evidenced in the work around cancer, which had seen a large culture shift. He highlighted examples of supporting place teams, involving people in the clinical strategy and commissioning plan, and fulfilling statutory duties on service change. He also referenced partnership work with the voluntary sector, Healthwatch and Spring North to roll out an engagement approach, as well as ongoing improvements to Patient Participation Groups (PPGs) and engagement with MPs. Work was being undertaken with partners to influence the public voice across the system, such as working with Trusts and Healthwatch around maternity and neonatal teams and partnerships. He further noted positive early feedback from recent cancer awareness work and confirmed that insight from partners and programmes would continue to inform the clinical strategy, commissioning plan and future activity. The Chair thanked N Greaves for the report, noting that it provided assurance on how insight was informing work at ground level. D Blacklock raised the importance of ensuring that, during periods of difficult decision making, the ICB continued to involve people meaningfully and did not lose focus on public engagement. He sought an update on the next steps regarding changes at Furness General Hospital and expressed strong support for strengthening PPGs as a vital engagement mechanism. N Greaves confirmed that a commitment to meaningful involvement would remain central to decisionmaking and that the clinical strategy work included conversations with the public about future models of care. An engagement report on Furness General

	Hospital had been published and that work was underway with the trust to develop materials for a preconsultation business case, with further updates to follow. He agreed on the importance of PPGs and outlined plans to support practices to strengthen and develop these groups as part of wider neighbourhoodlevel engagement. C Oliver queried how the voices of service user and carer groups within providers could be better reflected in the Board's work. N Greaves advised that, as part of developing the clinical strategy, many such groups had been invited to join the ICB's Health Advisory Group, which brought together volunteers and representatives from local forums. He confirmed that he had attended several of these groups to strengthen connections and ensure a range of perspectives were incorporated. Members with lived experience were actively influencing programmes such as the cancer pathway and continued to contribute through regular meetings. T Hopkins noted that the report demonstrated the breadth of community-listening activity and emphasised the value of additional insight from hospital-based groups. She encouraged Board members to read the Healthwatch Blackpool 'Conversations About Cancer' report, highlighting that community-led engagement often generated deeper insight and that acting on such findings could significantly improve outcomes. She stressed the importance of commissioning more community-based engagement, particularly involving people with lived experience. R Fisher referenced the government discussions around the abolishment of Healthwatch but stated that he felt this was an important service to support work in the community. A Cummins emphasised the need to use evidence and data in strategic commissioning and noted significant variation in PPGs across the system. He highlighted the importance of understanding their purpose and impact and stressed that the ICB could not respond to feedback from every practice individually. He emphasised the need to devolve greater autonomy to places and neighbourhoods and to strengthen feedback loops to ensure communities understood how their input had informed decisions. D Blacklock suggested a repository of intelligence from feedback would be beneficial to deduce common themes and learning. D Corcoran noted the report referenced gathering principals through drawing communities together and queried how the overall impact of engagement activity would be evaluated. N Greaves advised that common themes from engagement and patient experience had been built into commissioning intentions and would inform future strategy. D Blacklock emphasised the need for planned balanced engagement that did not privilege the loudest voices. **RESOLVED: That the ICB Board note the contents of the report and the insight captured from engagement and involvement activities.**
11/26	**<u>Quality and Outcomes Committee Escalation and Assurance Report – 7 January 2026</u>** S Cumiskey provided an update from the Quality and Outcomes Committee held on 7January 2026 and highlighted the following alerts to Board: • The Patient Experience and Complaints Report highlighted a backlog in complaint responses due to staffing pressures, affecting patient experience and learning. The issue had been escalated previously, and recruitment to the team had since been agreed. • The Integrated Performance Report evidenced the challenges around waiting lists. • The committee continued to monitor AACC from the quality aspect and there remained challenges around staff sickness and organisational change. Mitigations were being sought in terms of additional support to staff. **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.**
12/26	**<u>Integrated Performance Report</u>** A Patel outlined the national context of sustained pressure on waiting lists following the pandemic and noted that despite rising demand, the system had reduced overall waiting numbers and made significant progress in eliminating the longest waits of 65+ weeks. Improvements were also noted in 52-week waits and in narrowing the health inequality gap. Cancer performance had improved, with the faster diagnosis standard being met, though the 62-day standard remained very challenged. There remained continued pressures in primary care due to workforce shortages and increasing complexity of patient need, however it was noted that GP practices continued to deliver high-quality care supported by wider roles. There was sustained improvement in mental health services, with no inappropriate out-of-area placements but further work was required to strengthen reporting on community services, which was being considered through the Quality and Outcomes Committee. T Hopkins noted the positive achievements but recognised that significant challenges remained, particularly regarding 52-week waits and commented that lengthy wait times affected people's lives, ultimately limiting their ability to work or progress with daily activities, and often resulted in increased GP visits. She highlighted that this had a wider social and economic impact and linked to national concerns about rising disability claims and long-term withdrawal from the workforce following the pandemic. A Patel advised this triangulated with deprivation as often those from more deprived areas had to take time off work to attend appointments and cancellation of appointments caused serious issues. It was noted that the Quality and Outcomes Committee was also scrutinising clinical prioritsation. J O'Brien noted the report stated that the patient cohort aged 18 and under was experiencing longer waits on average than the adult population for elective treatments. A Patel explained this was due to several factors which included specialty, geography, deprivation and gender and he advised that a supplementary paper on elective waiting times would be presented as part of the scheduled deep dive at the next Quality and Outcomes Committee meeting. D Blacklock queried when sufficient primary care appointment capacity would be available and that the report would benefit from detail related to mitigating actions regarding access to primary care and the trajectory for improvement. A Knox advised that this would need to be reviewed with input from A Patel, noting that provision varied across the region and that longitudinal data showed an exponential increase in appointments in some areas that had not been replicated system-wide. He highlighted effective examples of modern general practice and total triage models, which had removed the traditional 8am queues for appointments. D Blacklock also raised concern regarding changes to AACC eligibility criteria and J Scattergood advised that the AACC checklist and decision-making tool were highly prescriptive and were nationally set. She explained that the region had been identified as an outlier in relation to the proportion of spend for its population and cited cases where fast-track support for end-of-life care had not been reassessed in a timely manner, resulting in payments continuing unnecessarily. Subsequent reassessments had aligned cases correctly with the established framework descriptors and work was ongoing with partners, family groups, carers and patients to address the associated challenges. J Colclough reflected that general practice faced similar challenges to urgent care in directing patients to the most appropriate service, given the wide range of primary care options available. References to GP appointments often overlooked the breadth of clinical roles, and a GP was not always the most suitable professional for every case. Patients on waiting lists

	also required a number of appointments, thereby reducing appointment availability for others and it was agreed that patients awaiting treatment should be actively managed across the system to help them remain well and, where possible, stay in work. A Knox advised that 30% of people on waiting lists for neurology were on the headache pathway but 90% of people did not need to see a neurologist. He commented that often, basic interventions had not been undertaken initially, but a digital solution had been developed to look at all parts of the pathway to avoid unnecessary referrals and would be rolled out into primary care with new guidance. S Spill commended that there were 0 people in inappropriate out of area placements but questioned how that been achieved and if it was sustainable. C Oliver advised this was multifaceted and system work on clinically ready-for-discharge processes had strengthened collaboration with local authorities, ensuring appropriate facilities and placements for patients. Further work on purposeful admission and community-based alternatives had reduced admissions and length of stay. Focus on key clinical pathways supported this improvement and efforts were also underway to expand discharge placements and address housing-related barriers, including tenancy loss and restrictions linked to patient histories. Although progress fluctuated, the system was on the right trajectory and delivering better outcomes for patients. A Cummins noted that a gap remained between transactional performance updates and the Board's wider strategic commissioning role. Performance trajectories needed to be aligned with commissioning intentions focused on demand management, growth reduction and alternative access pathways. Stronger strategic links were required in areas such as in cancer, planning and diagnostic capacity to ensure long-term improvement, although significant background work was underway during this transitional period. **RESOLVED: That the Board note the achievement and on-going actions against key performance indicators and the work underway to improve quality and safety and reduce health inequalities across Lancashire and South Cumbria.**
13/26	**<u>Finance and Contracting Committee Escalation and Assurance Report – 21 November 2025 and 7 January 2026</u>** S Igoe presented the key points from the reports: • Money had been the key issue in the system, and the ICB remained under financial undertakings in relation to the recovery support programme, with a plan to come out of that by March 2026. However, this required significant deliverables to be progressed over the following weeks and months. • Common themes from the reports had included key costs of AACC, prescribing, and overruns in the independent sector, which had resulted in significant pressures, though substantial mitigations had been in place to manage these. • There had been considerable enhancement in grip and control of cost management and in the quality of the underpinning information, as reporting had improved significantly over recent months. • M Bakewell and colleagues in AACC were thanked for the enhancement of the report, as it had improved conversations in committee meetings. • Continued work had been required on the cost recovery programmes and in preparation for 2026/27 and beyond. • Risks had been flagged around ensuring costs were accounted for in the correct period. • The year 2026/27 had been expected to be incredibly challenging, and the ICB would have had to manage the challenges associated with moving to £19 per head of population. **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.**
14/26	**<u>Finance Performance Report – Month 8</u>** M Bakewell highlighted: • The system was £54.2m behind plan, which was a £78.7m deficit against its planned year to date deficit of £24.5m. • The breakdown was included within the report and the ICB was reporting a break-even position, with provider Trusts having a largely negative position against plan. This was mainly due to shortfall on delivery of efficiency savings due to delayed implementation, with recovery of that expected during the last part of the year. • A balanced position was being reported for both the year to date and the forecast outturn for the ICB, although there was a lot of risk to be managed in the last 4 to 5 months of the year to meet that break even position. • The main areas consistently reported included contracts across both the independent sector and NHS providers, costs in relation to mental health and learning disabilities and autism packages of care, AACC (which had a wider pooling of costs), and prescribing expenditure related to new drug pressures and the international market. • Looking ahead, a risk-based report was being developed each month assessing scenarios to determine the range of the position. The most likely forecast showed a potential £14.5 million deficit, based on identified risks and mitigations. The executive team continued work on delivering efficiencies and finding further mitigations to support the break-even forecast. It was noted that the forecast excluded the voluntary redundancy scheme, deficit support funding and other wider system impacts still under discussion with NHS England. T Hopkins queried whether some of the schemes were not delivering cost savings and if this would jeopardise any of the support funding. She also commented that the report referenced underspend on capital and queried whether that funding would be lost. M Bakewell advised that some financial pressures stemmed from delays in last year's planning and confirmed that earlier planning had been undertaken this year to ensure a fully developed plan for 1 April 2026. He advised that high-risk efficiency schemes were now reflected in the position, and weekly internal scrutiny meetings were in place to identify further mitigations. He recognised that there were risks with deficit support funding as this was non-recurrent and an uncertain funding stream, which posed technical and operational challenges and confirmed that discussions with NHS England continued. It was noted that a capital underspend at this stage was common due to planning timescales and late-year funding allocations, and often new capital funding became available at this time. The Chair requested that consideration be given to ensuring the capital allocation was used in the most strategic way next year. ***D Blacklock left the meeting.*** **RESOLVED: That the ICB Board note the content of this report.**
15/26	**<u>Urgent and Emergency Care Delivery and Winter Planning 2025/26</u>** C Harris provided key highlights and updated on the position since the paper was written: • There had been an extremely busy period since Christmas and formal thanks were noted to all system colleagues who had provided support. During that period mental health had fared very well due to support with flow and discharge from LSCFT. • The Operational Pressures Escalation Levels (OPEL 4) framework had been consistently applied and there had been two incidents of OPEL 4 triggered by BTH and UHMB to date due to a significant number of admissions related to walk-ins, increased cases of flu, norovirus and RSV, also industrial action for resident doctors prior to Christmas. However,

	performance had only had marginal deterioration in 3 areas of 12-hour waits, ambulance handovers and 4-hour waits. Work was undertaken closely with primary care colleagues and whilst there were some small hot spots of increased referrals and admissions based on healthcare professional referrals; most of primary care received more patients and kept them out of hospitals. • BTH had a level 2 critical incident related to urgent and emergency care pressures, which was stood down after 72 hours. • The paper included an update on 'hospital at home' and positively reported that most of the national target was being met by services in the community. However, there was variation across the region, which highlighted the requirement to focus on certain areas for improvements to be made. • Wait times in A&E would continue to be monitored along with soft intelligence measures across primary care. • Uptake of vaccinations was encouraged and that message should be promoted. • The importance of communications around only using A&E for emergencies and life-threatening situations, and the alternative services for other situations was acknowledged. S Nicholls noted that system pressures continued to be significant and he recognised the supportive collective response across the system and that, despite capacity changes and reduced flexibility due to financial constraints, performance had not deteriorated to the extent anticipated, which he considered to be highly positive. However, further pressures were expected, including a likely second wave of flu outbreak in late January or early February, and the situation was being monitored closely. It was further noted that ongoing work to promote alternatives to GP and A&E services, including communications led by N Greaves and his team to raise public awareness of available options such as pharmacy support, remained important and required continued support from the ICB. D Corcoran referenced triangulating this report with the performance report as whilst substantial assurance had been given regarding performance, processes and impact, there had been a significant increase of 3,000 additional attendances at A&E in November 2025 compared with the previous year. The reasons for this increase were queried and whether work was underway to identify the causes and associated learning for commissioning and system planning. She emphasised that accurate forecasting relied on assumed activity levels, and the unexpected rise in attendances required further examination, particularly given the additional capacity being put in place across primary and community services. C Harris advised that work was still underway to understand the reasons for and implications of the increased activity. He noted increased walk-ins and a higher number of ambulance attendances had been observed, despite improvements in see-and-treat and call-before-convey processes. There had also been a general increase in the use of urgent and emergency services across the system, and that pressures would likely have been substantially worse without the additional support measures already implemented. Further analysis was required, including qualitative intelligence, and that this work would inform the all-year-round review and future urgent and emergency care planning report that would be presented at the April Board meeting. J Colclough referenced the importance of Single Point of Access (SPoA) to primary care services. C Harris agreed that the capabilities of this were significant and these were being worked through as currently it was mainly around community and acute services and linked to ambulance services. The intention was to have information at 'the touch of a button' to simplify access to services by offering clinicians advice and guidance to support onward referral, ensuring patients get the right care for their needs quickly and safely and to improve patient outcomes regardless of where they present. There had been an extension to the hours of strategic command centre staff to manage handovers with acute Trusts and to provide more up to date position information for on-call managers. It was suggested that a more detailed

	update could be provided at a future meeting. S Cumiskey commented that 12-hour waits did not meet the required standard of care and the solution to this resided in the whole system approach and ensuring that demand was met more effectively with timely patient flow through the system. Attention was drawn to the requirement for Trusts to review the standards of care provided to acutely unwell patients during the first 72 hours of admission. The Quality and Outcomes Committee would consider this work to seek assurance on the focus, learning and systemwide application of the findings. **RESOLVED: That the ICB Board note the content of this report.**
16/26	**<u>Audit Committee Escalation and Assurance Report – 10 December 2025</u>** S Spill advised this report had been produced by the previous committee Chair, Jim Birrell, who left the ICB at the end of December 2025. He commented on the following alerts: • With regards to the new finance system, ISFE2, he had met with the auditors and they were comfortable in relation to the forthcoming audit, although it would add some complexity as they would have to review 2 systems. • The AACC turnaround plan was being monitored from different perspectives by Audit Committee, Quality and Outcomes Committee and Finance and Contracting Committee. Since this report had been drafted, further assurance had been provided that this was progressing positively. M Bakewell commented that ISFE2 continued to pose challenges, particularly in terms of reporting, as often information had to be taken from the ledger, processed manually and then entered back into the ledger, which caused difficulties when working to deadlines. The team continued to work well despite these issues and colleagues across the country were working together to find workarounds. It was noted the external auditors were comfortable with having a split year, but it was anticipated that there would be discussion regarding increased testing costs, as a cutover would be required between the old and new systems. S Igoe added that this had been discussed at Finance and Contracting Committee and it was a national system imposed on organisations. Reporting issues had caused a delay in data being provided and the practical implications meant this was less effective, less efficient and added risk as this was more work for staff at an already challenging time. **RESOLVED: That the ICB Board:** • **Note the Alert, Advise and Assure and approve any recommendations as listed.** • **Note any summary of items or issues referred to other committees of the Board over the reporting period.** • **Note the ratified minutes of the committee meetings.**
17/26	**<u>NW Specialised Joint Committee Escalation and Assurance Report – 11 December 2025</u>** C Harris provided the following updates from the meeting of the committee: • The committee had endorsed a direct award approach for NW Osteochondral Allograft transplantation (OCA) and Autologous Chondrocyte Implantation (ACI) Services under the Provider Selection Regime. • The committee reviewed the financial planning process for specialised services, noting the importance of triangulation with contract teams to support assurance frameworks. **RESOLVED: That the ICB Board:**

	• **Note the Alert, Advise and Assure 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, as appropriate.**
18/26	**<u>Annual Review and publication of the ICB's Registers of Interests including Gifts and Hospitality</u>** D Atkinson advised that the report presented the annual review of the ICB's registers of interests including gifts and hospitality and commercial sponsorship which are published on the ICB's website. The report provided an overview of the activity undertaken during the reporting period to provide assurance that the ICB's systems and processes are effective and the statutory requirements for managing conflicts of interest were met. There were a total of 150 staff whose interests were required to be held on the published registers and 129 staff (86%), had met this requirement and it was noted the corporate team would continue to support all remaining staff to review and update their declarations. **RESOLVED: That the ICB Board:** • **Note the contents of the report.** • **Note the work undertaken to ensure that the ICB's systems and processes for declaring conflicts of interests effective and the statutory requirements for managing conflicts of interest are met.** • **Approve the annual review and publication of the ICB's registers of interests.** • **Note the compliance rates against mandatory training to support staff in the management of conflicts of interests.**
19/26	**<u>Use of the ICB Seal</u>** D Atkinson advised the ICB was required to keep a register of every sealing and present to Board on a biannual basis. The report detailed the use of the ICB Seal on 6 occasions during September – December 2025. **RESOLVED: That the ICB Board note the use of the ICB Seal since the last report to Board.**
20/26	**<u>Report concerning matters considered in Private Board meetings</u>** D Atkinson advised the Board had met 3 times in private with the main themes of discussion around the medium-term plan and requirements on a draft submission for NHS England, the model ICB blueprint and progression of voluntary redundancies. **RESOLVED: That the ICB Board note the contents of the report.**
21/26	**<u>Any Other Business</u>** There were no issues raised.
22/26	**<u>Items for the Risk Register</u>** **RESOLVED: That there were no items to be included on the ICB Risk Register.**

23/26	**<u>Closing Remarks</u>** The Chair thanked all members for their contributions to the meeting.
24/26	**<u>Date, Time and Venue of Next Meeting</u>** The next meeting to be held in public would be held on Thursday, 19 March 2026, 1.00 pm - 4.00 pm, in the Lune meeting room, ICB Offices, Level 3 Christ Church Precinct, County Hall, Preston, PR1 8XB. The meeting closed.

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