

Subject to approval at the next meeting

**Minutes of a Meeting of the Integrated Care Board Held in Public on
Thursday, 19 March 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
	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	Interim 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	Professor Craig Harris	Chief Operating Officer & Chief Commissioner
	Debra Atkinson	Company Secretary/Director of Corporate Governance
	Neil Greaves	Director of Communications and Engagement
	Tracy Hopkins	Voluntary, Community, Faith and Social Enterprise Sector
	Cath Whalley	Director of Adult Services (Westmorland and Furness)
In attendance	Lynn Almond <i>(for Item 29/26)</i>	Greenwich Leisure Limited at Kendal Leisure Centre
	Dani Houghton <i>(for Item 29/26)</i>	Greenwich Leisure Limited at Kendal Leisure Centre
	Bimpe Kuti-Matekenya	Aspirant Non-Executive Member
	Davina Upson	Board Secretary and Governance Manager

Ref	Item
25/26	<p><u>Welcome and Introductions</u></p> <p>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. An extended welcome was made to Lynn Almond and Dani Houghton, from Greenwich Leisure Limited at Kendal Leisure Centre who were in attendance to present the item on the community experience.</p>

26/26	<p><u>Apologies for Absence/Quoracy of Meeting</u></p> <p>Apologies for absence had been received from Sheena Cumiskey, Non-Executive Member; Denise Park, Partner Member and regular participants Asim Patel, Debbie Herring, David Blacklock and Dr Sakthi Karunanithi.</p> <p>The meeting was quorate.</p>
27/26	<p><u>Declarations of Interest</u></p> <p>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.</p> <p>Board Register of Interests - Noted.</p>
28/26	<p>a) <u>Minutes of the Board Meeting Held on 22 January 2026, Matters Arising and Action Log</u></p> <p>There were no current outstanding actions for Board members on the action log.</p> <p>RESOLVED: That the minutes of the meeting held on 22 January 2026 be approved as a correct record.</p>
29/26	<p><u>Community Experience /Story – Different by Design</u></p> <p>J Scattergood introduced the community story. She noted the importance of schemes like this in the continued development of neighbourhood working and commented that service users had reported significant benefits and had described improvements across multiple aspects of their lives, including reduced pain and strengthened social connections.</p> <p>L Almond provided background to the project. It had been developed in partnership with University Hospitals of Morecambe Bay by creating a joint, holistic prevention and rehabilitation model with MSK services located within the leisure centre at Kendal. She explained the approach followed pathway mapping work to understand how the leisure centre could support both the NHS and the local community. She explained the focus of the model was on prevention and rehabilitation, drawing on the strength of community engagement and peer support, noting the service enabled participants to make healthier lifestyle choices, reducing the likelihood of re-presentation to the NHS and supporting long-term improvements in health. L Almond confirmed that there had been minimal requirement for funding, as the programme had successfully developed self-sustaining models.</p> <p>D Houghton outlined the range of services provided, including the Healthwise (12-week exercise on referral with two-year subsidised membership), Escape-pain programme (six-week education and exercise intervention), WorkWell (supporting return to work for people with long-term conditions) and Chatter Matters (addressing social isolation among older adults). She noted the high demand for these services, demonstrating the strong case for prevention over treatment. The estimated impact equated to a £505k net saving for the NHS and a £8.80 return on investment for every £1 invested.</p> <p>L Almond advised that a wide range of activity was underway, with ongoing work to measure impact, outcomes and commented that £8.2m had been generated in social value last year for Westmorland and Furness. She noted the opportunity to overlay primary care data to demonstrate the benefits of neighbourhood-based health initiatives, including the potential to avoid GP appointments, support reductions in medication use, and evidence the contribution</p>

	<p>of primary and community-led prevention.</p> <p>A video was played to the board which included comments from the participants of the various schemes.</p> <p>The Chair thanked colleagues for the presentation and referenced her recent visit to East Lancashire where she had observed similar innovative approaches, and she emphasised the value of these community-based models in supporting prevention and improving outcomes.</p> <p>A Cummins reflected on the strategic relevance of the model, highlighting its alignment with neighbourhood health ambitions noting that traditional NHS financial frameworks often undervalue community based provision. He emphasised the importance of understanding how existing budgets can be deployed most effectively and positioned correctly within the local market and noted the need for strengthened performance reporting in future.</p> <p>C Oliver queried how the model could be expanded across Lancashire and South Cumbria, noting that it provided a clear purpose for individuals following hospital discharge and he emphasised the need for a consistent, strategic approach to implementation. L Almond confirmed that she was working closely with S Sandford at the ICB to develop plans for wider roll-out across Lancashire and South Cumbria, to ensure alignment, consistency and sustainability.</p> <p>S Nicholls reported that the Provider Collaborative Board had recently considered opportunities to scale up the MSK model across Lancashire and South Cumbria, given the clear benefits demonstrated for patients and the positive feedback from staff working within the collocated service environment.</p> <p>T Hopkins welcomed the work and stressed the importance of ensuring that any expansion was viewed through a health inequalities lens, noting that the model may not translate directly into all areas of Lancashire and South Cumbria, particularly where charges could limit affordability. She stressed the need for local adaptation to reflect differing community needs and highlighted the importance of being mindful about how funding was deployed to ensure that different delivery models were developed where required to meet the needs of each area.</p> <p>The Chair thanked L Almond and D Houghton for attending and they left the meeting.</p> <p>RESOLVED: That the ICB Board note the video and discussion.</p>
30/26	<p><u>Chair's Report</u></p> <p>The Chair took her report as read and welcomes any questions on the content.</p> <p>The Chair commented on three major areas of work that had dominated the time of the executives and many colleagues across the ICB over recent months noting that these were reaching their culmination.</p> <p>Firstly, she noted that the ICB were saying goodbye to nearly 200 members of staff, at all grades, who had taken voluntary redundancy as part of the national scheme, and she expressed sincere thanks to each member of staff for their patience, professionalism and dignity during what had been a difficult period. She recognised that for colleagues who were remaining within the ICB there was continued uncertainty about the future operating model and what it meant for individual roles. She committed to address that uncertainty with clear structures that would enable the ICB to deliver on the vision set out by the executive team.</p> <p>Secondly, she was noted that the ICB had successfully submitted the medium term three year</p>

	<p>plan, which had been a significant undertaking across the whole system to ensure that plans were aligned and triangulated across performance, activity and resources. She noted this plan, together with the strategic commissioning intentions, formed a key part of the agenda today.</p> <p>The Chair advised that the ICB remained on track to deliver the planned financial outturn for 2025/26, both as an ICB and as a system, which was recognised as a considerable achievement. She commented that members would recall that over the last year, the importance of establishing and demonstrating a culture of delivery was emphasised and achieving the year-end position was an important milestone. The Chair expressed her thanks, and that of the Board, to A Cummins, his predecessor S Proffitt and to the executive team for their leadership throughout this period.</p> <p>RESOLVED: That the ICB Board note the report.</p>
31/26	<p><u>Report of the Chief Executive</u></p> <p>A Cummins reiterated the Chair's reflections, noting that colleagues across the system had delivered improvements in care, quality, performance and financial outcomes despite ongoing uncertainty. He acknowledged that further work remained, particularly around access for patients and continued financial pressures; however, the system had made a positive start.</p> <p>From the report A Cummins highlighted:</p> <ol style="list-style-type: none"> 1. As part of the ongoing ICB restructure, the following appointments were confirmed: <ul style="list-style-type: none"> • C Harris to continue as Chief Commissioning Officer; M. Bakewell confirmed as Chief Finance Officer; A Heritage appointed as Chief Strategy and Planning Officer, effective 1 June 2026. • The recruitment to the Chief Clinical Officer post was unsuccessful and this would be revisited later in the year. He noted that A Knox and J Scattergood had agreed to continue in their interim roles (Interim Medical Director and Interim Chief Nurse respectively), and he advised that there would be a shared Chief Medical Officer function, with a formal announcement expected at the next Board meeting. 2. During February, the Kendal locality was visited by Dr Minal Bakhai, NHS England's Director of Primary Care and Community Transformation. The visit provided an opportunity to showcase neighbourhood health and wellbeing work, including approaches that may be replicated nationally. 3. Following earlier Board discussions, the ICB had expected to confirm plans for weight-loss medication prescribing (GLP-1) aligned to NICE Technology Appraisal and NHS England funding guidance. However, contractual changes announced by NHS England on 24 February 2026 meant the ICB needed to review the implications. Further information would be published on the ICB website once operational guidance was received and updates would be brought to a future Board meeting. Action: A Knox (emailed) 4. Three East Lancashire health centres, Barbara Castle Way Health Centre (Blackburn), St Peter's Centre (Burnley) and Acorn Primary Health Care Centre (Accrington), were undergoing major refurbishment works funded by the Department of Health and Social Care. The investment totalled £8 million and aligned with the Government's 10-year NHS Plan to expand and modernise local health facilities. 5. There had been recent media coverage regarding pressures on ADHD and ASD assessment services, and A Cummins recognised that these services were under

	<p>significant pressure. The ICB continued to work with Lancashire and South Cumbria NHS Foundation Trust and other partners, alongside Parent Carer Forums, to develop a sustainable commissioned and funded framework for assessments and treatment where no additional mental health need was present. A future update would be brought through to Board through the commissioning intentions and will be held as an action for the Commissioning Committee.</p> <p style="text-align: right;">Action: via Commissioning Committee</p> <p>D Corcoran queried the Caring Together Memorandum of Understanding (MoU) between the ICB, Lancashire County Council, Blackburn with Darwen Council, Blackpool Council and Westmorland and Furness Council. She sought clarification on what the MoU would deliver, the success measures and how the Board would receive updates on impacts and benefits. A Cummins advised that the MoU provided a more structured framework for partnership working, particularly where shared responsibilities (e.g., budgeting decisions) had led to delays in packages of care and access to services. He noted that the MoU was intended to bring clarity and consistency to joint working arrangements.</p> <p>T Hopkins reflected on the forthcoming changes in local government structures, including the formation of shadow unitary boards over the next 12 months and queried what impact this may have across statutory sectors. A Cummins advised that relationships across partners remained strong, with a pragmatic approach being taken and he noted that partners were working effectively in anticipation of future changes, and no disruption had been observed.</p> <p>RESOLVED: That the ICB Board note the report.</p>
32/26	<p><u>Working with People and Communities - Insight Report</u></p> <p>N Greaves advised that a question from a member of the public had been received relating to a specific service change and he confirmed that a direct response would be provided.</p> <p>N Greaves outlined that the report set out the themes emerging from public engagement activities, the mechanisms used to capture insights, and how these informed commissioning intentions and strategic planning. He advised that insight was gathered through Healthwatch, local partners and wider engagement activity. He emphasised the importance of the statutory guidance on Working with People and Communities and described how the ICB was using this to ensure public engagement was meaningfully incorporated into commissioning decisions and future service design.</p> <p>The Chair commented that the report contained insightful observations.</p> <p>D Corcoran noted the clear alignment between the report and the commissioning strategy. She sought further detail as to how the insight generated was used to influence outcomes, how the impact would be measured and understood, and how the Board would receive assurance that public engagement insight directly informed commissioning decisions and led to tangible impacts. N Greaves advised that some evidence was already emerging through the community stories shared with the Board, all of which stemmed from the ICB's population health improvement approach. He acknowledged the need to expand process driven evidence, particularly in pre-consultation business cases and case for change documentation and noted that demonstrating the impact of engagement was not always immediate, however, future reports and commissioning decisions brought to the Board should more clearly describe how engagement has shaped proposals. The Chair added that there were different levels to consider, including the need to provide narrative and context, and she highlighted the role of the Commissioning Committee in ensuring commissioning intentions are rooted in population health data.</p> <p>J Colclough observed that whilst the ICB continued to strengthen neighbourhood level</p>

	<p>approaches, patients and service users often expressed a desire for face to face appointments as highlighted in the report. She noted the challenge of balancing local expectations with NHS England's direction of travel towards digital access models. A Knox noted that where new digital services had been introduced (e.g., online access for GP appointments), initial apprehension from patients often reduced over time and data showed high satisfaction rates and reduced access barriers once confidence grew in digital pathways, leading to improved outcomes and faster access. This demonstrated that patient insights sometimes led to the need for more support and reassurance as new approaches are introduced.</p> <p>N Greaves commented that the report described the changing ways in which services were being delivered, drawing on public perceptions and insight to highlight where further work was required to improve public awareness and understanding. He noted that there was value in more clearly demonstrating how services were changing in practice, to support people to understand what was different and why. He emphasised the importance of doing more to articulate what future ways of working would look like, how the ICB would work with partners and communities to influence delivery, and how communications activity would be used to create greater awareness and understanding of service change and commissioning intentions.</p> <p>RESOLVED: That the ICB Board Note the contents of the report and the insight captured from engagement and involvement activities.</p>
33/26	<p><u>Quality and Outcomes Committee Escalation and Assurance Report – 4 March 2026</u></p> <p>J O'Brien presented the report on behalf of the Quality & Outcomes Committee Chair. She highlighted two areas escalated to the Board as alerts, providing context and assurance on mitigations in place.</p> <p>Alert: LSCICB Safeguarding Dashboard 2025-26, Q4 The first escalation related to safeguarding, specifically the backlog of cases within the Multi-Agency Risk Assessment Conference (MARAC) process concerning high-risk domestic abuse. She explained that safeguarding was a shared responsibility across agencies and relied heavily on effective multi-agency collaboration. It was noted the committee had discussed the backlog of cases, noting the actions being taken by police partners to improve timeliness. She emphasised that as the ICB reduced staffing, it was essential to maintain sufficient capacity and expertise to continue fulfilling both statutory safeguarding duties and partnership responsibilities.</p> <p>Alert: Urgent & Emergency Care / Winter Plan update The Committee had received a detailed report which evidenced a sustained system wide pressure, including prolonged waits, corridor care, and challenging clinical environments. Whilst acknowledging examples of harm and workforce strain, it was highlighted that the committee had also received assurance regarding mitigation actions, leadership focus, and regional and national initiatives intended to alleviate pressures.</p> <p>Advise: All Age Continuing Care (AACC) and Individual Patient Activity (IPA) – monthly update A review would be undertaken to understand why a higher than expected proportion of patients admitted from home were not returning home following discharge.</p> <p>Assure: Rapid Improvement Event – All Age Continuing Care (AACC) Complaints Process The significant improvement following the implementation of a new complaints process for AACC was noted, which had been developed through a focused improvement event and centred on learning and service improvement.</p>

	<p>Assure: Quality Impact Assessment update Assurance was received on the embedding of Quality Impact Assessments (QIAs), the progress was noted that they were being undertaken prospectively and meaningfully, rather than retrospectively.</p> <p>The referral to the People & Culture Committee regarding LSCICB Safeguarding Dashboard 2025-26, Q4 was noted related to the statutory responsibilities to ensure resources were maintained to meet statutory obligations.</p> <p>The Chair welcomed the clarity of escalation and assurance, noting that sustained oversight of safeguarding and UEC pressures would remain critical.</p> <p>RESOLVED: That the ICB Board:</p> <ul style="list-style-type: none"> • 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.
34/26	<p><u>Integrated Performance Report</u></p> <p>C Harris presented the Integrated Performance Report on behalf of the Chief Digital Officer and advised the report provided a comprehensive overview of performance across all areas.</p> <p>The Board noted that system demand continued to exceed demographic growth and C Harris highlighted that elective care performance showed an improvement, with over 61% of patients waiting less than 18 weeks at December 2025. He advised that a focused Q4 improvement sprint was underway to further reduce long waits, particularly within pressured specialties including oral surgery, neurology and gynaecology, and it was noted that work was being undertaken with colleagues from the independent sector. D Corcoran raised a concern regarding the pace of reduction in 52-week waits, acknowledging that waits were below the regional average, however she queried the timeliness of the response in specific areas. C Harris provided assurance that mitigation actions were already embedded within the Q4 sprint and would continue into the new financial year, although noted that challenges differed between specialities.</p> <p>Diagnostics performance remained above the national average overall, although significant variation between providers was highlighted, which had prompted targeted intervention. Cancer performance demonstrated compliance with Faster Diagnosis and 31-day standards, with overall improvement noted despite some residual challenges. Urgent and Emergency Care (UEC) performance remained below the 78% target, and C Harris commented that this reflected exceptionally challenging winter conditions. It was noted that all Trusts had reached OPEL 4 simultaneously during the period, which was an unprecedented scenario locally.</p> <p>Mental health performance showed improvement, with only two inappropriate out-of-area placements recorded at January 2026, and Primary care activity had increased, with an additional 10,000 appointments delivered in December 2025.</p> <p>A Cummins outlined the triangulation between the escalation from the Quality and Outcomes Committee in relation to Urgent and Emergency Care pressures across both physical and mental health services during the period. He commented that the medium term plan would focus on demand management and place based working to reduce the non-demographic growth demand for UEC. He was mindful that there had been a significant reduction in cost</p>

	<p>and capacity over the winter period. The Chair commented that the medium term plan had been appropriately triangulated and was signed up to by all providers. She acknowledged that further work was required in key areas and that this was reflected in the plan.</p> <p>A Knox provided a broader national context, highlighting significant long-term improvements in cardiovascular and cancer outcomes and he cautioned against interpreting short-term pressures without acknowledging sustained progress. S Nicholls further highlighted improvements in trauma outcomes and the introduction of a 24/7 mechanical thrombectomy service in Lancashire and South Cumbria. He also commented on the UEC service and the experience of older frail patients acknowledging that the waiting times for this cohort had deteriorated, he advised that the Provider Collaborative Board were concentrating on the frailty pathway.</p> <p>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.</p>
35/26	<p><u>Finance and Contracting Committee Escalation and Assurance Report – 30 January 2026 and 20 February 2026</u></p> <p>S Igoe presented the report and highlighted four key themes; the 2025/26 financial outturn, the 2026/27 Medium-Term Financial Plan, All Age Continuing Care (AACC) expenditure, and the organisational financial grip and control.</p> <p>He advised that the system was on track to deliver the 2025/26 financial plan, which would enable the release of non-repayable deficit support funding. He cautioned, however, that actions taken to secure the year-end balance would increase the financial challenge and risk profile in 2026/27, which would require delivery of significant cost reduction programmes.</p> <p>S Igoe emphasised the scale of AACC expenditure, noting that percentage improvements would deliver a substantial financial impact. He commented that strong financial controls and assurance mechanisms were in place, which had been supported by regulatory oversight.</p> <p>C Whalley reflected positively on the strengthened relationships within AACC, noting improved experience for service users and frontline staff.</p> <p>RESOLVED: That the ICB Board:</p> <ul style="list-style-type: none"> • 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.
36/26	<p><u>Finance Performance Report – Month 10</u></p> <p>M Bakewell advised that the detail expressed by S Igoe as Chair of the Finance and Contracting Committee complemented the finance report.</p> <p>He reminded members that in 2025/26 performance was judged at system level, which required close coordination with provider partners, and the year-to-date position at the end of January 2026 highlighted some figures as behind plan with some performance and operational pressures. However, it was confirmed that the overall position remained to deliver the plan.</p>

	<p>A Cummins emphasised the need to maintain financial discipline and avoid complacency as year-end approached, noting that many improvements achieved during 2025/26 were non-recurrent and would require sustained effort to embed.</p> <p>RESOLVED: That the ICB Board note the content of this report.</p> <p><i>The meeting paused for a short break.</i></p>
37/26	<p><u>Medium Term Plan</u></p> <p>M Bakewell confirmed that the three year medium term plan had been successfully submitted, and he noted the extensive system collaboration and alignment across finance, performance and workforce. It was noted that the plan was initially submitted in February 2026 with an opportunity provided for a refresh of the plan which was submitted 18 March 2026. He acknowledged that, due to the national submission deadline, it had not been possible to circulate the full final plan in advance of the Board meeting.</p> <p>M Bakewell advised that whilst final feedback from NHS England was pending, the plan reflected compliance with national requirements.</p> <p>Key points included:</p> <ul style="list-style-type: none"> • A system financial gap which would be addressed through a waste reduction programme, cost of commissioning adjustments and demand management schemes. • Significant progress had been made in identifying and developing waste reduction schemes prior to year start (as at 16 March 2026 £73.2m fully developed, £22.8m had plans in progress, £28.8m regarded as an opportunity and £2.41m remained unidentified). • Cost of Commissioning and other mitigations including the review of do once opportunities, design of a new staffing model and demand management reviews were progressing. • Performance compliance was planned across most national standards, with limited areas of non-compliance related to trajectory rather than overall delivery, specifically Referral to Treatment 18 weeks performance and cancer metrics. There were challenges in diagnostics. It was also to be noted that there was no combined UEC performance position as performance will be judged at provider level. • Workforce reductions aligned with efficiency requirements, with assurance provided that activity levels had been reviewed so they can be delivered in a safely and sustainably. • Capital allocations supported primary care and strategic system transformation, with work being undertaken with Trusts to ensure making the best use of the resources to improve local patient services. • Risks noted relating to acute contracting and the ability of providers to deliver the activity required to meet constitutional standards, prescribing budget pressures in both primary and secondary care, All Age Continuing Care and work (still to conclude with local authority colleagues) on learning disability pooled resources. Further risks related to the ICB's ability to support the 'shift left' and prevention agenda, particularly given the current balance between recurrent and non-recurrent delivery of savings. <p>The next steps were noted including the further work required. This included a review of the internal governance arrangements with a newly formed meeting that would receive regular updates on the required mitigations. M Bakewell advised of an enhanced contract management process which would build on activity plans which were in place across all contracts.</p>

	<p>A Cummins highlighted the limitations within national planning templates, noting that significant areas of expenditure lacked equivalent performance assurance metrics, and he committed to improving transparency for the Board.</p> <p>T Hopkins commented on the need to understand how system support arrangements were being reviewed alongside plans to significantly reduce the headcount and emphasised the importance of maintaining organisational capability during this transition. M Bakewell outlined that the Improvement and Assurance Group meetings had highlighted areas where performance was not as strong as required and emphasised the need to embed improvements into business as usual processes and continue to develop reporting to ensure that grip and control was maintained. He commented that during the transition period, there may be occasions where additional temporary resources would be required to maintain momentum. Investment in systems was also highlighted as necessary, with contracting cited as an example of a manual process where improved systems could enable smarter and more effective reporting with the potential role of artificial intelligence being noted as an area for future exploration.</p> <p>A Cummins highlighted the value that had been added through the Recovery Support Programme and commented on the strategic commissioning development programme which would launch in May 2026, and the requirement to utilise allocations more effectively to drive improved outcomes. The Chair added that the proposed changes to the governance structures would help to streamline how issues were discussed and considered.</p> <p>C Whalley commented on the system’s strong ethos around prevention and emphasised the continued need to deliver high quality services, highlighting the opportunity of collaborative working and further developing strong relationships across the system.</p> <p>The Chair noted the significance of the submission, both in terms of timing and level of detail, and acknowledged the extensive work undertaken across the system. She expressed her appreciation to colleagues across the system for their collective efforts.</p> <p>S Spill queried whether there were tangible opportunities within the ‘other’ category of the WRP slide, and M Bakewell confirmed that these schemes were at a later stage of development and had been supported by a programme initiation document. He advised that they had emerged from benchmarking opportunities and would be reflected in future reporting, which would be presented to the Finance and Contracting Committee.</p> <p>RESOLVED: That the ICB Board:</p> <ul style="list-style-type: none"> • Approve the final version of the operational plan • Note the updates regarding the ICB Capital Plan • Approve the use of the ICB operational Capital Plan
38/26	<p><u>5 Year Strategic Commissioning Plan and 2026/27 Commissioning Intentions</u></p> <p>C Harris introduced the 5-Year Strategic Commissioning Plan alongside the 2026/27 Commissioning Intentions, which were presented as an integrated set of documents to the Board. He advised the 5-Year Strategic Commissioning Plan set the long-term direction of travel and the commissioning for success 2026/27 detailed the year 1 commissioning intentions as the first phase of delivery. It was noted that this was a live and iterative document to respond to policy changes, the financial constraints and operational pressures.</p> <p>It was noted the plan had been developed through extensive internal collaboration across commissioning, clinical and finance teams with engagement with local authorities, provider collaboratives and VCSE partners and reflecting significant public engagement. It was aligned</p>

with the clinical strategy, neighbourhood health development and place-based integrated delivery plans.

The plan moved decisively away from input driven commissioning and annual contract led cycles towards a focus on clear articulation of population outcomes, explicit measures of impact and value and greater alignment with population health data and insight. C Harris explained that a central theme of the plan was active market shaping, including moving beyond a narrow view of “the provider market”, commissioning whole pathways, not isolated services and enabling providers, local authorities, VCFSE partners and communities to co-design solutions and respond flexibly to outcome-based specifications.

C Harris formally acknowledged the contribution of colleagues involved in the development, particularly Jane Cass and Jess Williams, and the wider commissioning team.

C Whalley commented on the opportunities around market sustainability to negotiate together to obtain better value for money.

C Oliver commented that national priorities for mental health were clearly and consistently woven throughout the plan, which was welcomed as a positive feature of the submission. He further commented that the section on financial sustainability was notably realistic, recognising that the plan was focused on stabilisation rather than immediate transformation and acknowledged that delivery would require collective commitment from all providers across the system. The Chair supported these comments, emphasising the importance of establishing a stable operational and financial platform and noted that, without achieving this stability, the system would be unable to progress to the next phase of meaningful transformation.

S Spill queried the practical application of the concept of “shaping the market”, and that there appeared to be limited provider choice and therefore limited scope for traditional market shaping. C Harris emphasised that there was further work required within primary care, including through mechanisms such as the capacity investment fund and explained that the strategic intent was to define the outcomes the system was seeking to achieve within the financial envelope available, and then work collectively with partners to determine how resources could be used more flexibly across pathways to deliver those outcomes. It was noted that this approach would need to be undertaken at scale and represented a key element of the ICB’s developing strategic commissioning capability.

A Cummins commented that the commissioning of services should be understood primarily as an exercise in contract management, rather than market shaping in the traditional sense. He advised that the system needed to move away from viewing individual providers as “the market” and instead focus on a clearer articulation of the needs of local communities. He explained that the strategic intent was to define the outcomes the system sought to achieve for populations, determine the financial envelope available, and then engage the provider sector to signal the nature of the work the ICB wished to commission within those constraints. This approach would enable a more purposeful and outcomes driven dialogue with providers, rather than incremental adjustments to existing service configurations. A Cummins further noted that the ICB needed to become more explicit about what it was seeking to achieve through commissioning, including undertaking horizon scanning and exploring best practice and emerging models of care. This would allow the system to be clearer about the measures of success it expected and to commission with greater confidence and intent. He concluded that this represented a developmental area for the ICB and that there was a need to build skills and capability in strategic commissioning, particularly in market management, outcome specification and system leadership, as the ICB transitioned to its future operating model.

T Hopkins welcomed the plan and specifically commended the way in which the Voluntary,

	<p>Community, Faith and Social Enterprise (VCFSE) sector was embedded throughout the strategy. She highlighted the market development element of the plan and confirmed that, through the VCFSE Alliance, the sector was keen to act as a partner to the ICB in helping to develop the market, including supporting a shared understanding of the VCFSE sector not only as a delivery arm, but also as a commissioning partner. T Hopkins further reflected that, when considering acute services in Blackpool, the system had not always been able to build alternative options into clinical pathways. She emphasised that, if pathways were considered more holistically and aligned more closely with prevention and early intervention, there were opportunities to involve a wider range of providers and partners to reduce reliance on acute services. She also highlighted that moving greater financial autonomy and decision making into place-based arrangements would be critical to realising the full potential of this approach, which would enable commissioning to be driven more explicitly by local need, rather than by existing pathway configurations or historical service models.</p> <p>J O'Brien highlighted the importance of the enablers set out within the strategy, noting the critical role of workforce in delivering the commissioning ambitions outlined in the plan. She made a specific plea for a continued focus on innovation, emphasised that innovation should be seen as integral to effective commissioning and not as an optional or secondary consideration.</p> <p>R Fisher referred to the commitment within the strategic commissioning plan to work closely with Health and Wellbeing Boards on commissioning at a local level. He acknowledged that the forthcoming local government reforms could introduce changes to structures and responsibilities but noted that timescales for these reforms were not yet clear. He queried whether this uncertainty could inhibit or delay the planned transfer of resources and decision making into place based arrangements. C Harris advised that local government reform would not prevent progress in this area, although it would be important to remain mindful of evolving arrangements. He reiterated that the ICB's intention was to continue developing population based commissioning, noting that neighbourhood pilots were already in place and demonstrating the benefits of commissioning for outcomes rather than activity.</p> <p>The Chair noted that, of the five strategic enablers set out within the plan, three were not within the direct control of the ICB, which introduced an additional layer of delivery risk that would need to be actively managed through partnership working, influence, and system leadership. A Cummins advised that the emerging ICB and regional blueprint provided greater clarity on the delineation of leadership responsibility and accountability and that overall accountability for strategy sat at the regional level, whilst the ICB retained a significant role in shaping and influencing delivery, particularly through commissioning levers, partnership arrangements, and place-based working.</p> <p>RESOLVED: That the ICB Board:</p> <ul style="list-style-type: none"> • Approve the final Five-Year Strategic Commissioning Plan • Approve 2026/27 Commissioning Intentions
39/26	<p>The Chair commented that the next three papers presented cases for change. She advised that there were clear, prescriptive processes that must be followed for any service change, depending on the scale of the change and the likely impact on patients and the public. It was noted that the three cases for changes being presented had been developed either by a Trust or by the Provider Collaborative Board and represented a request from a provider perspective for ICB approval to proceed with the relevant process for that service change. She stressed that this was the first step in any substantial change to services and ICB approval would not necessarily mean that the change, as proposed would happen, merely that the process could proceed to the next stage where there would be further opportunity for engagement and</p>

involvement of staff, patients and communities.

The Chair advised the role of the ICB at this stage was to decide whether there was sufficient merit in the case for change to justify further consideration and that in making this decision, consideration must be given to whether the proposed change would further the strategic commissioning intentions previously considered, as well as how it would further our core purposes of improving outcomes in population health and healthcare, tackling inequalities in outcomes, experience and access and enhancing value for money and productivity.

C Harris advised of indicative timeframes for each case for change, noting that there had been engagement with the scrutiny committees. Further to approval from the ICB they would progress to a stage 1 assurance with NHSE, followed by a pre consultation business case being, stage 2 approval via NHSE and subsequently presented to the ICB Board after which formal public consultation would commence.

Service Change

(a) Case for Change: Permanent Cessation of Level 3 ICU services at Furness General Hospital

C Harris advised that a temporary suspension of Level 3 Critical Care at Furness General Hospital (FGH) had been implemented on 23 September 2024 due to patient safety concerns. The proposal to make the change permanent was supported by the Critical Care Network, Trust Executive and ICB clinical leadership. He confirmed that patients requiring Level 3 Critical Care would be stabilised locally and transferred to Royal Lancaster Infirmary. He emphasised that this was not a decision to close critical care services at FGH, but a proposal to formalise an existing temporary arrangement based on sustained clinical risk and workforce challenges.

It was noted that a question had been received in relation to the engagement with residents of Barrow, C Harris advised that this would be considered as part of the pre consultation business case and through the engagement process.

A Cummins acknowledged his previous role as CEO at University Hospitals of Morecambe Bay and advised that extensive pre-engagement and informal consultation had already taken place with local stakeholders, clinicians, and partners, recognising that the proposal was clinically driven. He emphasised the importance of now following the formal, nationally prescribed process.

The Chair reinforced that the Board's role at this stage was not to approve the change itself, but to determine whether there was sufficient merit to proceed to the next stage. She noted that the case for change was framed clearly around patient safety and quality, rather than organisational convenience.

S Nicholls, reminded the board of his role as Chair of the Critical Care Network. He confirmed that the Network had concluded that the current permanent model at FGH was not sustainable and posed a risk to patient safety if reverted to. He also confirmed that the transfer and stabilisation protocols in place for patients under the transitional model were robust, with strong support from NWS and air ambulance services, acknowledging the geographical challenges of the Furness peninsula.

C Whalley highlighted the significant sensitivity of the proposal for Barrow in Furness residents, particularly given wider local infrastructure concerns and recent service changes in the area. She stressed that whilst the proposal was clinically justified, it would be emotive and would require careful and compassionate engagement.

RESOLVED: That the ICB Board approve appendix 1 Case for change

(b) Case for Change: Managing demand in the community enabling reduction in beds at the Royal Lancaster Infirmary

C Harris introduced the item which related to a ward closure at Royal Lancaster Infirmary, emphasising that this was about changing the architecture of care delivery, not reducing access or quality.

He clarified that patients who were currently occupying the 24 bedded ward should not be in an acute hospital environment and that the proposal was part of a broader system shift rather than an isolated bed closure. He advised that both Quality Impact Assessments (QIA) and Equality Impact Assessments (EIA) had been completed by the Trust and that the change was consistent with the emerging 10-Year Health Plan direction and that workforce implications had been considered, with staff redeployment.

The Chair reflected that such changes would require a clear narrative and communication, as reductions in beds are often misunderstood by the public if not framed within the wider system strategy.

RESOLVED: That the ICB Board:

- **Note the contents of the report.**
- **Approve the Case for Change, in line with NHS service change guidance.**

(c) Case for Change: Vascular Reconfiguration Programme

C Harris advised that vascular services were currently delivered across two sites (Lancashire Teaching Hospitals and East Lancashire Hospitals) and that whilst current services were safe, the model did not meet national service specifications for complex vascular surgery. It was noted that the issue had been under consideration for nearly a decade, with repeated attempts to reach resolution. He advised that national guidance, including Getting It Right First Time (GIRFT) and the Vascular Society, supported centralisation of complex vascular procedures.

It was noted that the proposal was to move to a single specialist site for complex procedures, whilst retaining local outpatient, diagnostic, and rehabilitation services, and it was confirmed that the proposal was about securing the future of high quality vascular services, not reducing access.

S Nicholls highlighted that complex vascular surgery required immediate access to multiple specialist teams and advised that this also supported the wider major trauma centre model and 24/7 emergency readiness. He noted the importance of engagement with Wigan residents, who were also affected by the service configuration.

The Chair noted strong parallels with historical cardiac reconfiguration, where centralisation led to improved outcomes.

R Fisher reflected on his involvement in earlier attempts to resolve this issue, noting that whilst consensus had historically been difficult, the case now appeared stronger and more mature.

RESOLVED: That the ICB Board recommended to endorse the Vascular Reconfiguration Programme Case for Change for in line with the Major Clinical Service Change process.

40/26	<p><u>Constitution and Board Membership</u></p> <p>The Chair commented that the papers set out changes to the board and committee membership, which was designed to improve the assurance provided by the committees and to streamline the effectiveness of the board.</p> <p>The Chair expressed her thanks to Sakthi Karunanithi, Cath Whalley, Tracy Hopkins, David Blacklock and Victoria Gent, for their commitment and contributions as regular participants at the Board.</p> <p>D Atkinson advised that the paper presented proposed amendments to the ICB constitution, specifically relating to board composition and membership, to align with the new Model ICB Blueprint and national operating model requirements. She confirmed that the proposed constitutional changes had already been submitted to and approved by NHS England in February 2026, subject to formal ratification by the Board. It was noted that the amendments reflected national guidance on the future operating model for ICBs, the transition of the ICB into a strategic commissioning organisation and the need to ensure appropriate skills, accountability, and representation at board level.</p> <p>The revised Board composition would increase from 15 to 19 members, and the proposed key changes included expansion of the Executive Director membership to reflect revised executive portfolios, strengthened Local Authority representation and Voluntary, Community, Faith and Social Enterprise (VCFSE) sector representation and clarification of quorum and voting arrangements to remain compliant with statutory requirements.</p> <p>D Atkinson clarified that there would be an increase from three to five executive members, in addition to the Chief Executive to include the Chief Commissioning Officer and Chief Strategy and Planning Officer roles as full Board members. It was recognised that the intention of the ICB was to move to a single Chief Clinical Officer but until that time the Interim Chief Nurse and Interim Medical Director would remain within the board membership.</p> <p>The Board currently had four partner members, and the revised board membership proposed one additional Local Authority partner member and one new VCFSE partner member, with both roles appointed through a formal nominations and appointments process expected to take effect from April 2026.</p> <p>RESOLVED: That the ICB Board:</p> <ul style="list-style-type: none"> • Note the submission to NHS England to vary the constitution, and its approval. • Approve the changes to the Board Membership from 1 April 2026. • Approve publication of the amended Constitution with effect from 1 April 2026.
41/26	<p><u>Governance and Committee Review</u></p> <p>D Atkinson presented the recommendations of a review of the ICB's governance and committee arrangements to align to the publication of the Strategic Commissioning Framework. The purpose of the review was to ensure governance arrangements remained proportionate, focused, and aligned to the ICB's evolving role and to improve assurance and decision-making, which had been aligned through a mapping exercise of core requirements.</p> <p>The key outcomes were noted:</p>

1. Establishment of a new Commissioning Committee to provide focused oversight of:
 - Strategic commissioning intentions
 - Population needs assessment
 - Service change proposals
 - Market management and system commissioning
 - To act as the primary route for assurance to the Board on commissioning decisions
2. Refinement of existing committees, including:
 - Finance and Contracting Committee
 - Quality and Outcomes Committee
 - Audit Committee
 - Remuneration Committee

It was noted that there had been a review of the committee membership to reflect recent changes in executive portfolios and to ensure consistent executive and non-executive representation through committees.

3. Future consolidation of committees, specifically:
 - A planned review to merge the People and Culture Committee with the Transition Committee from June 2026, subject to Board approval.
4. Refresh of core governance documents, including:
 - Scheme of Reservation and Delegation
 - Functions and Decisions Map
 - Governance Handbook

The proposed changes were designed to take effect from 1 April 2026, subject to Board approval.

The Chair highlighted that governance must enable delivery, not inhibit it, and noted that the existing committee structure had evolved incrementally since ICB establishment.

D Corcoran welcomed the clarity provided by the assurance mapping, noting that this made explicit which committees provided first-line assurance, where escalation should occur and how risks and performance issues flowed to the Board. She observed that some strategic themes appeared across multiple committees and noted the importance of ensuring chairs and members were clear on distinct committee responsibilities, particularly where functions overlapped.

S Igoe reflected on discussions earlier in the year related to the Board Assurance Framework in that there was an element of confusion between ICB and system-level risks and he welcomed the stronger triangulation between governance structure, Board Assurance Framework and committee work programmes.

RESOLVED: That the ICB Board:

- **Note the outcome of the review of the ICB committee structure and associated governance documents**
- **Approve the new terms of reference to establish a Commissioning Committee**
- **Approve amendments to the following Committee Terms of Reference – aligned to the Strategic Commissioning Framework**
- **Finance and Contracting Committee**
- **Quality and Outcomes Committee**

	<ul style="list-style-type: none"> • Executive Committee • Approve the changes to the documents associated with the above as follows: <ul style="list-style-type: none"> ○ Scheme of Reservation and Delegation incorporating the Operational Scheme of Delegation ○ Functions and Decisions Map ○ Governance handbook • Support that the People and Culture Committee and Transition Committee are reviewed over Q1 of 2026/27, with the intention that one committee is established from June 2026 to undertake the role of both (aligned to the Model ICB Blueprint) • Note that the Chair will approve any further changes to members of committees
42/26	<p><u>Emergency Preparedness, Resilience and Response (EPRR) Core Standards</u></p> <p>C Harris noted that this was the third consecutive year the Board had received an EPRR update and highlighted the scale of progress made with the ICB achieving 91% compliance, assessed as “substantial compliance”. He advised that this represented a significant improvement compared to previous years. All provider Trusts within Lancashire and South Cumbria had also declared substantial compliance and the ambition for 2026/27 was to achieve 100% full compliance.</p> <p>He reported that comprehensive action plans were in place to address the remaining areas of partial compliance and continuous improvement and learning from incidents remained a core focus. The EPRR on call arrangements had been reviewed considering organisational change and workforce reductions. It was reported that key areas of improvement included command and control arrangements during incidents, business continuity planning and multi-agency training and exercising.</p> <p>C Harris acknowledged that the organisational transition had required a comprehensive review of business continuity arrangements, particularly where functions had been consolidated or roles removed. He confirmed that a significant number of business continuity plans had been refreshed.</p> <p>S Nicholls commented that whilst EPRR reporting can appear technical and procedural, it was critically important in practice and he referenced recent real-world incidents, including civil disorder and large-scale emergency responses, to emphasise that EPRR arrangements are live and operational, not theoretical.</p> <p>RESOLVED: That the ICB Board:</p> <ul style="list-style-type: none"> • Note the contents of the report • Note the significant improvements in EPRR compliance ratings across L&SC ICB • Approve the proposed EPRR Core Standards Action Plan (Appendix B)
43/26	<p><u>Audit Committee Escalation and Assurance Report – 18 March 2026</u></p> <p>The Board received a verbal update from the Audit Committee Chair, S Spill, noting that the most recent Audit Committee meeting had taken place shortly prior to the board meeting and that a written report would be included in the subsequent Board cycle.</p>

	<p>Alert: Internal Audit – Limited Assurance Reports The Audit Committee had received two Internal Audit reports providing Limited Assurance, which, in accordance with agreed practice, required escalation to the Board.</p> <p>The first limited assurance report related to Financial Governance, with findings indicating that improvements were required in:</p> <ul style="list-style-type: none"> • Budget monitoring and forecasting • Financial analysis and reporting • Timeliness of budget acceptance by budget holders • Ownership and acceptance of the All Age Continuing Care (AACC) budget, which was identified as a material area of financial risk. <p>M Bakewell acknowledged the findings, describing the report as disappointing but not unexpected given the scale of change and pressure within the organisation. He emphasised that the ICB accepted the audit recommendations in full and noted there was a single high-risk recommendation driving the limited assurance rating and that significant improvements had already been implemented in relation to this recommendation, particularly around budget setting processes, alignment of budgets with WRP schemes and strengthening of financial reporting and grip.</p> <p>M Bakewell also noted the impact on staff morale, recognising the significant effort made by finance teams during a period of exceptional organisational pressure and system change.</p> <p>Alert: Limited Assurance report related to Business Continuity and IT Service Continuity. The audit had identified weaknesses in the system of internal control. The responsible officer had not been present at the Audit Committee meeting, however, the auditors had confirmed that management had accepted the recommendations and had an improvement plan in place.</p> <p>S Spill commented on a broader concern regarding organisational capacity to respond to an increasing volume of audit actions at a time when the ICB’s workforce was reducing. He cautioned that audit expectations were not diminishing and the organisation would need to consider more automated and systematic approaches to assurance, including greater use of data analytics and digital tools.</p> <p>Alert: External Audit Risk – Financial Ledger Implementation S Spill advised the Board of a potential external audit risk arising from the implementation of the new ledger system part-way through the financial year. He explained that external auditors would require assurance reports and delays in completion of these reports could impact the timetable for the annual audit. He emphasised that the risk was currently assessed as low, but that the Board should be sighted on the issue to avoid issues during the accounts approval process.</p> <p>M Bakewell confirmed that engagement with external auditors was ongoing and the finance team was working closely with system suppliers. He confirmed that he did not anticipate a material delay but accepted that the risk required active monitoring.</p> <p>RESOLVED: That the ICB Board note the update.</p>
44/26	<p><u>Northwest Specialised Joint Committee Escalation Report</u></p> <p>C Harris commented on the current misalignment between the joint committee and ICB Board reporting cycles noting the risk of delayed escalation of emerging specialised commissioning issues, which he would discuss with D Atkinson outside of the meeting. He suggested that greater coherence may be achieved by strengthening the reporting flow through the Commissioning Committee, ensuring clearer sequencing of information provided to the Board.</p>

	<p style="text-align: right;">Action: C Harris/D Atkinson <i>(emailed ✓)</i></p> <p>C Harris specifically drew the Board’s attention to the Neonatal service review, confirming that this remained under active consideration at regional level with no immediate decisions requiring ICB Board action and confirmed that further updates would be provided as the review progressed.</p> <p>C Harris referenced that the previously escalated issue relating to mechanical thrombectomy services was no longer listed as an alert, reflecting the progress made in service delivery and improved assurance at regional and local levels.</p> <p>RESOLVED: That the ICB Board Note the Alert, Advise and Assure the committee report and approve any recommendations as listed.</p>
45/26	<p><u>Report concerning matters considered in Private Board meetings</u></p> <p>D Atkinson advised that since the previous public board meeting, the board had met in private on four occasions. She noted the principal themes considered in private included the Medium-Term Plan (MTP) development and submission and Model ICB Blueprint and Operating Model.</p> <p>The Chair thanked Board members for their flexibility in attending additional meetings at short notice, noting that this had enabled the ICB to remain compliant with statutory and regulatory requirements.</p> <p>RESOLVED: That the ICB Board note the contents of the report.</p>
46/26	<p><u>Any Other Business</u></p> <p>There were no issues raised.</p>
47/26	<p><u>Items for the Risk Register</u></p> <p>A Cummins recognised that, as the ICB finalised the Medium-Term Plan, it would be essential to ensure that the Board’s risk oversight remained current and aligned to the emerging delivery challenges. He advised that a dedicated Board risk workshop was scheduled to take place in April, which would focus on updating and refreshing the Board Assurance Framework (BAF).</p> <p>RESOLVED: That there were no items to be included on the ICB Risk Register.</p>
48/26	<p><u>Closing Remarks</u></p> <p>The Chair commented that the discussion throughout the meeting had felt much more strategic in nature; she welcomed the quality of the debate and thanked Board members for their constructive challenge, insight, and contributions during the meeting.</p>
49/26	<p><u>Date, Time and Venue of Next Meeting</u></p> <p>The next meeting to be held in public would be held on Thursday, 14 May 2026, 1.00 pm - 4.00 pm, in the Lune meeting room, ICB Offices, Level 3 Christ Church Precinct, County Hall, Preston, PR1 8XB.</p> <p>The meeting closed.</p>

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).