NHS
Lancashire and South Cumbria
Integrated Care Board

ANNUAL REPORT

2025 - 2026

www.lancashireandsouthcumbria.icb.nhs.uk

lscicb.contactus@nhs.net

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PERFORMANCE REPORT

Aaron Cummins
Accountable Officer
15 June 2026

Performance Overview

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

Introduction

This Annual Report sets out how NHS Lancashire and South Cumbria Integrated Care Board (LSC ICB) has discharged its statutory duties and responsibilities during the financial year 1 April 2025 to 31 March 2026. It provides a clear and transparent account of our performance, governance and use of public resources, and reflects our commitment to being open, accountable, and responsive to the people and communities we serve.

The report explains our purpose as an Integrated Care Board and describes how we have worked with NHS partners, local authorities, the voluntary, community and social enterprise sector, and other stakeholders to improve health outcomes, reduce inequalities and deliver high-quality, sustainable services across Lancashire and South Cumbria. It outlines our priorities for the year, the progress made against our objectives, and the challenges and risks we have faced, alongside the actions taken to manage them.

The Annual Report brings together our Performance Report, Accountability Report and Annual Accounts. Together, these sections provide readers with a comprehensive overview of what we have delivered, how we have governed the organisation, and how we have managed and safeguarded public funds. The report is intended to be fair, balanced and understandable, enabling readers to assess our performance and hold us to account for the decisions we have taken on behalf of our population.

Our Year in Review 2025/26

System leadership and governance

During 2025/26, Lancashire and South Cumbria Integrated Care Board (ICB) continued to strengthen its role as a system leader. The ICB Board maintained clear oversight of quality, equity, productivity and system sustainability, supported by regular Board reporting and assurance processes. Engagement at regional and national level supported alignment with wider NHS priorities and enabled shared learning across the health and care system, and in our places.

Reducing health inequalities

Reducing health inequalities remained a central focus throughout the year. Our population health teams worked with place-based teams to engage with communities with identified health needs, and tackle health inequalities. Equality and health inequalities considerations were routinely embedded within Board and committee decision-making, supported by the consistent use of Equality and Health Inequalities Impact and Risk Assessments across policy development, in our commissioning activities and service redesign and transformation. The Board recognised the needs of groups at increased risk of health inequality, reinforcing a whole-system approach to improving access, experience and outcomes.

Working with people and communities

The ICB continued to strengthen its approach to engagement and involvement, ensuring that public insight and lived experience informed commissioning intentions, strategic planning and service transformation. Collaboration with Healthwatch and voluntary, community, faith and social enterprise partners as well as with local authority Health and Wellbeing Boards and Health Overview and Scrutiny Committees, supported our approach to working with people and communities and supporting inclusive decision-making. Our engagement with partners has helped to reinforce and deliver our strategy of listening to people and communities at place and across the system.

Strategic commissioning and planning

During the year, the ICB progressed work on medium-term planning and commissioning intentions, which built on our engagement with communities and partners to help shape priorities. This approach has not only involved partners and communities in a transparent and open way but has ensured alignment with population need, and shared ownership across the system during a period of continued operational and financial challenge.

Clinical leadership and collaboration

The ICB has established effective clinical leadership through our Chief Nurse and Chief Medical Officer roles, along with strengthened clinical leadership, clinical engagement and collaborative oversight across the system, and at place, as well as focused clinical leadership for our priorities and transformation work. Collaborative engagement with primary care, the provider collaborative, focused on specific priorities which has supported shared accountability, partnership working and system-wide assurance. This has helped drive sustainable and meaningful clinical improvement across the ICB and the health and care system.

Environmental sustainability

The ICB continued to progress its environmental responsibilities in 2025/26, supported by formal governance through the Net Zero Board. Ongoing oversight and published information, including the ICB's Green Plan, reinforced the organisation's commitment to sustainable healthcare and alignment with national ambitions on net zero.

A foreword from our Chair

As Chair of the Lancashire and South Cumbria Integrated Care Board, I am pleased to introduce our Annual Report for 2025/26. This year has been one of continued challenge, transition and important progress, both for our organisation and for the wider health and care system within which we operate.

Throughout the year, the Board has remained focused on our statutory purpose: improving health outcomes for our population, reducing health inequalities, ensuring effective stewardship of our finances, and working with partners to shape a system that is sustainable for the future.

These priorities have been pursued at a time of significant national change, including the publication of the Government's 10 Year Health Plan and the continued evolution of the role of Integrated Care Boards as strategic commissioners. The context in which we work continues to be demanding, but it also reinforces the importance of collaboration, strong governance and clear leadership.

A defining feature of the year has been our commitment to engagement with communities, partners and stakeholders. As a Board, we have spent time in places and hearing about neighbourhood-based models of improving health and care across Lancashire and South Cumbria. This has enabled the Board to better understand how integrated, neighbourhood-based approaches are working to improve access to healthcare and the experiences for people and communities. Visits by Board members to community settings such as family hubs and community health facilities have shown how the NHS, local government and voluntary, community, faith and social enterprise (VCFSE) partners are delivering care closer to home, particularly in areas of greatest deprivation. Through these visits we have seen the real impact of our work in neighbourhoods that has created a real and positive impact and we will look to enable more of these approaches through our strategic commissioning role going forwards.

We have also strengthened relationships with elected representatives. Regular meetings with Members of Parliament throughout the year have created valuable opportunities for open dialogue on issues such as neighbourhood health, women's health, continuing healthcare and service transformation. These conversations have helped to ensure that our strategic decisions are informed by local insight and reflect the concerns and aspirations of the communities we serve.

Good governance has rightly been a major focus during 2025/26. The Board has continued to respond to feedback from NHS England through the Recovery Support Programme, with midyear and follow-up reviews confirming positive progress in strengthening leadership, governance and organisational effectiveness. We have reviewed and refined our committee structure, undertaken a Board Effectiveness Review, and embedded learning into a Single Improvement Plan that supports delivery of our statutory responsibilities. This work is essential to ensuring that the ICB is well-placed to lead the system through further change.

The year has also required significant leadership to support a transition to a new operating model for the ICB. I would like to recognise the contributions of colleagues who have stepped down from roles during this period and thank them for their service. At the same time, I was pleased to welcome new appointments, including our Chief Executive, Aaron Cummins, and a number of executive and non-executive colleagues who have joined or taken on new responsibilities. These changes bring valuable experience and fresh perspectives at a time when clarity of purpose and stability are vital.

Workforce remains a critical issue for health and care services, and the Board has paid close attention to people and organisational development. Without a doubt, the transition and change experienced this year has had a significant impact on our people. We have seen the development of the 5-year Strategic Commissioning Plan which is aligned to the 10 Year Health Plan, a new operating model which aligns to the national Model ICB Blueprint, work to develop a new organisational structure and the voluntary redundancy programme which has led to many staff leaving the organisation. I am very grateful to, and would like to thank all our staff, both those who have opted to remain and those who decided to take voluntary redundancy. Every member of staff has contributed to the development of the ICB and to the improvements we have seen delivered over the past year.

Looking ahead to 2026/27 and beyond, we recognise that further transformation is required. The national direction towards prevention, neighbourhood health and system integration aligns strongly with the work already underway across Lancashire and South Cumbria. However, delivering these ambitions will require clear, strategic decision making, continued financial discipline and an unwavering focus on reducing health inequalities. Success will depend on the strength of our partnerships and our ability to maintain trust with the public and our workforce.

I would like to thank our partners across the NHS, local government and the voluntary and community sector for their continued collaboration, and to acknowledge the extraordinary dedication of staff working across health and care services. Their commitment, professionalism and compassion underpin everything we do.

This Annual Report reflects a year of purposeful activity, learning and progress. As Chair, I remain confident that Lancashire and South Cumbria Integrated Care Board is building the foundations required to meet the challenges ahead and to continue improving outcomes for the people we serve.

Emma Woollett
Chair,
Lancashire and South Cumbria Integrated Care Board

Chief officer's statement

As I reflect on 2025/26, I do so with a strong sense of pride in the people, partnerships and communities that make up Lancashire and South Cumbria's health and care system. This year has been one of significant challenge, change and transition for the NHS nationally and locally, but also one that has reinforced the resilience, professionalism and commitment of our workforce and partners across the system.

In taking up the post of Chief Executive in November 2025, I was struck by the warmth of the welcome I received and the openness with which colleagues, partners and stakeholders engaged.

I am grateful to my predecessor, Sam Proffitt, whose leadership during a particularly demanding period ensured a strong platform on which to build. The progress made before and during this year reflects a system that is learning, improving and increasingly confident in its direction of travel.

Throughout 2025/26, colleagues across health and care continued to deliver services in the face of sustained operational pressure. High levels of urgent and elective demand, workforce challenges, industrial action and seasonal illness placed significant strain on services, particularly during the winter period. That our system continued to provide high quality, safe and effective care is a testament to the excellent planning, flexibility and the dedication of our teams across the NHS, local authorities, the voluntary, community, faith and social enterprise sector, and other partners.

This year has also been a pivotal one in shaping the future role of the Integrated Care Board. In line with national direction, we have focused on our development as a strategic commissioning organisation, strengthening our operating model based on the national blueprint for commissioning, developed our five-year strategic commissioning plan, and clarified our ambitions for shifting to neighbourhood-based models of health and care. Engagement with staff and partners has been central to all of this work. This has ensured that our vision and ambitions are grounded in the practical realities of insight, understanding and commissioning services which meet the needs of our population and communities.

Financial sustainability and performance improvement have been key priorities throughout the year. We have worked closely with providers, partners and NHS England on the development of our medium-term financial plans, investment prioritisation and the delivery of operational standards, while maintaining a clear focus on reducing health inequalities and improving outcomes for those with the greatest need. These are complex and difficult issues, but they are fundamental to securing a sustainable future for our system.

I have been particularly encouraged by what I have seen during visits to places and neighbourhood teams across Lancashire and South Cumbria. Innovative partnership working, strong relationships with local authorities and VCFSE organisations, and a shared commitment to prevention and early intervention are already making a difference in some of our most challenged communities. These examples bring to life our ambition to design services focused on the needs of people and places, rather than organisations.

As we look ahead, there is no doubt that further change lies before us. The continued evolution of the ICB, workforce transitions, improving our organisation culture and the expectations set out in national plans will require strong leadership grounded in our organisation's values. However, I remain confident and optimistic that by working together, listening to our

communities and supporting our people, we can continue to improve health outcomes and reduce inequalities across Lancashire and South Cumbria.

I would like to close by thanking everyone who has contributed to the work of the Integrated Care Board during 2025/26. Towards the end of the year, as part of our evolution to strategic commissioning, and alongside the development of our operating model, and 5-year strategic commissioning plan, the organisation offered our workforce the option of voluntary redundancy as we worked towards a new organisational structure to meet the challenge of reduced funding. I am particularly grateful to those staff who took this opportunity and would like to thank them for their service, much of which was long and distinguished.

It is clear to me that, whether through direct patient care, strategic leadership, partnership working or community support the work of our staff matters. It is a privilege to lead this organisation, and I look forward to building on the progress of this year as we move forward together.

Aaron Cummins
Chief Executive Officer
Lancashire and South Cumbria Integrated Care Board

Statement of Purpose and Activities

Purpose of the Organisation

NHS Lancashire and South Cumbria Integrated Care Board (ICB) is a statutory NHS body which was established on 1 July 2022. The ICB is responsible for planning, commissioning and overseeing NHS services for the population of Lancashire and South Cumbria and for ensuring that NHS resources are used effectively to improve health outcomes, reduce health inequalities and secure high-quality services.

The ICB is accountable for the stewardship of NHS funding allocated to the system and for translating the priorities of the Lancashire and South Cumbria Integrated Care Partnership (ICP) into delivery through NHS commissioning and performance oversight. The ICB works in partnership with NHS providers, local authorities, primary care, the voluntary, community, faith and social enterprise (VCFSE) sector and other partners to support a more integrated, prevention-orientated and community-focused health and care system.

Vision and strategic context

The ICB operates within the shared vision of the Lancashire and South Cumbria Health and Care Partnership, which aims to empower and support healthy communities so that people have the best start in life and can live and age well. This vision is underpinned by a long-term ambition to shift from a reactive, “sick care” model towards prevention, early intervention and care delivered closer to home.

The Integrated Care Strategy sets out five life-course priorities—Starting Well, Living Well, Working Well, Ageing Well and Dying Well which will galvanise and guide collective action across the health and care system in Lancashire and South Cumbria and is endorsed by all partners. The ICB’s role is to align NHS commissioning, operational planning and performance management with these priorities and to support system-wide delivery at scale.

Business Model

In May 2025 NHS England published a model blueprint for ICBs. This clarified the purpose of the ICB, but also initiated a challenging process of organisational change to align the structure of the ICB to the model blueprint core functions and to reduce the running costs of the organisation.

To achieve this, our new operating model will be implemented through five major portfolios. Four portfolios (commissioning, clinical, finance and resources, strategy and planning) will be led by executive directors. The fifth portfolio (corporate) will ensure the organisation continues to discharge its functions as a statutory body under the direction of the Board. Portfolios will be delivered through directorates. The portfolios are structured broadly around the commissioning cycle as set out in the model ICB blueprint. Portfolios have also been updated to take account of the transfer of functions from the ICB to the regional tier of NHS England (NHSE) and the Department of Health and Social Care (DHSC), and vice versa, for example, with the hosting of the Office of Pan Integrated Commissioning (OPIC) which will work across the three ICB’s in the North West.

The operating model has been developed because:

- We want our people to work in well-led, cross functional teams;

- We understand the need to set realistic priorities for the organisation over the next 1-3 years;
- We place a significant value on convening effective partnerships with colleagues in providers, local authorities and the VCFSE;
- We wish to strengthen confidence and capabilities within the organisation after a period of uncertainty and poor morale;

We believe the emphasis on moving towards outcomes-based commissioning will help those with the poorest health improve their health quickest.

The ICB works closely with the Lancashire and South Cumbria Integrated Care Partnership (ICP), which brings together a wider range of partners to set strategic direction, while the ICB focuses on NHS delivery and accountability.

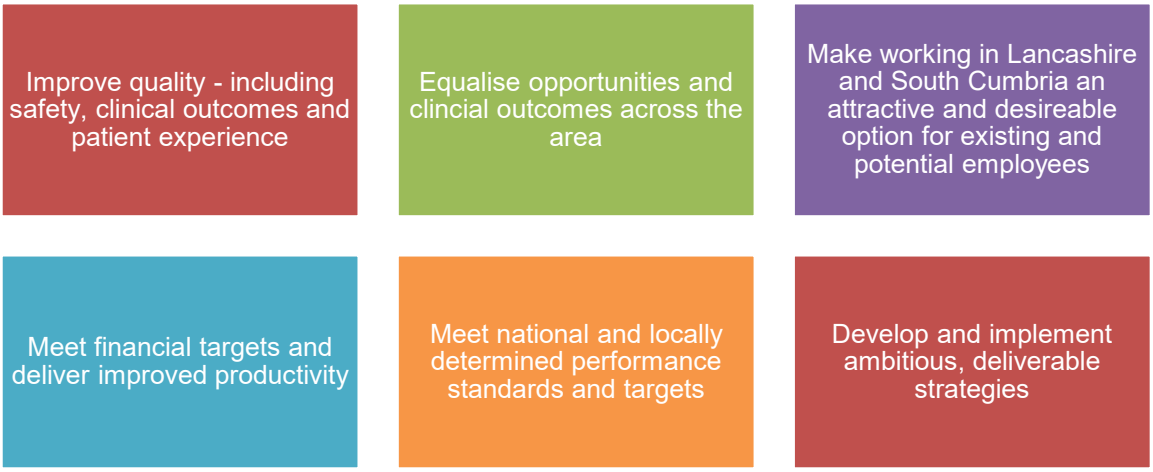
NHS England's Investigation and Intervention (I&I) targets Integrated Care Boards (ICBs) and trusts at high risk of financial failure, providing intensive support to improve and address, poor financial performance. Lancashire and South Cumbria ICB was subject to this intervention, and in response to this, a single improvement plan has been established and delivered as a priority. Alongside this, the financial position continues to be monitored through a system Improvement & Assurance Group (IAG) with meetings on a monthly basis to facilitate financial turnaround and improvement.

Detail regarding the governance structure of the ICB is contained with the accountability report.

Objectives and Strategies

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

ICB strategic objectives



Key Areas of focus:

- **Population Health:** Proactive management of long-term conditions and mental health.
- **Community Care:** Moving care closer to home and creating end-to-end pathways for recovery.
- **Partnership:** Working with local government, VCFSE (Voluntary, Community, Faith, and Social Enterprise) groups, and NHS partners.

The ICB's strategies are delivered through the establishment of annual commissioning intentions, operational delivery plans and multi-year transformation programmes. These are

developed in collaboration with partners and informed by demand modelling, performance data and engagement with patients, staff and communities.

Principal activities during 2025/26

During the year, the ICB's principal activities included:

- Planning and commissioning NHS services across primary care, community services, mental health and acute care.
- Oversight of performance against constitutional standards, quality measures and financial plans.
- Coordinating system-wide responses to demand pressures and recovery priorities.
- Supporting place-based partnerships to deliver integrated care closer to communities.
- Strengthening prevention, tackling health inequalities through population health management and ensuring sustainability as core elements of system planning.

Looking Ahead

The ICB enters 2026/27 with a clear focus on the delivery of our single improvement plan and no longer being in intervention as well as accelerating recovery. Alongside this, improving productivity and addressing long-standing inequalities remains a continuing focus. Partnership work across the health and care system, and engaging with people and communities to respond to demand, and need through the delivery of high quality and well-designed services is a key aspect of our long-term vision for Lancashire and South Cumbria.

Further information

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

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

Integrated Performance and Delivery of ICB Objectives

During 2025/26, Lancashire and South Cumbria Integrated Care Board (ICB) continued to deliver its statutory responsibilities in the context of sustained operational pressure, rising demand and workforce constraints.

The ICB participated in NHS England's Investigation and Intervention (I&I) which targets Integrated Care Boards (ICBs) and NHS Trusts at high risk of financial failure, with the aim of providing intensive support to improve and address financial performance. A key priority of the ICB has been the establishment and delivery of a single improvement plan to achieve this. System performance over the year has demonstrated notable areas of resilience and progress, alongside several persistent challenges where recovery against national standards remained challenging.

Overall, performance has been broadly consistent with expectations for a system at this stage of financial recovery, with performance targets and outcomes comparing favourably to national and North West averages. However, the challenging financial situation, the scale of demand and the challenge of the workforce capacity constraints that services have experienced has limited the pace of improvement in some priority areas.

NHS Medium Term Planning and the 5 Year Strategic Commissioning Plan

Every year, the ICB has published its commissioning intentions and shared these with health and care providers, as well as other partners and stakeholders. These confirm ICB priorities both in the short and medium terms and outline how it wishes to work with partners to deliver against these priorities.

For 2026-27, the development of our commissioning intentions started earlier in 25/26 with the aim of undertaking engagement with people and communities, as well as partners and stakeholders to shape the priorities, identify potential contractual changes and understand activity shifts. This work progressed throughout the Autumn of 25/26 and into the Spring of 2026.

Several new NHS planning documents were issued, which provided further clarity on overall NHS priorities through guidance and frameworks setting out how ICBs will operate in the future. The NHS Planning Framework (August 2025) set out the high-level direction for strategy development and operational planning in the short and medium term. This was followed by the publication of the Medium-Term Planning Guidance (October 2025) and finally the Strategic Commissioning Framework (November 2025).

These frameworks represent a fundamental shift towards medium to long-term planning, integrated commissioning, and population health management. In addition, they represent a shift for the NHS away from the historical short-term planning cycles to a longer term, more sustainable model of strategic commissioning built on innovation, local empowerment, and financial discipline. Lancashire and South Cumbria ICB welcome these changes and has worked hard to respond to them.

The process for the development of the ICBs 5 Year Strategic Commissioning Plan has been guided and supported by the following additional work and documents:

- Integrated Needs Assessment - based on the existing Joint Strategic Needs Assessment (JSNAs), population health needs, performance, quality, outcomes and finance
- Clinical Strategy (including the ICB emerging Neighbourhood Model)
- Delivery Plans for provider trusts and neighbourhood health plans, and
- An ICB organisational development plan.

Throughout this period the ICB also developed the commissioning intentions for the next year (2026/27). This development work has meant that commissioning activity is now prioritised to align with the “three shifts” as outlined in the NHS 10 Year Plan. The shifts are: (1) Hospital to Community, (2) Sickness to Prevention and (3) Analogue to Digital. This represents the commencement of the ICB moving into the strategic commissioning space as determined by the recent release of the NHS Strategic Commissioning Framework.

Commissioning intentions are a vehicle for improving care, transforming pathways, improving health and lives. These intentions for 2026-27 are framed in the context of the NHS 10 Year Plan and the current strategic priorities which are: (1) improving population health and patient outcomes (2) addressing health inequalities through managing long-term conditions in primary care, (3) improving end-of-life and frailty care, (4) intermediate care and service configuration.

Over the last year, the ICB has been working towards our joint forward plan. This Annual Report demonstrates that the ICB has exercised its functions in accordance with the plans published under section 14Z52 (Joint Forward Plan) and section 14Z56 (Joint Capital Resource Use Plan). Both the Joint Forward Plan (JFP) and Joint Capital Resource Use Plan (JCRUP) were formally approved by the ICB Board and published in line with statutory requirements, and their delivery is subject to ongoing oversight through the ICB’s governance framework. This includes regular reporting through the Board and committee structure. There has been a relentless focus on system performance, the financial position and progress against strategic priorities. This Annual Report, includes the Performance Report which provides a year-end summary of activity, performance and delivery, demonstrating how the ICB has discharged its functions through commissioning, system leadership and partnership working aligned to the priorities set out in the Joint Forward Plan. These priorities include improving prevention and reducing inequalities, strengthening community-based care, improving quality and outcomes, and enhancing system productivity.

In relation to capital planning, the ICB has exercised its functions in accordance with the Joint Capital Resource Use Plan through robust governance, financial stewardship and system-wide prioritisation of capital investment, supported by Board approval and monitoring arrangements.

Publicly available information on the ICB’s website provides further supporting evidence of alignment between planning and delivery. The Joint Forward Plan is published and sets out how the system will meet population health needs through prevention, partnership working and service transformation.

This is supported by commissioning intentions and system strategies, which translate these priorities into delivery actions, including care closer to home, digital transformation and financial sustainability.

In addition, the Joint Capital Resource Use Plan is published annually in accordance with statutory requirements, evidencing compliance with section 14Z56. The Infrastructure Strategy further demonstrates that capital investment is explicitly aligned to service strategies and transformational priorities, with infrastructure acting as an enabler of delivery and informing investment prioritisation across the system. Together, these elements demonstrate that the ICB has exercised its functions in accordance with its statutory plans, with clear alignment between

strategy, governance, financial planning and delivery. Furthermore, the ICB has developed a Five-Year Strategic Commissioning Plan, which builds on and incorporates the statutory requirements of the Joint Forward Plan, providing an enhanced medium-term framework that aligns commissioning decisions, system priorities and delivery.

Performance appraisal

During 2025/26, Lancashire and South Cumbria Integrated Care Board (ICB) demonstrated strong overall progress in delivering its objectives despite operating within a highly challenging environment characterised by sustained demand, workforce pressures and financial recovery requirements. The ICB showed clear evidence of resilience, system leadership and improvement, with performance in several key areas meeting or exceeding expectations and comparing favourably to regional and national benchmarks. At the same time, several areas require further improvement to achieve national standards and support long-term sustainability.

Planned Care

In planned care, the ICB delivered performance broadly in line with expectations. At the end of March 2026, 66.3% of patients were treated within 18 weeks, exceeding the local target and performing above both regional and national averages. Performance against 52-week waits was also in line with plan and slightly better than the national position. This reflects effective system coordination and targeted elective recovery work. While a small number of patients continued to wait over 65 weeks, this was limited to specific specialties and represents a significantly reduced cohort compared to earlier in the recovery period. Focused improvement programmes are in place to address these residual delays, demonstrating a clear trajectory of improvement.

Diagnostics

Diagnostic services experienced continued pressure, with performance below the national six-week standard and increases in waiting lists across the year. However, the ICB has taken proactive steps to address this, by utilising Community Diagnostic Centre capacity, implementing mutual aid arrangements and strengthening the “CDC First” approach. These actions have helped stabilise performance and provide a foundation for further recovery. The ongoing challenge reflects national capacity constraints and rising demand, rather than a lack of system oversight.

Children and Young People

Performance of services for children and young people showed notable improvement, particularly in reducing long waits. The number of children waiting over 52 weeks reduced significantly across the year, demonstrating the impact of targeted interventions, including the “90 day challenge” and additional commissioned capacity. While 18-week performance remains below target, the reduction in the longest waits and stabilisation of waiting lists represent meaningful progress. This indicates that the ICB has successfully prioritised the most vulnerable patients while continuing to build longer-term capacity.

Cancer

Cancer services delivered a positive outcome in early diagnosis, with the achivement of the Faster Diagnosis Standard. This reflects effective pathway improvements and system-wide collaboration. While treatment standards, particularly the 62-day pathway, remain below national expectations, the ICB has strengthened governance through the work of the Cancer Board, increased investment in key pathways and enhanced operational oversight. These actions demonstrate a clear and structured response to improving cancer performance and reducing variation between providers.

Urgent and emergency care

Urgent and emergency care services were a particular area of strength in performance during the year. The ICB exceeded the national four-hour A&E target, performing better than both regional and national averages. There were also significant improvements in ambulance handover times and response times, particularly towards the end of the year. These achievements highlight effective system coordination, strong partnership working and the impact of targeted improvement plans. While pressures remain, particularly around discharge and flow, the overall trajectory is positive and demonstrates increasing system resilience.

Primary care

The performance of Primary care was also strong, with GP appointment activity exceeding plan and continued improvement in pharmacy and dental access. The high level of Pharmacy First participation and increased consultation activity demonstrate successful delivery of national priorities to shift care closer to home. While workforce capacity remains a constraint, particularly in general practice, the ICB has taken steps to mitigate this through service redesign, improved access routes and targeted initiatives.

All-age continuing care

Across all-age continuing care services, the ICB has begun to reduce previously high eligibility rates over consecutive quarters, indicating improving control and consistency. This represents early progress in addressing a longstanding pressure, although the area continues to require close management due to its financial and operational impact.

More broadly, the ICB made significant progress in strengthening its strategic approach. The development of commissioning intentions and the five-year Strategic Commissioning Plan has provided a clearer framework for delivering long-term objectives, including prevention, neighbourhood care and digital transformation. This demonstrates a maturing approach to continuing care, with the ICB increasingly focused on its role as a strategic commissioner and aligned with national policy direction.

Despite these positive developments, several key risks remain that could affect future performance. These include sustained high demand across services, particularly in diagnostics and planned care; workforce capacity constraints; and variation in provider performance. These risks are important because they directly influence waiting times, access to care and the pace of recovery against national standards. The ICB has managed these risks through strengthened governance, regular performance oversight, targeted recovery plans, additional investment and system-wide collaboration. Over the course of the year, these risks have generally become better understood and more systematically managed, although they have not been fully mitigated.

In summary, the ICB’s performed inline with expectations during 2025/26 especially in the context of the challenges faced. There is clear evidence of progress across multiple priority areas, with performance meeting or exceeding expectations in some areas and demonstrating improvement over time. Where standards have not yet been met, there is clear evidence of active management and structured recovery plans. The ICB enters 2026/27 with strengthened foundations, clearer strategic direction and an improved ability to manage risk, while maintaining a continued focus on improving outcomes, reducing inequalities and delivering high-quality care for its population.

Research and Innovation

The Health and Care Act 2022 set out the legal duties and roles of ICBs to facilitate, co-ordinate and promote research across the Integrated Care System (ICS). The ICB has been undertaking this duty through the Research and Innovation Collaborative. The Research and Innovation Collaborative met monthly over the last year, and brought together a wide range of stakeholders from across the ICS including all four HEIs (Higher Education Institutes), all five NHS Trusts, primary care, local authority representation and VCFSE colleagues. The ICB People and Culture Committee has the responsibility to seek assurance on arrangements for ensuring promotion of research as an essential function for continuous improvement, oversee and monitor delivery of the work of the Research and Innovation Collaborative, and report against this to the Board as necessary. The committee received a paper in this regard at its July 2025 meeting which outlined that significant progress has been made across the Lancashire and South Cumbria Integrated Care System to embed research and innovation. Progress aligned closely with the four development pillars from the 'Research Priorities – Plan on a Page'; embedding research and innovation, developing career pathways, health creation, and commercial research and innovation. The plan's delivery is enhanced by targeted funding via the Research Engagement Network (REN). The Committee endorsed a move toward regional collaboration in research delivery, aligning with Greater Manchester and Cheshire and Merseyside system partnerships. This strategic direction is not only consistent with the 2023 NHS England guidance and reconfiguration of clinical research networks (CRNs) into Regional Research Delivery Networks, but it is now emphatically endorsed by the 2025 NHS 10-Year Plan. This model aims to:

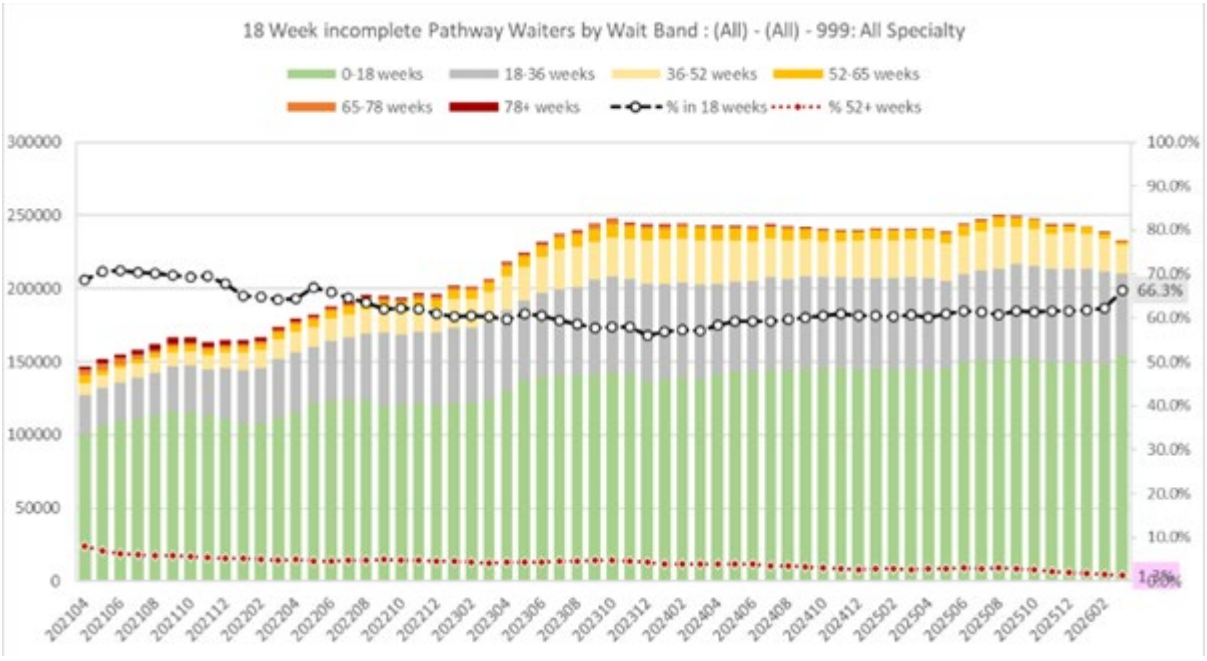
- Leverage shared infrastructure to drive efficiency and scale
- Enable staff across all disciplines to participate meaningfully in research
- Strengthen community partnerships to ensure research reflects the needs of our respective populations
- Position our ICB to secure future national and commercial funding streams

Performance analysis (As at March 2026)

Domain	Metric	Mar-25	2025-26 Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Latest comparable position	
																NW	National
Elective	Total patients waiting more than 78 weeks to start consultant-led treatments	11	0	10	29	19	30	23	22	6	5	3	0	2	4	-	-
	Total patients waiting more than 65 weeks to start consultant-led treatments	155	0	202	368	350	306	245	246	127	91	36	23	46	42	-	-
	% Patients waiting more than 52 weeks to start consultant-led treatments	2.8%		2.9%	3.0%	3.1%	3.0%	3.0%	2.8%	2.7%	2.3%	2.0%	1.8%	1.6%	1.3%	1.3%	1.4%
	% Patients waiting 18 weeks to start consultant-led treatments	60.7%	92%	60.1%	61.0%	61.6%	61.4%	60.7%	61.6%	61.4%	61.6%	61.7%	61.7%	62.3%	66.3%	64.7%	65.2%
Diagnostic Waiting Times	% Patients waiting less than six weeks for diagnostic test	80.7%	95%	80.1%	78.7%	79.1%	80.0%	77.8%	79.3%	80.7%	79.7%	77.4%	77.0%	81.0%	79.1%	87.3%	78.8%
CYP / Maternity	Smoking at time of delivery [Year-to-Date]	7.8%	6%		6.9%			5.6%			5.6%			not available		5.20%	4.50%
	Population vaccination coverage - MMR for 2 doses (5yrs old)	87.7%	95%		87.4%			86.9%			86.4%			not available		not available	not available
Cancer	31 Day First Treatment	91.9%	96%	91.1%	93.3%	94.7%	95.1%	94.6%	92.9%	95.4%	95.5%	93.5%	92.50%	95.40%	95.60%	95.0%	92.5%
	62 Day referral to treatment	69.5%	85%	67.2%	65.3%	63.0%	66.3%	67.7%	63.2%	66.4%	66.4%	70.8%	64.40%	65.80%	71.90%	77.4%	72.8%
	% meeting faster diagnosis standard	79.4%	75%	73.7%	71.5%	74.2%	72.9%	70.3%	70.3%	74.0%	75.1%	76.4%	72.10%	78.70%	77.50%	80.7%	79.4%
Urgent and Eergency Care	A&E 4hr Standard	76.9%	78%	77.4%	77.5%	77.2%	77.3%	76.8%	76.2%	76.1%	75.5%	75.7%	74.4%	74.7%	78.5%	74.9%	77.1%
	Average ambulance response time: Category 2 [NWAS]	00:25:31	00:30:00	00:23:52	00:23:34	00:25:39	00:26:02	00:23:04	00:25:00	00:27:37	00:30:18	00:33:28	00:32:48	00:27:09	00:24:33	00:24:33	00:26:18
	Ambulance handover delays over 60 minutes			8.5%	6.5%	7.0%	6.1%	2.8%	4.0%	5.7%	4.4%		14.2%	14.16%	5.13%	5.60%	5.40%
Mental Health and Learning Disabilities	Inappropriate adult acute mental health Out of Area Placement (OAP)	14	0	14	2	2	16	6	4	0	0	0	2	1	3	-	-
	Estimated diagnosis rate for people with dementia	68.4%	66.7%	68.1%	68.2%	68.4%	68.7%	69.0%	69.0%	69.3%	69.0%	68.8%	68.5%	68.1%	68.5%	70.30%	66.30%
	Reliable Improvement	65.8%	67%	66.9%	67.7%	65.9%	68.9%	65.1%	65.6%	67.5%	62.2%	65.4%	65.9%	66.3%	68.1%	67.30%	68.70%
	Reliable Recovery	44.0%	48%	46.0%	44.8%	43.5%	45.2%	42.4%	42.7%	42.9%	40.8%	40.9%	43.9%	43.0%	43.5%	45.0%	48.4%
Primary Care	Number of general practice appointments per 10,000 weighted patients	4334	in month (latest) 4343	3930	3926	4130	4389	3725	4386	5477	4232	4188	4499	4141	4560	4612	5478
	Urgent dental appointments	11285	in month (latest) 13743	11486	11208	11388	12171	11078	12361	12468	11598	12799	13061	12201	12661	not available	not available
	Pharmacy first activity	29678	in month (latest) 28366	31667	31373	30670	34888	28287	29170	39648	31760	33949	32574	tbc	tbc	not available	not available

Planned Care

The number of patients waiting for treatment in the ICB was a total of 232,460 patients at the end of March 2026. At the end of March 2026, Lancashire & South Cumbria ICB reported:



- 4 patients waiting in excess of 78 weeks.
- 42 patients waiting in excess of 65 weeks.
- 2,991 x 52+ week waiters of which 370 patients (12.4%) were waiting at Independent Sector (IS) providers or at NHS providers outside of the L&SC area.

During 2025-26, the focus has moved back to the 18-week referral to treatment (RTT) measure. There was a national average target of 65% by March 2026 as a milestone towards recovery back to the 92% constitutional standard. Within the 2025-26 planning round a level of expected performance (5% above baseline by March 2026) has been articulated for each provider (and ICB).

At the end of March 2026, the ICB reported that 66.3% of patients were waiting 0-18 weeks for treatment (against our 66.2% target). The ICB performed better that the regional average (64.7%) and the national average (65.2%). However, there were variations in performance across the four main acute providers within our system.

1.3% of patients were waiting 52 weeks or longer for treatment at the end of March 2026 which was in line with the ICB plan. This was in line with the regional average and a better position than the national average (1.4%). It should be noted that there is variation by provider and specialty.

Specific programmes of work are underway across the system to support delivery and address these pressures through both the Planned Care commissioning and Elective Reform provider initiatives.

NHS England outlined the requirement that “all providers are expected to eliminate their remaining 65 week waits by mid-December and meet the planning guidance requirements for 52 week waits by the end of March 2026”. Despite every effort by providers and ICB commissioners to get all patients seen and treated by the deadline, the March 2026 Referral to Treatment (RTT) data reported a total of 42 x 65+ week waiters for L&SC ICB patients. Gynaecology and Cardiothoracic Surgery are responsible for the majority of these long waiters.

Pre-referral Advice and Guidance utilisation has been increasing this year, supported by the national enhanced service for general practice. However, our diversion rates are below the nationally anticipated range of 40-45% with variations by specialty and provider.

Diagnostics

The national ambition is for 99% of patients to receive their diagnostic test within 6 weeks. Performance was 79.1% for the ICB in March 2026, although again there was variation in performance between acute providers.

The diagnostic waiting list for the ICB and the 4 main acute providers increased in March 2026 from the previous month. Overall, the ICB waiting list increase by 4,775 (9.2%) since the end of 2025-26 while the aggregated waiting list for the 4 main acute providers has increased by 4,734 (10.9%) over the same period. This trend is comparable against both the national and Northwest diagnostic waiting list sizes, which have both increased over the same period.

The ICB position is driven by challenged performance at Lancashire Teaching Hospitals Trust and Blackpool Teaching Hospitals. Echocardiography, Audiology, Colonoscopy and Non-obstetric Ultrasound (NOUS) had the highest number of patients waiting over 6 weeks.

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

Across Lancashire & South Cumbria, community diagnostic centre activity was under plan in March 2026. 27,477 tests were undertaken against a plan of 33,390, 17.7% under plan. Preston Healthport and Westmorland saw the greatest variance. Mitigations throughout the year to optimise as much CDC capacity as possible have included mutual aid within CDCs for Echo, optimising the 'CDC First' approach by diverting elective activity from Acute hospitals to CDCs where possible and adjusting the profile of tests delivered to meet demand.

Children and Young People (CYP)

There was a fall in the number of 52 week waits in community services to 24 at the end of March 2026, as the service offer developed in partnerships with the VCFSE provider, Spring North impacts positively on long waiters. The 18 weeks performance was 50.4% for the ICB, significantly below the target of 78% for the medium term NHS plan for 2026-27.

Long waits for community paediatrics services were monitored through the '90 day challenge' work requested by NHSE in quarter 3 of 2025-26. The plan was to reduce the number of those waiting 52 weeks in the service by the end of quarter 4 2025-26. The children and young people's team worked with the main providers through the vulnerable services process and commissioned a third party to undertake initial assessment on those children waiting over 52 weeks for these services.

At the end of March 2026 there were 18,291 children on waiting list across the four main providers. The size of the waiting list remained static since the start of October 2025 which was challenging with the need to reduce the overall size. There were 194 (1.06% of the total waiting list) children waiting over 52 weeks at the end of March in the four main providers, which had more than halved since the beginning of the calendar year, driven by falls in children waiting for Paediatric Dentistry and Maxillofacial Surgery. The 18 weeks RTT performance was 61.8% continuing a steady increase since the start of the calendar year.

At the end of March 2026 there were 252 children waiting over 52 weeks across the ICB, down from 544 at the start of the calendar year, with 51 waiting out of area. The total waiting list was 22,169 and remains static in the year.

The smoking at time of delivery (SATOD) indicator very slightly deteriorated in Q3 2025-26 to 5.63% from 5.61% in the previous quarter and resulted in the 6% target been met across 2 consecutive quarters. This sustained improvement has been driven across all areas within the ICB. Although the rate continued to fall in Blackpool, the level of SATOD remains relatively high and is one of the highest rates in England when the rate is reported at sub-ICB level. The position in quarter 3 of 2025-26 is significantly below the position at quarter 1 2024-25 (17.7%). Finally, the level of patients with smoking status of 'not known' fell further in quarter 4 of 2025-26 to 5.15%.

Cancer

In March 2026, the ICB achieved the Faster Diagnosis Standard of 75% with performance at Blackpool Teaching Hospital being the most challenging.

The "31-day Decision to Treat to Treatment" standard in England refers to the NHS target that 96% of cancer patients should begin their first definitive treatment within 31 days of a decision

to treat. This standard applies to all cancer patients, regardless of how they were referred for treatment. Performance for the ICB in aggregate across the 4 providers was below the standard at 95.4% in March 2026, with the total ICB position being 95.6%.

Achievement against the 62-day standard remains less favourable. Overall, performance across the ICB in March 2026 was 71.9%, with none of our main providers achieving the target.

At least 80% of Lower Gastrointestinal (LGI) urgent suspected cancer referrals should include a Faecal Immunochemical Test (FIT) result. The ICB has achieved this target since February 2025.

Service improvement work has been ongoing across a range of pathways including Urology, Skin, Lung and Gynaecology. Investments have been made to each Trust to support improvements in their local pathways.

The ICB-led Cancer Alliance Board which includes representation from all acute trusts, NHSE, Public Health, and the Cancer Alliance oversees early diagnosis, screening, and secondary care delivery. Operational oversight takes place at monthly trust-level reviews and fortnightly cancer manager meetings focusing on variation, milestone tracking, and best practice.

Urgent and Emergency Care

In March 2026, the number of patients seen and treated within 4 hours in A&E exceeded the 78% target at 78.49%. This performance was better than both the England (77.1%) and the Northwest (75.0%) achievement.

The latest data showed an improvement on the proportion of patients waiting more than 12 hours in A&E (8.89%), a similar position to that across the North West (9.64%).

There was a requirement to minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards. In March 2026 the proportion of delays over 30 minutes fell to 21.37% from 34.97% in the previous reporting period. In comparison, performance across the Northwest was 25.6% and 22.6% nationally. There was variation between providers with East Lancashire Hospitals Trust at 16.5% and University Hospitals Morecambe Bay at 32.6%.

45-minute ambulance handover implementation (Release to Rescue) required all providers to have processes to support safe and successful implementation at site levels. In March 2026, 88.3% (9,692 out of 10,596) of ambulances were handed over in 45 mins.

The Category 2 response time target in the planning guidance is an average of 30 minutes across the year. This had been achieved up to November 2025, when a deterioration was seen across the winter months. The position improved in March 2026 to 24 minutes and 33 seconds across the North West which was favourably to the national achievement of 26 mins and 18 seconds.

*CAT 2 - A serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport

Once people no longer need hospital care, being at home or in a community setting (such as a care home) is the best place for them to continue recovery. However, unnecessary delays in being discharged from hospital are a problem that too many people experience. To track the scale and extent of this issue a metric looks at the average number of beds occupied by

patients who no longer meet the criteria to reside in a hospital bed (NMC2R) as a percentage of the average number of occupied adult General and Acute (G&A) beds available during the month.

Across Lancashire & South Cumbria 13.0% of all adult General and Acute (G&A) beds were occupied by patients who were not meeting the criteria to reside (NMC2R). The data can fluctuate daily (and weekly) while there is variability at provider level, Overall, the ICB performed better than Northwest and national averages.

The Hospital@Home service (previously referred to as the Virtual Ward Programme) across Lancashire and South Cumbria is predominantly designed to deliver community capacity to support admission avoidance. Capacity across Lancashire & South Cumbria was 384 beds and occupancy was 77.9% for the March 2026 snapshot, slightly below the planning trajectory of 80.2%. Capacity and utilisation are consistently in line with national averages, and our system has among the highest patient throughput of systems in England, a measure we believe is essential to consider alongside utilisation.

Work continues on reporting the delivery, impact, exceptions and de-escalation cost reductions of place-based Urgent and Emergency Care improvement plans. The Urgent and Emergency Care (UEC) Strategic System Improvement Group continues to review delivery of improvement plans, their impact and key challenges and constraints.

Mental Health

There were three inappropriate out of area placements for the ICB at the end of March 2026, mainly due to an increase in demands for mental health beds. Work has continued with Lancashire and South Cumbria Foundation Trust on a 5-point plan to improve the position. One of the key elements of the plan, the number of patients Clinical Ready for Discharge (CRFD) has seen a fall in the last quarter.

The proportion of patients achieving a reliable recovery increased to 43.5% in March 2026 against a target of 48%. The ICB continued to work with providers on the primary drivers of ‘reliable recovery’ including engagement and reducing early drop-out, ensuring adequate therapy dose and timely step-up, reducing waits within the treatment pathway, strengthening recovery- focused supervision and governance and improving the accuracy of outcomes data.

The dementia prevalence target was met, albeit performance remained below the Northwest but above the national average.

Primary Care

The 2025-26 Operational Planning guidance required the ICB to submit a plan for the anticipated volumes of GP appointments that would be undertaken profiled across the year. March 2026 data shows the ICB was ‘above plan’ by +43k appointments (+4.98%) for the month and continued to improve the year-to-date performance against the original planning submission which was -0.23% down on the total plan for the year.

Lancashire & South Cumbria has a lower general practice workforce per head of population than national averages and this will impact upon the number of appointments able to be provided. This is particularly significant in terms of GPs per head of population as the latest position suggests that there are 5.69 full time equivalent GPs per 100k weighted population for the ICB compared with 6.29 FTE GPs per 100k weighted population nationally.

It was the ICB's ambition for 40.3% of the adult resident population (in a 24-month period) and 63.03% of resident children (in a 12 month period) to have seen an NHS dentist by March 2026. The latest available position for March 2026 indicates that the ICB surpassed both these targets with 41.5% for adults and 68.1% of children.

In February 2025, the ICB was given a target allocation for the number of additional urgent dental appointments the ICB would need to provide as part of the Government's commitment to deliver an additional 700k urgent appointments nationally. The ICB has reported a level of delivery consistent with the programmes baseline, which is around 11,500 urgent appointments per month. Updated data indicates some increase in the average monthly volumes to around 12,500 though this is still short of the target. Additional capacity from the call handling service that was initiated in the last year, should direct more people into the dental services the ICB has commissioned. The ICB also implemented the Urgent Dental Care Incentive Scheme in the second half of this year with an associated communications campaign to support this initiative.

The Pharmacy First service enables patients to be referred into community pharmacy for an urgent repeat medicine supply, minor aliments consultation, or for one of seven minor illnesses. Pharmacy provision is excellent across the system with 98% of pharmacies signed up to deliver Pharmacy First. GP referrals into the service are not consistent and are variable, however the ICB has a Pharmacy Access programme to look at those practices who are sending low and no referrals. Consultation activity reported to date is running above planned levels. The number of consultations for defined clinical pathways has increased again, with December 2025 reporting the highest volumes of consultations over the past two years. Blood Pressure checks increased to a peak in October 2024 and this was repeated in October 2025. Oral contraception consultations are also continuing to steadily increase.

All Age Continuing Care

'NHS Continuing Healthcare' (NHS CHC) is a package of ongoing care that is arranged and funded solely by the NHS where the individual has been assessed and found to have a 'primary health need' as set out in the National framework for NHS Continuing Healthcare and NHS-funded nursing care. Such care is provided to an individual aged 18 or over, to meet needs that have arisen because of disability, accident or illness.

The ICB is a national outlier in both monthly eligibility rates and eligibility per 50 thousand population with almost double the rate seen nationally. The rate has reduced for the last five quarters.

Mental Health Expenditure

During 2025/26, the ICB continued to prioritise mental health and emotional wellbeing as a core element of its statutory commissioning responsibilities. Investment in mental health services supported delivery of national and local priorities, including access standards, crisis care, community mental health transformation, and system-wide approaches to prevention and early intervention. This focus is consistent with the ICB's strategic objectives and its commitment to improving outcomes and reducing health inequalities for people with mental health needs.

The financial performance in relation to the Mental Health Investment Standard is reported in the ICB's Annual Accounts at Note 21.

Safeguarding children

Throughout 2025/26, the ICB Board and Quality and Outcomes Committee have received safeguarding children assurance reports which have ensured that the ICB has discharged its statutory safeguarding duties. These reports have provided the board and the Quality and Outcomes Committee with the assurance that systems to safeguard children are in place, monitoring is undertaken, clinical leadership provided, and the required multi-agency work is undertaken across the Lancashire and South Cumbria system.

National learning, audits, safeguarding datasets and the Child Voice Strategy

Key aspects of the ICBs safeguarding work draw on:

- National review and panel reports, including learning from independent inquiries, to strengthen local safeguarding practice.
- NSSG ICB SAAF implementation audits, reported quarterly, which provide assurance on statutory compliance and identify areas requiring improvement.
- Child death overview processes, which ensure lessons from child deaths are shared and acted upon.
- Monitoring and oversight of vulnerable cohorts, including looked after children and care leavers, children subject to Section 47 enquiries, unaccompanied asylum-seeking children, children affected by FGM, information flows via CPIS, and children experiencing domestic abuse.

The Board and the Quality and Outcomes Committee received reports throughout the year, highlighting strengthened quality assurance arrangements for children's services. The Children and Young People's Quality Team has continued to develop a Quality Assurance Framework, monitor compliance with guidelines, and support improvements for SEND, and neurodevelopmental pathways.

The ICB has prioritised "child voice" by adopting the Lundy Model of participation. This framework ensures that children and young people are listened to, their views are taken seriously, and they are actively involved in shaping health and care services. The strategy emphasizes protecting rights and improving lives for children and young people.

Safeguarding reports to the Quality and Outcomes Committee throughout 2025/26 have demonstrated ongoing oversight of safeguarding risks, mitigations and learning, supported by datasets contained in the ICB Safeguarding Dashboard.

Working with safeguarding partners (Local Authority, ICB and Police) under *Working Together to Safeguard Children (2018)*

It is a statutory requirement for the local authorities and the ICB, along with the relevant constabulary to jointly set out and publish their local multi-agency safeguarding arrangements.

These arrangements explain how agencies collaborate to promote children's welfare, share intelligence, coordinate responses to risk, and ensure effective oversight of system-wide safeguarding practice. There are four children's safeguarding partnerships of which the ICB is an active member, these are:

- BwD Safeguarding Childrens Board
- Blackpool Safeguarding Partnerships -

- Lancashire Safeguarding Partnership - About Lancashire Safeguarding Children
- Welcome | Westmorland and Furness Safeguarding Children Partnership

Multi-agency partnership work across each area, and across the system was reported to the ICB's Quality and Outcomes Committee, as well as the Board. Executive leadership from the Chief Nurse has ensured board level oversight of the work of each safeguarding partnership. System-wide working was reinforced throughout the last year, in quality-related performance reports, multi-agency task and finish groups, contributions to SEND inspections, cross-agency quality improvement workstreams, and shared safeguarding learning forums. Safeguarding partners have operated collectively to identify concerns, respond to themes, and improve the care and experiences of vulnerable children. Each partnership produces an annual report which can be located on their website.

Board-level quality reports regularly reference the ongoing cycle of learning, review and assurance, including how findings from reviews, audits and independent reports have informed improvements to care and safeguarding systems for children and young people. These include strengthened governance, clearer escalation processes, improved quality monitoring, and enhanced collaboration with provider partners.

Strategic, clinical and professional safeguarding leadership, and confirmatory statement of compliance with the Safeguarding Accountability and Assurance Framework

The ICB's responsibilities for clinical, professional and strategic safeguarding leadership were managed through the Chief Nurse who reported to the Board and the ICB Quality and Outcomes Committee along with the ICB's System Quality Group. Over the last year, the Chief Nurse and the Nursing and Quality directorate ensured that the ICB discharged its duties and was accountable for ensuring that safeguarding was embedded across all commissioned and contracted services, including independent providers, and that systems exist to assure practice quality and risk mitigation.

Safeguarding leadership is exercised through:

- Regular reporting to the ICB Quality and Outcomes Committee, providing oversight of risks, learning and improvement actions.
- ICB-wide safeguarding dashboards and structured assurance processes.
- Engagement in the safeguarding boards, multi-agency forums and local authority partnerships to ensure coordinated safeguarding responses.

The ICB has fully followed the statutory assurance processes set out in the Safeguarding Accountability and Assurance Framework (SAAF) which is set out on the ICB website: LSCICB_NF01_SG_CYP_and_Adults_at_Risk_in_the_NHS_SAAF_v3_July_2022.pdf.

The ICB promotes its safeguarding approach on it's website: LSC Integrated Care Board :: Safeguarding and includes its Strategic Safeguarding Plan – 2024-2027: 250218_LSC_ICB_Strategic_Safeguarding_plan_2024-2027_V2_FINAL.pdf along with consecutive annual reports.

Over the last year, the Board, Quality and Outcomes Committee, and the System Quality Group have received assurance that the ICB has:

- Drawn on national safeguarding learning, local audits, child death reviews, and intelligence from high-risk cohorts.
- Strengthened and embedded safeguarding leadership, governance, dashboards and quality assurance processes.
- Worked closely with local authorities and police through published safeguarding arrangements.
- Contributed to multi-agency reviews and is positioned to publish links to these reports in its Annual Report.
- Maintained full compliance with statutory assurance duties under the SAAF.

Maternity and Neonatal Services

The Lancashire and South Cumbria Local Maternity and Neonatal System (LMNS) is a partnership of leaders, organisations and services involved in the delivery of maternity and neonatal services, working together to improve services, make them safer, more personal and kinder to people who use them. During 2025/26, Lancashire and South Cumbria has continued to deliver significant improvements in maternity and neonatal services through the Local Maternity and Neonatal System (LMNS), building on the priorities set out in the Maternity and Neonatal Three-Year Delivery Plan (2023–2026).

A central achievement over the past year has been the embedding of equity and equality as a core system function. Dedicated governance arrangements and coordinated delivery programmes have enabled the system to move from isolated initiatives to a more strategic and data-driven approach to reducing inequalities in outcomes and experience. This has been supported by improved data capability, including the introduction of a system-wide equity dashboard and consistent use of digital maternity records across all providers.

The system has also delivered targeted improvements in models of care, particularly for women and families at highest risk. Enhanced Midwifery Continuity of Care models have been developed and expanded, alongside wider improvements in personalised care, prevention, and early intervention. This includes strengthened programmes to reduce smoking in pregnancy, improve infant feeding outcomes, and support maternal health across the life course. There has been a continued focus on reducing unwarranted variation and improving quality and consistency of care. This has been achieved through the development of system-wide service specifications, clinical pathways, and performance metrics, enabling more equitable access and outcomes regardless of where care is received. Significant progress has also been made in strengthening the maternity workforce, with the development of a sustainable “grow your own” pipeline, improved workforce oversight, and enhanced learning environments for students and trainees. Alongside this, the system has delivered innovative and high-impact services, including the nationally recognised reproductive trauma (maternal mental health) service, which has improved outcomes and experience for women and families requiring specialist support.

Environmental Matters

Introduction

In accordance with the Department of Health and Social Care Group Accounting Manual (GAM) 2025/26, Lancashire and South Cumbria Integrated Care Board (ICB) is required to report annually on environmental sustainability, including climate related risks and opportunities, and progress against its Green Plan. This section provides an overview of performance during 2025/26, progress against national Net Zero commitments, and the ICB's priorities for the year ahead.

The Green Plan 2025–2030, approved in June 2025, sets the framework through which the ICB supports delivery of the NHS ambition to achieve Net Zero for the NHS Carbon Footprint by 2040 and Net Zero for the NHS Carbon Footprint Plus by 2045. The Plan brings together ten workstreams covering estates and facilities, travel and transport, medicines, digital transformation, procurement, food, biodiversity, climate adaptation, sustainable models of care and leadership.

Strategic oversight of sustainability is provided through the ICB Net Zero Board, with delivery supported by system partners including NHS Provider Trusts, Primary Care, NHS Property Services and local authorities.

Performance During 2025/26

The organisation manages climate-related risks and opportunities through national NHS net zero milestones and locally defined Green Plan targets, supported by annual reporting and performance dashboards. The 2025/26 system-wide performance data is being validated by NHSE and will be available in late 2026. The extract in the table below is to 2024/25. Most of the ICB's carbon footprint stems from commissioned services, as office-based activities have lower carbon intensity compared to direct healthcare delivery. The table therefore includes carbon footprint data reported by Trusts, except for inhaler data, which relates to Primary Care only. Emissions currently included in the carbon footprint reduced from 130,480 tCO2e in 2019/20 to 106,639 tCO2e in 2024/25, a 18% reduction. The national NHS Carbon Footprint interim target is to reach a minimum of 47% of the 2019/20 baseline level by 2028-2032.

Estates and Facilities

During 2025/26, the ICB and its Provider Trusts continued to prioritise decarbonisation of the healthcare estate, supported by national capital investment and locally led programmes. Investment in energy efficiency and renewable generation progressed across multiple sites, including the installation of LED lighting and solar photovoltaic systems, alongside continued expansion of sub-metering to improve energy monitoring and identify further efficiency opportunities. Although the reduction in carbon emissions associated with energy reported for 2024/25 has only reduced by 4 per cent since the 2019/20 baseline, it is anticipated that the impact of this investment will be seen in the next set of data available later this year.

The primary care estate also continued to strengthen its sustainability performance, with refurbishment works at Ingol Healthcare Centre completed to net zero building standards.

Measured against the 2019/20 baseline, the system has achieved a collective reduction of 7 per cent across all major estate related emission categories. Of note, waste has been reduced by

38 per cent and water/ sewage by 80 per cent. These improvements place Lancashire and South Cumbria ahead of the national trajectory in several key areas.

Travel and Transport

Travel and transport remain a material contributor to the NHS carbon footprint. During the year, the ICB supported a range of initiatives aimed at reducing emissions associated with staff, patient and fleet travel. These included incentivising sustainable travel choices through the *BetterPoints* scheme in Lancashire, expanding electric vehicle charging infrastructure across Trust and ambulance fleets, and introducing the Healthier Greener Travel Toolkit to support behavioural change in primary care.

Hybrid working arrangements continued to be embedded across the ICB, contributing to reduced commuting related emissions.

Medicines and Clinical Emissions

Reducing emissions associated with medicines and clinical activity remains a priority area. During 2025/26, continued progress was made in reducing the carbon impact of inhaler prescribing, with increased uptake of lower carbon alternatives and a reduction in inhaler related emissions compared with the previous year. Primary care inhaler emissions reduced by 35 per cent in 2024/25 against the 2019/20 baseline.

Across provider trusts, desflurane has been fully eliminated and nitrous oxide emissions have reduced by 48 per cent compared with the baseline levels. Medicines optimisation initiatives, including the continued expansion of KidzMed and structured medication reviews in primary care, have contributed to reductions in waste while supporting high quality, safe prescribing.

Digital Transformation

Digital transformation continues to support both service improvement and environmental sustainability. Growth in online and video consultations has reduced the need for patient travel, while plans to reduce paper-based correspondence will further support carbon reduction over the longer term.

Innovative approaches were also piloted during the year, including drone-based surveying across hospital sites, reducing both costs and emissions associated with traditional inspection methods. Collaboration with system partners continues to support the rollout of smart metering and digital energy efficiency solutions.

Waste, Food and Circular Economy

The ICB and trusts continued to embed waste reduction and circular economy principles. Improvements in waste segregation in primary care delivered both cost and carbon savings, while increased use of the *WARP IT furniture reuse* platform avoided significant volumes of waste and associated emissions.

Trusts also continued to expand sustainable food initiatives, including the introduction of carbon labelled menus, promotion of lower carbon meal options and use of digital tools to inform menu planning and procurement.

Workforce and Leadership

Progress continued in embedding sustainability awareness and leadership across the workforce. Sustainability training formed part of staff induction, with further expansion planned, and the primary care sustainability leadership programme for trainee GPs continued to develop, gaining national recognition. A growing network of Green Champions across trust and primary care settings supported local delivery and staff engagement.

Overall, the organisation has made measurable progress against a number of climate-related targets, particularly in relation to inhalers, anaesthetic gases, waste and procurement. However, significant areas, including full estate decarbonisation, climate adaptation, supply chain emissions and broader carbon reporting, remain under development and will require continued investment, delivery planning and monitoring.

Plans for 2026/27

During 2026/27, the ICB will prioritise actions that support delivery of its Green Plan and strengthen system-wide resilience to climate change. Key areas include completion of heat decarbonisation plans for in-scope hospital buildings, achieving the national clinical waste segregation target and publishing the ICB sustainable travel plan that will include the requirement to offer only zero-emission salary sacrifice vehicles.

Climate risks are already incorporated into emergency preparedness arrangements, with an ICB climate adaptation plan being drafted in 2026. Trust adaptation plans are being driven by One LSC with an aligned timescale. Blackpool NHS Trust and Morecombe Bay Hospitals Trust already have plans in place.

Another key priority for 2026/27 is embedding sustainability in the new integrated impact assessment to ensure the environment and climate change is considered during commissioning and service redesign.

An ICB performance dashboard to support monitoring of Green Plan implementation is in development by the national NHS greener team and will be released during 2026/27, to enable closer monitoring.

Climate Related Financial Disclosures (TCFD)

The DHSC GAM sets out a phased approach to incorporating task force on climate related financial disclosures (TCFD) requirements into sustainability reporting for NHS bodies, aligned to HM Treasury guidance for public sector annual reports.

Local NHS bodies are not required to disclose Scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements, as these are calculated nationally by NHS England. TCFD aligned disclosures, structured around the four pillars of (1) governance, (2) strategy, (3) risk management, and (4) metrics and targets, have been introduced on a phased basis up to and including the 2025/26 financial year.

The ICB has applied judgement in determining the scope of its disclosures, reflecting both its direct responsibilities and its wider system leadership role. The ICB's Greener NHS - Our Green Plan provides detail against the four TCFD pillars. It is anticipated that the depth and maturity of reporting will continue to develop in future years as data quality improves and understanding of climate related risks and opportunities deepens.

Climate-related risks and opportunities are material to the ICB's operations, strategy and financial planning. The principal risks identified in the Green Plan are extreme heat, flooding and supply chain disruption, each of which could affect service continuity, estate resilience and access to care, particularly across a large and diverse geography and for vulnerable communities. In response, climate and net zero considerations have been incorporated into the Green Plan, Infrastructure Strategy, Digital and Data Strategy, procurement arrangements and the development of climate adaptation plans.

Short, medium and long term: In the short term, the main impacts relate to operational resilience, compliance and investment in adaptation planning, heat decarbonisation, reporting capability and infrastructure. NHSE's climate change risk assessment (CCRA) tool can support development of TCFD disclosures. The ICB has incorporated climate risks into emergency preparedness arrangements and in 2025/6, has undertaken a benchmarking exercise to baseline our current adaptation capabilities, identify priorities, timescales and next steps. This will inform our adaptation plan that once complete will provide a roadmap to ensure our NHS services are climate resilient.

Over the medium to longer term, climate risks are expected to place increasing pressure on estates, transport, supply chains and service delivery, while transition requirements are likely to influence capital prioritisation, procurement and care model redesign. The Green Plan also identifies opportunities to reduce costs and improve outcomes through estate decarbonisation, digital transformation, lower-carbon prescribing, waste reduction, more sustainable travel and stronger supplier standards.

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

	Baseline 2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Annual change (2023/24 to 2024/25)
Trust Estate Carbon footprint (tCO_2e)	84,533	94,594	83,008	79,468	80,348	78,675	2% reduction
Energy (tCO_2e)	79,873	89,893	79,560	76,647	77,812	76,442	2% reduction
Water & Sewage (tCO_2e)	1,575	1,256	578	412	376	314	16% reduction
Waste (tCO_2e)	3,085	3,445	2,870	2,409	2,160	1,919	11% reduction
Medical Gases (Nitrous oxide and Entonox) (tCO_2e)	10483	8839	7691	6496	6011	5400	10% reduction
Anaesthetic Gases (tCO_2e)	1,681	595	569	584	437	437	0%
Inhalers (tCO_2e) Primary Care prescribed data only	33,783	31,698	32,226	27,636	22,797	22,127	3% reduction
Total of Emissions listed (tCO2e)	130,480	135,726	123,494	114,184	109,593	106,639	3% reduction

Improving quality

How the ICB has discharged its duty to secure continuous improvement in the quality of services

During 2025/26, NHS Lancashire and South Cumbria Integrated Care Board (ICB) continued to discharge its statutory duty under section 14Z34 of the Health and Care Act 2022 to secure continuous improvement in the quality of services it commissions, with a sustained focus on patient safety, clinical effectiveness and patient experience. The Board received assurance on quality through a strengthened governance framework, systematic oversight of risks and performance, and targeted action to address areas of concern across commissioned services.

Strengthening quality governance and system assurance

The ICB maintained clear and robust oversight of quality through the Quality and Outcomes Committee, which replaced the former Quality Committee and operated as the primary forum for assurance on quality, safety, safeguarding and patient experience during the year. The committee's terms of reference and work programme were reviewed to ensure alignment with national expectations, including the NHS England quality functions and national quality board requirements, and to strengthen clarity of accountability and escalation routes to the board.

A comprehensive self-assessment against national quality requirements confirmed that the ICB had appropriate arrangements in place for the strategic and operational management of quality. Regular reports enabled the committee to triangulate intelligence from provider quality reports, safeguarding dashboards, complaints and incidents, and external assurance, providing a coherent picture of quality across the system. Where assurance was limited, the committee maintained enhanced oversight until evidence of sustained improvement was demonstrated.

Driving continuous improvement through quality impact assessment

Throughout 2025/26, the ICB embedded a strengthened quality impact assessment (QIA) framework, ensuring that all service changes, transformation programmes and cost improvement schemes were prospectively assessed for their potential impact on quality, safety, experience and health inequalities. The enhanced framework enabled clearer risk stratification and mitigation planning and strengthened the link between quality risks and the Board Assurance Framework.

The Quality and Outcomes Committee monitored the application of the QIA process across commissioning activity, providing assurance that decisions were taken with due regard to patient safety and service quality, particularly in the context of ongoing financial and operational pressures.

Learning from incidents, complaints and patient experience

The ICB continued to promote a culture of learning and improvement across the system, drawing on intelligence from incidents, complaints and patient feedback. The board received assurance that learning from serious incidents and provider investigations was reviewed systematically, with themes and actions tracked through established governance routes.

Patient experience and complaints data were recognised as a critical source of insight. The ICB's patient experience arrangements, published on the ICB website, set out clear routes for raising concerns and ensured that feedback was used to inform service improvement and

commissioning decisions. The Quality and Outcomes Committee reviewed emerging themes from complaints and concerns and sought assurance that learning was translated into action at both provider and system level.

During 2025/26 LSC ICB received a total of 1,945 complaints including letters from constituency MPs. This compares to 1,808 in 2024/25 and represents an 8 per cent increase. We have categorised these under four headings (28 complaints were not ascribed a category).

Category of Complaint	Number	Percentage
Primary Care	878	46%
Secondary Care	470	25%
ICB – All-Age Continuing Care	189	10%
ICB – Other	380	20%
Total	**1,917**	**100%**

When complaints are upheld or partially upheld, we identify learning and include this in our response. This could be an individual remedy or a wider change. These are reported internally through our Quality and Outcomes Committee and Primary Care Quality Group and externally to a Regional Complaints Oversight group. In total, over 60 examples of learning were reported in 2025/26. One example is set out below:

A dental practice was charging a deposit of £10 to make an appointment for people who were entitled to free dental care - including children. We received three complaints about this, and others may have been handled by the practice directly. People had lost out on care because they could not pay. The practice response was that the regulations and the contract allowed them to do this. When we questioned this, the first advice we had also said it was permissible. We could not accept that Parliament can have intended practices to be able to insist on a payment in these circumstances. Consequently, we approached the national dental adviser who agreed it was not allowed. This is a group practice with branches across the North West so we also alerted the other two ICBs. A letter was sent to the practice telling them to change their policy and stop doing this. They accepted and discontinued the practice. The policy has been removed from their website. This was an example of tangible change as a result of complaints. It also demonstrates how we work with neighbouring ICBs.

During the year, we also worked over a longer period of time with a smaller number of families where their relatives had sadly died. The aim was to demonstrate tangible change, and this will continue into the coming year.

Safeguarding assurance

The ICB discharged its statutory safeguarding responsibilities through clear executive leadership, dedicated safeguarding expertise and systematic assurance arrangements. Quarterly safeguarding dashboards covering children, adults, children in care and compliance with statutory requirements were reviewed by the Quality and Outcomes Committee, enabling oversight of risks, workforce capacity and multi-agency pressures.

Where risks were identified, including pressures on local safeguarding systems and backlogs affecting statutory processes, these were escalated appropriately with agreed mitigation plans monitored through the committee and, where necessary, the board assurance framework. The ICB remained committed to partnership working with local authorities, safeguarding boards and other agencies to promote continuous improvement in safeguarding practice across the system.

Improving quality in priority pathways and services

During the year, the ICB maintained focused oversight of quality in priority pathways where risks to safety, access or experience were greatest. This included continued scrutiny of services for children and young people, SEND, and other high-risk or high-impact areas. Where intelligence indicated unwarranted variation or emerging quality concerns, the Quality and Outcomes Committee required enhanced monitoring, time-limited recovery plans and regular progress updates.

The committee also oversaw system-wide improvement activity designed to standardise pathways, reduce variation and strengthen clinical leadership, ensuring that improvement efforts were aligned with the ICB's wider commissioning and transformation priorities.

Infection control and prevention

The ICB Quality and Outcomes Committee received the annual Infection, Prevention and Control Report in November 2025. The report demonstrates that the ICB has established robust system-wide oversight and assurance arrangements for infection prevention and control (IPC), including routine reporting to the Quality Committee, active engagement with provider IPC governance, and collaborative working across partners such as NHS trusts, primary care, local authorities and UKHSA.

Demonstrating impact of IPC activity

Across 2024/25, a range of targeted IPC interventions and system actions have demonstrably influenced outcomes:

Outbreak management and system coordination

- Coordinated responses to outbreaks of influenza, norovirus, tuberculosis and invasive pneumococcal disease ensured rapid containment and mitigation, supported by multi-agency working and vaccination/prophylaxis programmes.
- This activity enabled continuity of services during periods of high demand, although the scale of outbreaks - particularly norovirus and flu - contributed to increased infection pressures across acute settings.

Implementation of national standards and quality improvement approaches

- Acceleration in the implementation of the National Cleaning Standards and strengthened collaboration with Estates teams has improved environmental safety and compliance in many areas.
- Adoption of the Patient Safety Incident Response Framework (PSIRF) has shifted the focus from incident investigation towards system learning and improvement, supporting more impactful actions.

Antimicrobial stewardship and prescribing practice

- System-wide antimicrobial stewardship has been sustained, with reported compliance above 90 per cent in key areas, contributing to the management of antimicrobial resistance risks.
- Strengthening primary care and community IPC capacity
- Expansion of the primary care IPC Champion network (covering the majority of practices) and increased training and engagement has improved the dissemination of best practice and strengthened prevention in community settings.

Evidence of outcomes and improvement

These activities have contributed to a mixed but increasingly outcome-focused picture across the system:

Areas of improvement

Some trusts demonstrated reductions in key infections, for example:

- Clostridioides difficile cases reduced year-on-year in certain organisations and, in some cases, achieved or remained below trajectory.
- Reductions in MRSA bloodstream infection cases were observed in some providers compared to previous years.

Thematic reviews and targeted interventions (e.g. catheter care, antimicrobial optimisation) have shown early indications of improvement in specific infection pathways, such as reductions in healthcare-associated GNBSI cases within reporting periods.

Areas of continued challenge

- Despite interventions, several trusts exceeded healthcare-associated infection trajectories for organisms including CDI, E. coli and Klebsiella.
- There was a system-wide increase in outbreaks (notably norovirus and influenza), exacerbated by operational pressures such as bed occupancy and limited isolation capacity.
- Flu vaccination uptake declined across several cohorts, increasing the risk of future seasonal pressures.
- Community-onset infections—particularly E. coli bloodstream infections—remain high and are often linked to wider determinants such as frailty, comorbidities and deprivation, requiring broader system action.

Demonstrating improvement over time

The report also highlights evidence of a maturing, more improvement-focused system approach:

- Increased use of **data, thematic reviews and post-infection reviews** to identify trends and inform targeted action (e.g. GNBSI deep dives and CDI reviews).
- A shift towards **population-level prevention**, particularly in community settings, with identified focus areas for 2025/26 including wound care, bladder and bowel management, invasive devices and oral health.
- Strengthened **system learning mechanisms**, including relaunched locality HAI meetings and wider dissemination of learning across partners

Conclusion

Overall IPC governance, oversight and partnership working are well established and are increasingly translating into targeted improvement activity. There is clear evidence that specific interventions such as enhanced outbreak response, antimicrobial stewardship, and focused quality improvement are influencing outcomes in key areas. However, variation in performance across organisations and continued pressures from seasonal infections and capacity constraints indicate that this improvement is not yet consistent across the system.

Working with People and Communities

Overview

Throughout 2025/26, Lancashire and South Cumbria Integrated Care Board (ICB) strengthened its commitment to involving people and communities in shaping health and care services. Engagement, involvement and insight gathering were embedded across programmes of work, supporting the ICB's statutory duties and ensuring decisions were informed by the voices and lived experiences of local residents. Throughout the year, the ICB continued to apply its strategy for Working in Partnership with People and Communities, developing a culture where listening, collaboration and community-led approaches are fundamental to improving outcomes and health equity.

Embedding Public Voice in Decision-Making

The ICB consistently gathered insights from a wide range of sources, including proactive outreach both in place and across the health and care system, via Healthwatch reports, patient experience intelligence, complaints, and targeted listening events. These insights directly informed commissioning intentions, strategic planning and service redesign.

For example, in July 2025, a workshop with Healthwatch, VCFSE partners and the population health team ensured that large volumes of public insight, highlighting the importance of access, waits, communication, fear, stigma and misinformation have shaped the ICB's 2026/27 commissioning intentions.

As part of the review of adult ADHD services in LSC, we have held five public workshops for people diagnosed with, awaiting assessment for, or supporting someone with ADHD. Insight gathered from 31 attendees will be included in service planning. A survey for the wider public is in hand. Ongoing public engagement opportunities are planned, with a further workshop for interested parties and a quarterly online patient experience group under development.

Public perception of the NHS was monitored through quarterly surveys, with more than 1,300 respondents contributing in June 2025. While people remained more positive about local services than the national NHS, more than 63 per cent felt the NHS needed "a fair amount or a lot of improvement", with concerns focused on waiting times, access, workforce pressures and coordination. A significant proportion (approximately half) did not know whether the NHS listens to feedback, signalling a continuing need for transparency about the impact of engagement.

The ICB works in partnership with local authority health and wellbeing boards, overview and scrutiny committees, and integrated care partnerships. Our engagement with local councillors through these forums has provided valuable insight into the needs and experiences of local people as elected members who engage with, and are directly accountable to their communities.

Reaching and Listening to Communities

A strong emphasis was placed on listening where it matters most. Throughout the year, the ICB undertook targeted outreach and community-based engagement across diverse geography and demographics. Our network of engagement co-ordinators who are based in Blackburn with Darwen, Blackpool, Lancashire and South Cumbria have worked with population health colleagues and partners to ensure that face to face engagement on the ground in communities

has taken place and insights and experiences of local residents has been heard and used to help shape policy, practice and commissioning considerations.

Campaigns Shaped by Public Insight

Public insight played a central role in shaping communications and prevention campaigns.

The *Good Health Starts…* winter wellbeing campaign was co-designed using insight from Healthwatch and communities, with materials developed to encourage healthy behaviours and appropriate use of services. Outreach involved community groups, dementia networks, Citizens Advice and VCFSE partners across the region. Early feedback on the clarity and accessibility of the materials was positive.

Cancer awareness campaigns—such as *Know Your Ovaries* and *Check It, Don't Chance It* were built using insight from thousands of women, including south Asian and underserved groups. These campaigns used real patient stories, such as those from Kelly in Chorley and Kirsty in Great Harwood, whose experiences were widely shared online and via local media, significantly boosting reach. The ovarian cancer campaign alone generated over 6,000 community interactions, encouraging symptomatic individuals to seek earlier primary care support.

Our male suicide prevention campaign was developed using the insights and experiences of men affected by mental health problems and suicide. The campaign continues to galvanise our communities to encourage them to have conversations, and ensure that men who need it, seek help.

Deep Engagement on Major Service Change

The ICB demonstrated robust, transparent processes for service change proposals. In autumn 2025, extensive face to face engagement took place concerning the future of Level 3 critical care at Furness General Hospital. Five public meetings, drop-in sessions and online events captured the views of over 200 people directly, with wider input through letters, petitions, and MP correspondence. Insights were used to update public information and inform the development of a pre-consultation business case.

The ICB, along with partners NHS Cheshire and Merseyside ICB and Mersey and West Lancashire Teaching Hospitals NHS Trust, concluded a 13-week consultation on A&E services for West Lancashire, Southport and Formby on 3 October 2025.

During the *Shaping Care Together* consultation, which began on 4 July 2025, more than 7,800 people actively engaged during the consultation period – a significantly higher response rate compared to the typical UK public consultation average. We received more than 5,000 responses to the consultation survey and visited more than 50 community venues and directly engaged more than 800 people in West Lancashire alone.

The feedback was independently analysed and an independent consultation report was produced, as well as a 'you said, we did' document, which helped to inform the development of the decision-making business case (DMBC). The DMBC was presented to the joint committee, made up of both ICBs, in March 2026 where the decision was made to co-locate adult and children's A&E at Southport hospital.

Similarly, consultation engagement and listening activities supported service changes procurement exercises in West Lancashire for urgent care and community services, and

potential service changes for orthodontics and vascular transformation as well as and GP practice transitions. Engagement included attending clinics, capturing lived experience, understanding transport challenges and addressing local inequalities.

Strengthening Participation and Partnerships

A core strength during 2025/26 was our expansion of structured participation through established forums and partnerships.

Community and citizen stories to the Board and the Quality and Outcomes Committee

The ICB Board and Quality and Outcomes Committee have been hearing stories from citizens and communities since the inception of the ICB. Over the last year the emphasis of these stories has focused on population health. The stories are usually filmed for the board, and written for the Quality and Outcomes Committee. They give both members the opportunity to bring the day-to-day realities of people and communities into the room and gain valuable insights that have informed discussions. Stories are promoted on the ICB website, and shared with the media, and on social media. Two recent examples can be viewed here: Primary Care Network engages volunteer group to improve cervical screening uptake and Wards in Lancaster and Morecambe benefit from targeted work to reduce health inequalities.

Virtual Citizens Panel (now renamed to Influence Network)

The ICB virtual citizen's panel is a membership scheme that enables residents to engage with the work of the ICB, including proposals and developments. Over the last year, membership exceeded 2,000 people, and quarterly surveys provided regular public insight into perceptions of NHS performance, priorities and feedback mechanisms.

Citizens Health Reference Group (now renamed to Influence Panel)

More than 50 volunteer citizen advisors supported ICB programmes throughout the year, influencing commissioning intentions, participating in procurement panels, contributing to virtual ward development, supporting frailty redesign, and attending clinical strategy workshops. The group met quarterly to engage directly with senior leadership and provide constructive challenge.

Eight members of the group attended a workshop to support the development of the ICB's clinical strategy in November 2025. Two members have also recently become part of the frailty transformation group and are supporting a task and finish group around anticipatory clinical management planning.

Readers Group (now renamed to Influence Readers Group)

Lancashire and South Cumbria Integrated Care Board (ICB) is committed to ensuring our communication is clear and easy to understand. We have established a readers group that regularly reviews letters and leaflets and offers suggestions to make them more patient-friendly. The panel has 179 members. We send out materials such as GP letters, leaflets, and web pages via email to assess whether the information is clear, easy to read and understand, useful, and whether the format could benefit from photographs or more text, etc. We ask members of this readers group to comment on these. Their feedback helps shape the final version of the document or web page.

Healthwatch partnership

The ICB continued to commission and collaborate with local Healthwatch organisations, receiving high-quality reports on women's health, disability voices, virtual wards, cancer awareness, pharmacy access, alcohol services and local service reviews. These shaped commissioning, strategy and service redesign, ensuring local voices, particularly from disadvantaged and marginalised populations, were reflected in decision-making.

In the early part of 2026, the ICB joined a piece of work lead by Healthwatch to address the use of Social Meda for Health with young people 14-25 and their parents. We offered support to the project and acted as a link with commissioners.

At the time of preparing this report the project has received over 1,000 responses from young people and their parents. The biggest piece of insight so far is around how young people see health conditions online and respond by visiting pharmacy and/or their GP for clarification. This means that there is a need to create more trustworthy, verified social media information about health conditions. This insight suggests that we need to consider more, innovative ways to use digital technologies to support young people and their parents.

Engagement with Specific Communities

The ICB invested in engagement with communities that experience barriers to equitable access, including:

- **Children and young people**: Launch of the Lundy Model e-learning programme, co-produced with young people, to strengthen participation in decision-making.
- **LGBTQ+ communities**: Staff network roundtables highlighted lived experience, training needs and the importance of inclusive commissioning.
- **Ethnically diverse communities**: Targeted engagement in Pendle, Preston, Burnley and Blackpool informed cancer and women's health programmes.
- **People ageing without family support**: Healthwatch engagement highlighted concerns around advocacy, consent and future care planning.
- **Parents and carers (SEND)**: Partnership working with local authorities supported SEND inspection activity, improved communications, and the development of a parent and carer podcast informed by lived experience.

Carer involvement and engagement

The ICB developed a carers charter in 2024 in partnership with the VCFSE and carer representatives, as well as partners. This has been influential in ensuring that the needs and voices of carers are heard by the ICB and our partners. Over the last year we ensured that listened to the lived experience of carers in our engagement and involvement work, described above. This was most notable in our commissioning of ADHD services for children and young people, ADHD services for adults, and work we undertook to improve community equipment as well as our development of support and services for SEND. This in particular, included the OFSTED reviews in Blackburn with Darwen and Westmorland and Furness as well as previously in other parts of Lancashire and South Cumbria. Our development of neurodevelopmental pathways has explicitly involved parents and carers, and we have ensured that we capture the views of carers in all of our engagement and involvement work as previously described. Our population health teams whose work to tackle health inequalities across Lancashire and South Cumbria is described below, have ensured that the needs of carers have been actively considered and acted upon.

Neighbourhood Engagement and Population Health

Over the last year, Place-based partnerships across Blackburn with Darwen, Blackpool, Lancashire and South Cumbria have demonstrated the impact of community-embedded approaches, including community-led health creation, culturally tailored health messaging, agricultural community outreach, enhanced health checks and youth mental health initiatives.

Population health teams worked directly with neighbourhoods to co-design interventions such as hypertension (blood pressure) checks in barbershops, diabetes awareness programmes and targeted lung health screening outreach.

During 2025/26, the ICB made significant progress in embedding meaningful engagement, listening and co-production with people and communities. Public insight demonstrably influenced commissioning decisions, strategic development, service transformation and population-level interventions.

The breadth and depth of engagement activity, supported by strong partnerships with Healthwatch, VCFSE organisations and citizens has been successful in developed an increasingly systematic approach to hearing the voice of people and communities. Priorities for 2026/27 include increasing the visibility of ‘you said, we did’ feedback, expanding outreach to under-represented groups and strengthening the link between insight, improvement and strategic decision-making.

All engagement reports and case studies can be found on the ICB website: Get involved

Reducing Health Inequalities and Improving Population Health

Improving population health and reducing health inequalities continued to be a core priority for the ICB in 2025/26. The ICB discharged its statutory duties under the NHS Act 2006 (as amended), the Equality Act 2010 and the Public Sector Equality Duty, ensuring that all communities can access services and benefit from improved health outcomes. This work was embedded throughout the organisation and across commissioning, performance, governance and assurance processes.

To meet NHS England's expectations under Section 13SA, the ICB undertook an internal audit on health inequalities and subsequently completed the resulting actions including strengthening governance and accountability. This included strengthening the role of the Prevention and Health Inequalities Steering Group and its reporting route via the Quality and Outcomes Committee to the ICB Board. The board also strengthened how it tracks and reports on health inequalities so the board can see both delivery and whether we are improving outcomes fairly. This included a new Health Inequalities and Prevention Delivery Plan monitored quarterly, and upon the board's request, the development of the Integrated Performance Report (IPR) so health inequalities are considered routinely alongside quality and wider performance.

Since last year's annual report, the IPR has been produced every two months and is designed to bring together performance, quality and health inequalities in one place for the Quality and Outcomes Committee and the board. The IPR structure explicitly includes (for each domain) the latest position, actions underway, available assurance, patient safety/experience intelligence, and the health inequalities identified across the system.

For example, the IPR paper in January 2026 highlighted the difference in use of urgent and emergency care in terms of deprivation and set out planned next steps. It also set out plans to strengthen inequality reporting further by adding *equality gap* data to more metrics and adding *Core20PLUS5* domains which the board endorsed.

In accordance with the NHS England Legal Statement requirements under Section 13SA ,the ICB reports in detail on its approach to addressing health inequalities and key metrics relating to both ethnicity and deprivation on an annual basis, and this is published alongside and is referenced within the annual report each year. This report for 2025/26 is currently being written and will be published on the ICB website in parallel with the publication of the annual report.

The ICB's Prevention and Health Inequalities Steering Group reports to the Quality and Outcomes Committee. It takes the format of a triple A report, identifying assurance, advice and alerts for the attention of the committee and to inform the committee's reports to the board. As part of this governance approach during 2025/26, the ICB has strengthened its understanding of risk in relation to health inequalities. The ICB has built into its risk reporting a requirement for all teams across the ICB to identify risks that impact on health inequalities so that the Prevention and Health Inequalities Steering Group can take an overview of these risks and escalate them as appropriate to the Quality and Outcomes Committee.

During 2025/26, the ICB has commenced its reset to deliver a new operating model aligned to the national ICB blueprint. This reset focuses on the ICB becoming a strategic commissioner and includes an explicit focus on meeting duties to understand population need and tackle health inequalities. The restructure of the ICB to reset the organisation to deliver the revised operating model is currently underway.

In March 2026 the ICB published its Five-Year Strategic Commissioning Plan, setting out its approach to meeting the needs of the population. This plan was informed by an integrated needs assessment bringing together evidence on population health, service performance and the lived experience of people in Lancashire and South Cumbria. The integrated needs assessment was informed by a comprehensive population health needs assessment undertaken during the autumn of 2025.It draws together data from local authority joint strategic needs assessments (JSNAs), demographic trends and analysis of wider determinants to understand current and future patterns of need across Lancashire and South Cumbria. The full population health needs assessment will be updated on a regular basis.

The Five-Year Strategic Commissioning Plan incorporates the ICB's commitment to addressing inequalities, exemplified our three unifying goals. As part of its reset, the ICB has developed its Clinical Strategy and as part of this work, has reviewed the evidence regarding the drivers of inequality to establish a clearer focus on what it needs to deliver. The Clinical Strategy will be finalised early in 26/27 and will include the refreshed focus on improving the health outcomes for the population and addressing inequalities.

During 2025/26 the ICB completed its Anti Racism Framework Bronze submission (March 2026). The ICB has undertaken work to strengthen health equity impact assessments including the development and piloting of an integrated impact assessment which will be embedded in the organisation's programme management approach and will be rolled out in 2026.

Ethnicity Data

To support both strategic and operational commissioning priorities within ICB, the business intelligence team routinely analyses a wide range of nationally mandated datasets.

These include inpatients, outpatients, community, maternity, and mental health data flows, among others. Reliable ethnicity data is essential to identify and address potential health inequalities across services and populations. Previous analysis has identified significant variation in the validity and completeness of ethnicity information, not only across different datasets and provider organisations but also within datasets from the same provider. Missing or invalid ethnicity coding posed a barrier to accurate inequality analysis and reporting. Leveraging the pseudonymised data warehouse, analysts developed a method to link multiple datasets at patient level. By integrating the monthly registered patient dataset (containing more complete ethnicity information, populated directly from the national spine) analysts were able to update and enrich provider-level data, filling gaps where ethnicity was missing or unknown. This linking approach effectively surfaced the most recent valid ethnicity data available within the NHS systems. The analysis demonstrated that many patients had a valid ethnicity recorded in the national spine data that was not reflected in providers' routine submissions. The process enabled the team to quantify this variation and identify potential data quality improvement opportunities. The findings were shared back with providers to highlight discrepancies between their internal data and national spine data. This benchmarking has sparked engagement and discussion into potential data quality reviews, peer learning, and possible best-practice sharing where completion rates were high.

The findings have also enabled the ICB to incorporate enhanced ethnicity data within analytical work, ensuring a more accurate representation of patient populations when considering health inequalities through specific pieces of analysis.

During 2025/26 we have seen a number of improvements in ethnicity data:

- Blackpool Teaching Hospitals has increased its valid ethnicity codes within submitted data for both CDCS and waiting list minimum datasets.
- The mental health service dataset has reached a new high of 84.6 per cent (99.1 per cent when corrected).

Primary care has now widened the ethnicity coding of patients to include our highest long term conditions including frailty, respiratory, diabetes, cardiovascular disease and severe mental illness. Due to this expansion in recording for patients in all the long-term condition areas highlighted above, this has significantly increased the target cohort of patients to 76,641 for 2025/26. Data is collected on a monthly basis from GP EMIS records to measure the ethnicity coding and the latest data at the end of September 2025 shows that 99 per cent (64,686) of all patient records have an ethnicity code, as of 15/01/26. This is the first full year of implementing this measure, and the ICB's target of 80 per cent accurate coding by the end of 2025/26 has been exceeded.

Leadership, Governance and Accountability

The ICB Board maintained clear oversight of equality and health inequalities through regular reporting, board development sessions and systematic use of the Equality and Health Inequalities Impact and Risk Assessment (EHIIRA) process. The Integrated Performance Report considered by the Board has health inequality metrics embedded throughout and provides clearer visibility of health inequalities within ICB services and outcomes. Board discussions continued to recognise the needs of groups most at risk of poorer access, experience and outcomes, including people living with social disadvantage and deprivation, socially excluded groups, those with protected characteristics, and coastal and rural communities.

Due regard to health inequalities was consistently applied to commissioning and service redesign. Examples included adaptations to urgent community response pathways to ensure non-digital access routes were retained, and changes to neurodevelopmental pathways informed by lived experience and EHIIRA findings.

Commissioning and Service Delivery

Reducing health inequalities remained a consistent theme in commissioning decisions. Public insight, population health intelligence and provider data informed commissioning intentions for 2026/27, with a focus on early intervention, prevention and targeted access improvements. To better understand the health of the ICB's population, a Population Health Needs Assessment was completed. This was used to inform long-term planning and commissioning.

During the year, targeted outreach supported improvements in cancer screening uptake, cardiovascular risk detection and smoking cessation in areas with the poorest outcomes. *Pharmacy First* and enhanced community pharmacy provision helped improve access for those facing digital or transport barriers.

Population Health Management

A strengthened population health management (PHM) approach underpinned the ICB's work during 2025/26. Risk stratification, segmentation, linked intelligence platforms and insight from the public health Joint Strategic Needs Assessment (JSNA) were used to identify health inequalities and variation. This was used to inform the development of targeted interventions.

Neighbourhood multi-disciplinary teams continued to deliver personalised prevention and localised outreach, including hypertension checks in barbershops, diabetes awareness sessions, targeted lung health screening and community-led wellbeing initiatives.

Core20PLUS5 and Targeted Improvement

The ICB aligned its approach with the national *Core20PLUS5* framework. The focus remained on the most deprived 20 per cent of the population and on locally identified *PLUS* groups, including people with severe mental illness, ethnic minority communities and those in coastal areas. A targeted demand management approach was implemented, helping to identify people with unmet needs and offering support in community settings so those least likely to access traditional services could receive health interventions earlier.

Action was delivered across the five clinical priorities, including improvements in early cancer diagnosis, chronic respiratory disease management, hypertension case-finding and maternity outcomes.

Analysis showed:

- Smoking in pregnancy rates improved by 4 per cent in the most deprived quintile.
- Breast and cervical screening gaps narrowed by up to 2.3 percentage points.
- 3,400 additional residents were added to hypertension registers in high-risk neighbourhoods.
- SMI annual physical health checks increased by 7 per cent across deprived cohorts.

Health and Wellbeing Strategies

This section sets out how the ICB has contributed during 2025/26 to the delivery of each joint local health and wellbeing strategy to which it is required to have regard. In accordance with statutory duties, the ICB has consulted with each relevant Health and Wellbeing Board (HWB) and worked closely with local authority partners to ensure alignment between NHS priorities, place-based plans, and wider ambitions to improve population health and reduce inequalities. Consideration of these is given in the development of our forward plan, and throughout the last year, the ICB worked with our health and wellbeing board partners to ensure that joint local health and wellbeing strategies have been considered and integrated into our planning. Towards the end of the financial year, we presented our draft Five-Year Strategic Commissioning Plan and commissioning intentions to each of the Health and Wellbeing Boards. This engagement has ensured strong alignment between the ICB and the Health and Wellbeing Boards. Consideration of progress in delivering in partnership, each of the Health and Wellbeing boards joint local health and wellbeing strategies is factored into presentations to the ICB Board, and incorporated into our integrated performance report with a focus on health inequalities.

As part of our continuing partnership and engagement with Health and Wellbeing Boards, we shared a draft of this annual report with the chairs and officers of each of the Health and Wellbeing Boards as outlined below. We received positive feedback from Blackpool Health and Wellbeing Board. Other boards have received the draft and had the opportunity to comment on, or suggest changes. The ICB's approach reflects the principles of partnership, subsidiarity, prevention, and shared accountability which underpin integrated care arrangements. Through membership of each HWB, participation in place-based partnerships, and continuous engagement with local authority directors, public health teams, NHS providers and the voluntary, community, faith and social enterprise (VCFSE) sector, the ICB has ensured its commissioning decisions and operational delivery contribute meaningfully to joint priorities.

Information about health and wellbeing boards and their joint local health and wellbeing strategies are publicly available:

- **Blackburn with Darwen HWB**
  HWB page: https://www.blackburn.gov.uk/health/health-and-wellbeing-board
  Strategy: https://www.blackburn.gov.uk/health/joint-health-and-wellbeing-strategy
- **Blackpool HWB**
  HWB page: https://www.blackpool.gov.uk/Your-Council/The-Council/Health-and-wellbeing-board.aspx
  Strategy: https://www.blackpool.gov.uk/Your-Council/Strategies-plans-and-policies/Health-and-social-care/Joint-Health-and-Wellbeing-Strategy.aspx
- **Lancashire HWB**
  HWB page: https://www.lancashire.gov.uk/health-and-social-care/health-and-wellbeing-board
  Strategy: https://www.lancashire.gov.uk/media/940911/joint-health-and-wellbeing-strategy.pdf
- **Westmorland and Furness HWB**
  HWB page: https://westmorlandandfurness.moderngov.co.uk/mgCommitteeDetails.aspx?ID=271
  Strategy:

https://westmorlandandfurness.moderngov.co.uk/documents/s24617/Joint%20Local%20Health%20and%20Wellbeing%20Strategy.pdf

- **Cumberland HWB**
  HWB page:
  https://cumberland.moderngov.co.uk/mgCommitteeDetails.aspx?ID=271
  Strategy: https://www.cumberland.gov.uk/healthwellbeingstrategy
- **North Yorkshire HWB**
  HWB page: https://www.northyorks.gov.uk/your-council/health-and-wellbeing-board
  Strategy: https://www.northyorks.gov.uk/sites/default/files/2023-11/NY_Health_and_Wellbeing_Strategy.pdf

The ICB is represented on each health and wellbeing board, except for North Yorkshire. While some residents of Lancashire and South Cumbria receive health services from, or in, North Yorkshire, it has been agreed that, while there will be no member of the ICB on North Yorkshire's Health and Wellbeing Board, there will be mutual engagement on matters of relevance.

System-Wide Approach to Joint Local Health and Wellbeing Strategies

During 2025/26 the ICB strengthened an integrated approach to improving population health across Lancashire and South Cumbria. This included aligning NHS planning with each HWB's strategy, reinforcing the role of prevention and inequalities, and ensuring place-based and neighbourhood-level delivery remained central to system transformation.

The ICB deepened alignment between NHS and local authority priorities, ensuring that major strategic developments, including the ICB's future operating model, financial planning, and national reform programmes were shaped through HWB consultation. Senior ICB leaders participated consistently in HWB meetings, supporting scrutiny, governance, the development of shared priorities and accountability for joint outcomes.

Place-based partnerships were a central vehicle for delivery, with the ICB contributing to neighbourhood model development, intermediate care transformation, urgent and emergency care improvement, children's services integration, mental health redesign and community-based prevention.

Across all areas, the ICB helped strengthen prevention and inequalities action, including targeted support for smoking cessation, screening uptake, immunisation, cardiovascular disease prevention, healthy weight, substance misuse and neighbourhood-based interventions in the most disadvantaged communities.

The ICB continued to work jointly with all local authorities on the Better Care Fund (BCF), supporting improvements in discharge, reablement, community-based pathways and the shift to *Home First*.

ICB Contribution by Place

Blackburn with Darwen

The ICB worked closely with the Blackburn with Darwen HWB to drive improved population outcomes, reduce health inequalities and support integrated care. Senior ICB membership strengthened HWB governance, refreshed terms of reference and aligned ICB commissioning intentions with the Joint Local Health and Wellbeing strategy (JLHWS).

The ICB contributed to delivery of the borough's strategic priorities, including early help, perinatal mental health, health visiting, SEND preparation and full transition to the family hub model. It supported the *Live Well* programme, including suicide prevention development, substance misuse improvement, long-term conditions management, screening uptake and targeted community initiatives. The ICB collaborated on fuel poverty reduction, health protection and neighbourhood community safety.

Neighbourhood integration progressed significantly. The ICB co-developed Blackburn with Darwen's neighbourhood health plan, strengthened integrated neighbourhood teams, embedded social prescribing and supported high-intensity user management, frailty pathways and multi-disciplinary working. Joint work on reablement, rapid response and coordination hubs supported intermediate care redesign.

The ICB jointly delivered the Better Care Fund, improving discharge, reducing residential admissions and increasing community reablement outcomes.

Blackpool

The ICB strengthened strategic leadership, governance and alignment with Blackpool HWB priorities. Contributions supported prevention, neighbourhood development, health protection and adult social care quality improvement.

The ICB supported maternal and infant health, smoking-in-pregnancy reduction, breastfeeding support, early-years wellbeing, oral health improvement and oversight of the Child Death Overview Panel. It contributed to employment and training initiatives, including Individual Placement and Support models and NEET support.

Across *Living Well* priorities, the ICB contributed to suicide prevention strategy development, community mental health transformation, cancer screening uptake and substance misuse pathways. The ICB supported multi-agency approaches to homelessness, housing-based inequalities and complex needs.

The ICB led aspects of Blackpool's place-based partnership work, including development of neighbourhood health plans, urgent and emergency care improvement, flow and discharge optimisation and redesign of intermediate care capacity.

The ICB supported vaccination uptake, infection prevention and adult social care improvement planning, particularly safeguarding, governance strengthening and service quality assurance.

Lancashire

The ICB made a substantial contribution to Lancashire HWB priorities, offering senior leadership and acting as deputy chair. It supported a governance review, strengthened

district-level engagement, and contributed to the development of the Five-Year Strategic Commissioning Plan.

The ICB supported the development of the Lancashire Joint Strategic Needs Assessment (JSNA), contributing data and analysis across early years, long-term conditions, inequalities, mental health, screening, social isolation and wider determinants. The ICB working in partnership undertook a pan-Lancashire pharmaceutical needs assessment in 2025.

Through the Better Care Fund (BCF), the ICB helped improve emergency admission performance, discharge delays, residential admissions and intermediate care pathways. It supported *Home First* and strengthened shared performance monitoring.

The ICB helped develop Lancashire's Neighbourhood Health Model, piloting approaches in Morecambe Bay and Chorley/South Ribble. Commissioning intentions aligned with this work, strengthening frailty, end-of-life care, long-term condition management, urgent community response and crisis services.

The ICB contributed to Lancashire's emerging prevention strategy, focusing on tobacco control, obesity programmes, cancer early diagnosis, mental health crisis response and women's health improvement. It also supported system reform, financial sustainability, and neighbourhood-level integration in light of national NHS changes.

Cumberland

The ICB worked closely with Cumberland Council through the HWB and Joint Commissioning Board to support delivery of the Joint Local Health and Wellbeing Strategy 2023–2028. Contributions included oversight of the Better Care Fund, alignment of commissioning and support for compliance with national requirements.

The ICB supported Start Well priorities through leadership in SEND improvement, contributing to Ofsted/CQC inspection preparation, EHCP quality improvement, multi-agency audits, development of specialist provision and redesign of neurodevelopmental pathways. It supported emotional wellbeing and early help.

For *Live Well* and *Protect Well* priorities, the ICB supported the health determinants research collaboration, ethnic minority and substance use needs assessments, and development of *Hope Haven*, the 24/7 community wellbeing hub. It supported development of the Neurodiversity and Emotional Wellbeing Service.

Age Well priorities were supported through falls pathway redesign, urgent community response development, modelling of intermediate care demand and work to reduce discharge delays through the MATCH hub.

The ICB also supported cross-boundary collaboration in Millom and South Cumbria relating to changes at Furness General Hospital, ensuring equitable access, clinical safety and effective public engagement.

Westmorland and Furness

The ICB worked closely with the HWB to support delivery of the Joint Local Health and Wellbeing Strategy 2024–2034. Senior representation ensured alignment across prevention, inequalities and integration.

The ICB contributed to Building Blocks of Health priorities by supporting poverty reduction programmes, fuel poverty mitigation, community insight work and targeted inequalities interventions in Barrow.

Contributions to mental health priorities included reducing CAMHS waiting times, supporting trauma-informed approaches, suicide prevention development, perinatal support and early help expansion.

The ICB played a major role in SEND improvement, contributing to EHCP quality, early years readiness and family hub development.

Across *Healthy Lives* priorities, the ICB championed smoke-free policy development, tobacco dependency treatment, workplace NHS health checks, cancer screening and early detection, substance misuse action and CVD prevention.

Ageing Well contributions included improvements in intermediate care, urgent community response, frailty transformation, end-of-life pathway development and discharge flow.

The ICB also supported place-based partnership development in South Cumbria, including data improvement, primary care development and children's early intervention.

Cross-Cutting Themes

Across all HWBs, the ICB's contributions support consistent system priorities:

- prevention and population health
- reducing inequalities
- community and intermediate care transformation
- mental health redesign
- neighbourhood integration and multidisciplinary working
- children, young people and SEND improvement
- strengthening health protection

Further information – end of year reviews

Last year, place teams each published an end of year review. A key theme throughout the reviews are the partnership approaches to listening, engaging and co-producing with communities. Each end of year review can be found on the ICB website.

Throughout 2025/26, the ICB has made a strong and demonstrable contribution to the delivery of all Joint Local Health and Wellbeing Strategies across its footprint. The ICB fulfilled its statutory obligations, worked in close partnership with all Health and Wellbeing Boards, and embedded joint priorities within commissioning, service transformation and operational delivery.

The ICB's contributions have strengthened prevention, improved system integration, supported high-quality care, and helped reduce inequalities across the diverse communities it serves. The ICB remains committed to deepening collaboration with each HWB and ensuring NHS responsibilities are fully aligned with local democratic accountability for improving the health and wellbeing of residents.

Financial review

Financial Performance Overview

The ICB was issued with enforcement undertakings in February 2024 by NHS England in connection with financial planning and joint system financial objectives for the ICB and its partner trusts. Throughout 2025/26 the ICB has remained in those undertakings. The ICB was placed in national oversight framework segment 4 (NOF4), the highest level of intervention, which indicates that there is a requirement for mandated intensive support via NHS England's recovery support programme (RSP).

The ICB entered the RSP on 28 January 2025 and this continued throughout 2025/26. This programme provides intensive support to help to address the complex, historical problems faced by the organisations within the health system, with an aim of embedding lasting solutions for a sustainable system and to ensure expenditure levels remain within resources allocated.

Following a review in November 2025, and recognition of considerable progress and improvements in governance and financial recovery NHSE approved the exit of the ICB from the national RSP on 23 December 2025. This decision is contingent on continued escalated oversight of delivery against the ICBs improvement plan and undertakings.

The ICB was set a control total of £54.8m deficit for the 25/26 financial year requiring savings (known locally as waste reduction plans (WRP) of £142.6m to be delivered and management of a number of risks in achieving the year-end position. If the ICB delivered its control total it would receive £54.8m of deficit support funding to facilitate a breakeven plan.

Meeting financial targets and delivering improved productivity was established as one of the ICB's six strategic objectives. Any risks to the achievement of this objective were monitored at board level. Further details on the ICB's risk management arrangements and risk assessment processes are set out within the Governance Statement section of this annual report.

During the course of the financial year, the ICB identified a number of risks that needed mitigating in order to achieve financial targets. Monitoring and reporting processes detected increased expenditure within acute contracts due to growing demand, all age continuing healthcare and prescribing expenditure. The ICB was required to identify further mitigations during the year to offset these pressures, including introducing further grip and control measures and placing new internal measures to manage expenditure. This included adoption of an incident management approach designed to strengthen the monitoring of WRP delivery and facilitate the identification of new mitigation opportunities.

These measures, along with the external support received, has enabled the ICB to deliver a surplus position in 2025/26 of £9.7m, despite the considerable risks and pressures observed and also in part being required to offset equivalent deficits within the provider side of the system. WRP savings of £106.5m were delivered against the original planned target of £142.6m (which will be a challenge for the future financial year) but the ICB was able to identify additional in-year mitigations to cover the shortfall and other in-year pressures.

The following section provides a brief overview of the ICB's financial performance in the 2025/26 financial year. The financial accounts have been prepared under a Direction issued by NHS England under the National Health Service Act 2006 (as amended). A full set of accounts, including associated certificates, is included later

Performance Summary

Over the last year, we tracked the progress of our service providers (for example local hospitals, community services and primary care practices) against several national outcomes indicators and ensured that patient rights within the NHS Constitution were maintained.

Additionally, we set local priorities against which provider progress was monitored. Performance reports were presented to and scrutinised by the Finance and Contracting Committee and a summary of key issues reported to the ICB Board.

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

Financial Key Performance Indicators

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

Key performance indicator	Target	Actual	Result
Revenue resource use does not exceed the amount specified in Directions	Maintain expenditure within the allocated in-year resource of £5,699.256m	Total expenditure £5,689.580m	Achieved
Delivery of a control total of breakeven	Deliver a control total of breakeven	Surplus £9.676m (overall system breakeven)	Achieved
Maintain expenditure within the Annual Cash Drawdown Requirement	ICB Annual Cash Drawdown Requirement total £5,691.196m	Total cash outflow £5,634.816m	Achieved
Revenue administration resource use does not exceed the amount specified in Directions	Maintain administration (running costs) expenditure within the allocated resource of £38.821m	Total administration (running costs) expenditure £37.772m	Achieved
QIPP savings targets identified and savings achieved	Overall QIPP savings target £142.660m	Total QIPP savings £106.536m	Not achieved (shortfall covered in part by other mitigations - additional allocations and underspends in other areas)
Capital resource does not exceed the amount specified in Directions	Maintain expenditure within the allocated in-year resource of £0.030m	Total expenditure £0.029m	Achieved
Comply with the Better Payment Practice Code (BPPC)	Ensure 95% (by value and volume) of all valid invoices are paid by the due date or within 30 days of receipt of a valid invoice, whichever is later	NHS payables: 99.53% by value 95.39% by volume Non-NHS payables: 99.38% by value 99.20% by volume	Achieved

Allocation

The total in-year allocation to NHS Lancashire and South Cumbria ICB for 2025/26 was £5,699.3m. This can be broken down as follows:

- We received allocations totalling £4,515.2m for commissioning NHS services for the local community. Of this:
    - £175.4m was non-recurrent deficit support revenue allocation, of which £120.6m was transferred to local provider trusts, i.e. the ICB received £54.8m net deficit support funding.
- We received a further allocation of £404.5m for delegated commissioning of primary care medical services.
- We received a further allocation of £229.1m for delegated commissioning of other primary care services (pharmacy, dental and optical).
- We received a further allocation of £511.7m for delegated commissioning of specialised services.
- We received a further allocation of £38.8m from which we were expected to cover all our running costs.

2025/26 financial duties

The ICB's performance against each of its financial duties, as reported in Note 2 to the Accounts and outlined above, for the 2025/26 financial year as follows:

- The ICB exceeded its in year control total of a breakeven position, finishing the year with a surplus of £9.7m (overall system breakeven position).
- The ICB maintained its administration expenditure within its Running Costs Allowance.
- The ICB maintained its capital expenditure within its capital resource limit.

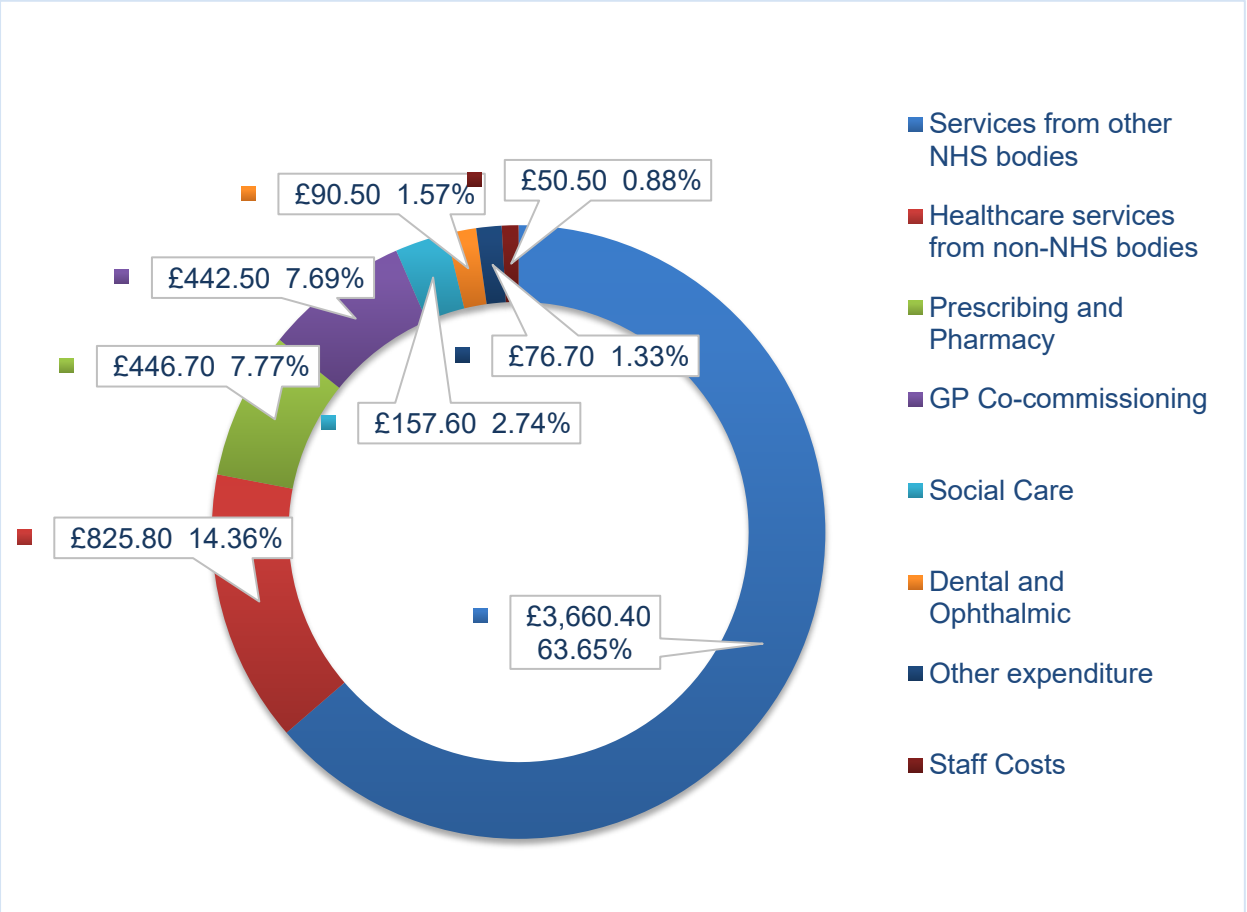
Accounting policies

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

We have made no changes to accounting estimates during the 2025/26 financial year.

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

Analysis of 2025/26 operating expenses £m:



Aaron Cummins
Accountable Officer

15 June 2026

ACCOUNTABILITY REPORT

Aaron Cummins
Accountable Officer

15 June 2026

Accountability Report

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

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2025 to 31 March 2026, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

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

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

Corporate Governance Report

Members Report

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

GP practices

There are currently 195 GP Practices across the ICB footprint. The list of providers of primary medical services is held in the Governance Handbook and can be accessed via the following link: https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook.

Register of Interests

The ICB maintains and publishes registers of interest for members of the Board, its committees, and those who hold decision making roles within the ICB:

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

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

Personal data related incidents

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

Modern Slavery Act

NHS Lancashire and South Cumbria Integrated Care Board fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2026 is published on our website at: LSC Integrated Care Board :: Modern slavery statement

Statement of Accountable Officer's Responsibilities

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

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

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

- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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

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

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

Disclosures:

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

The ICB was issued with enforcement undertakings in 2024/25 by NHS England in connection with financial governance and joint system financial objectives for the ICB and its partner trusts. Throughout 2025/26 the ICB has remained in those undertakings.

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

Aaron Cummins
Accountable Officer
15 June 2026

Governance Statement

Introduction and context

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

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

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

Between 1 April 2025 and 31 March 2026, the Integrated Care Board was subject to directions from NHS England issued under 14Z61 of the of the National Health Service Act 2006 (as amended).

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

The ICB was issued enforcement undertakings by NHS England in February 2024 in connection with financial governance and joint system financial objectives for the ICB and three of its partner trusts. The ICB has remained in these undertakings throughout 2025/26, the Financial Review section of this report provides an overview of the ICB's financial performance during the 2025/26 reporting period.

NHS England published a new one-year NHS Oversight Framework in June 2025. The new framework recognises that this will be a year of significant change for ICBs as they transform in line with the Model ICB Blueprint to focus on strategic commissioning and implement plans to meet the recommended running cost reductions. In transition from the existing oversight framework the ICB was placed into segment five due to the significant risk in controlling its expenditure.

Associated with this, the ICB remained in mandated intensive support through the nationally coordinated Recovery Support Programme (RSP) which provides focused and integrated support, working in a coordinated way with the ICB, regional and national NHSE teams. Following a review in November 2025, and recognition of considerable progress and improvements in governance and financial recovery NHSE approved the exit of the ICB from the national RSP on 23 December 2025. This decision is contingent on continued escalated oversight of delivery against the ICBs improvement plan and undertakings.

The ICB continues against its plan to meet the agreed exit criteria and support de-escalation and associated removal of the undertakings. These are published in full **here**.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Lancashire and South Cumbria Integrated Care Board's policies, aims and objectives, whilst safeguarding the public funds and assets for which

I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Lancashire and South Cumbria Integrated Care Board's Accountable Officer Appointment Letter.

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

Governance arrangements and effectiveness

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

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

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

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

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

The constitution was amended and submitted to NHS England (NHSE) in February 2026 to revise the composition of the Board with effect from 1 April 2026.

The ICB's board currently has three Executive Members (in addition to the CEO) namely Chief Finance Officer, Medical Director and Chief Nurse. The board composition has been reviewed in line with the publication of the NHS England Model ICB Blueprint.

As part of our response to the Model ICB Blueprint, the Strategic Commissioning Framework and the ICB's transition to a new target operating model, a review of executive portfolios has been undertaken, and the outcome means changes to the executive board member roles, being:

- Chief Finance Officer
- Chief Nurse
- Medical Director
- Chief Commissioning Officer
- Chief of Strategy and Planning

To ensure shared accountability, all five executives are members of the unitary board.

From establishment in July 2022 the Board has four Partner Members – three as required in legislation and an additional Partner Member for NHS Trusts Mental Health Services. The ICB has reviewed its Partner Members to include two additional members:

- An additional Local Authority Executive Level Role
- Partner Member – Voluntary, Community, Faith and Social Enterprise Sector

These changes mean full board membership of 19 members from 1 April 2026, with the ICB moving away from a large number of regular participants. This required changes to the ICB Constitution which were approved by NHS England with effect from 1 April 2026.

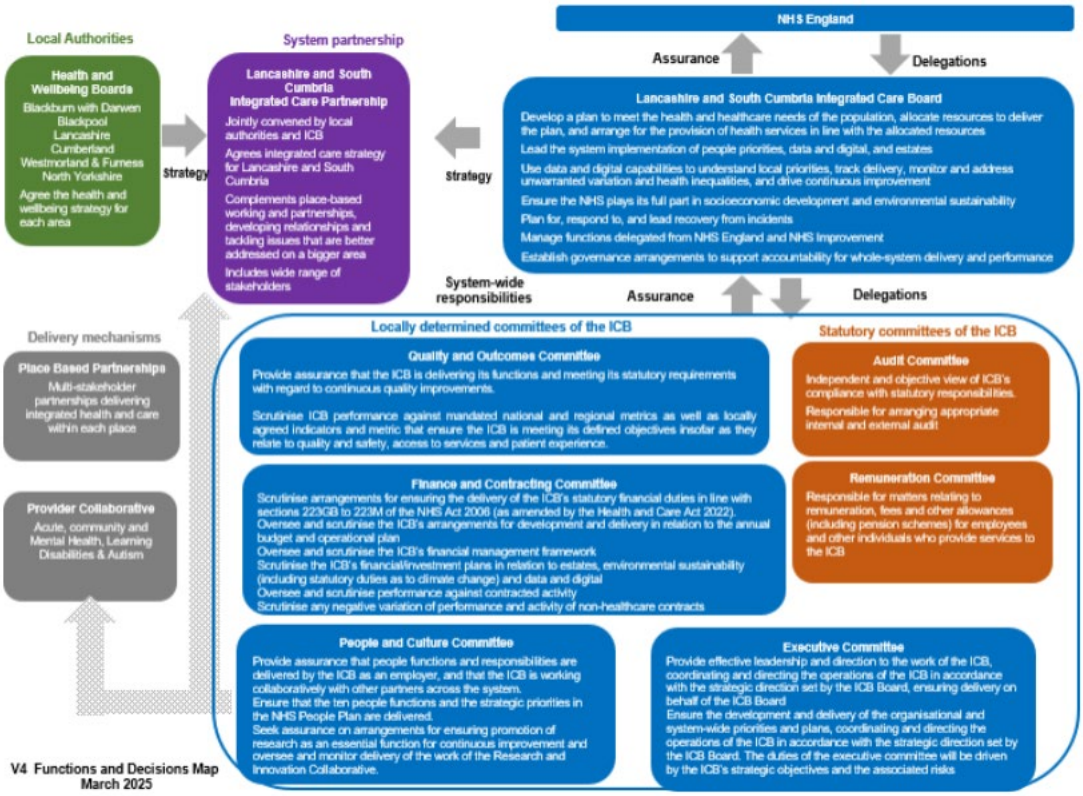
The constitution outlines that the ICB will publish an annual report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year, and that the annual report must in particular to explain how the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

Governance Handbook

The ICB's Governance Handbook brings together all the ICB's governance documents. The governance handbook has been reviewed and updated further to the approval of the amendments to the constitution to revise board composition, and in light of a revised committee structure from 1 April 2026. In this regard changes to the handbook, scheme of reservation and delegation (SORD), Operational Scheme of Delegation (OSOD), and Functions and Decisions Map were all approved by Board on 19 March 2026.

The handbook includes:

- The SORD which sets out key functions reserved to the Board of the ICB; functions delegated to committees and individuals; functions delegated jointly, and any functions delegated to the ICB.
- The OSOD is included within the overarching SORD and sets out delegated financial thresholds for functions and officers of the ICB.
- Standing Financial Instructions – which set out the arrangements for managing the ICB's financial affairs
- Terms of Reference for all committees and joint committees of the Board
- Delegation arrangements where ICB functions are delegated in accordance with section 65Z5 of the 2006 Act
- Key policy documents
- The Functions and Decisions Map (below) is a high-level structural chart that sets out the committees of the ICB, and where decision making is taken by which part or parts of the Integrated Care System.



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

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

The mechanisms described above have enabled the Board and its committees to take the effective decisions as described in the next section of this report. A review of the ICB's committee structure has been undertaken during 2025/26 and these proposals were approved by the Board at its meeting in March 2026 and will be implemented in the next financial year.

The Board

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

The Board is responsible for:

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

The appointment process for Board members varies according to the role they undertake and the appointment process specific to each role is outlined in detail within section 3 of the ICB's

constitution. In accordance with paragraph 3 of Schedule 1B to the NHS Act 2006, membership of the Board must consist of at least:

- Chair
- Chief executive
- Two non-executive members
- Three members who will bring knowledge and a perspective of their sectors. These members are known as Partner members, who are jointly nominated by their respective organisations and sectors

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

The Chair of the Board keeps under review the skills, knowledge and experience considered necessary for members of the Board to possess collectively in order for the Board to carry out its functions effectively and take such steps to address or mitigate any shortfalls. All Board members undertook an annual appraisal process during 2025/26, this allows the Chair and Chief executive to keep the skills, knowledge and experience of members under review. Over the reporting period the following appointments have been made:

- The role of Chief Executive was appointed to on an acting basis from 1 May 2025 to 31 October 2025, and from a substantive basis from 1 November 2025.
- The role of Medical Director was appointed to on an interim basis from 1 April 2025.
- The role of Chief Nurse was appointed to on an acting basis from 18 August 2025.
- The role of Chief Finance Officer was appointed to on an acting basis from 1 May 2025 – 30 September 2025, and from an interim basis from 1 October 2025 – 28 February 2025, and from a substantive basis from 1 March 2026.
- The role of Non-Executive Member and Finance and Contracting Committee Chair was appointed to from 1 April 2025
- The role of Non-Executive Member and Audit Committee Chair was appointed to from 1 January 2026
- The role of partner member Acute and Community Services was reappointed to from 1 October 2025

Composition of the Lancashire and South Cumbria Integrated Care Board

The Board is made up of 15 members and the table below includes those individuals who have taken up those positions over 2025/26:

Board Member	Position
Emma Woollett	Chair
Kevin Lavery (from 1 April 2025 – 30 April 2025) Sam Proffitt (Acting Chief Executive from 1 May 2025 – 31 October 2025) Aaron Cummins (Chief Executive from 1 November 2025)	Chief Executive (Accountable Officer)
Sheena Cumiskey	Deputy Chair / Senior Independent Non-Executive Member
James Birrell (until 31.12.2025) Stephen Spill (from 01.01.2026)	Non-Executive Member

Debbie Corcoran	Non-Executive Member
Roy Fisher	Non-Executive Member
Professor Jane O'Brien	Non-Executive Member
Stephen Igoe	Non-Executive Member
Dr Andy Knox (Acting Medical Director)	Medical Director
Professor Sarah O'Brien (until 29.06.25) Jane Scattergood (Acting Chief Nursing Officer from 18.08.25)	Chief Nursing Officer
Sam Proffitt (Until 30 April 2025) Stephen Downs (Acting Chief Finance Officer from 1 May 2025 Until 29 September 2025) Mark Bakewell (Interim Chief Finance Officer from 30 September 2025 and substantive from 1 March 2026)	Chief Finance Officer
Dr Julie Colclough	Partner Member, Primary Medical Services
Chris Oliver	Partner Member, Mental Health Services
Aaron Cummins (until 31.07.25) Silas Nichols (from 01.10.2025)	Partner Member, Acute and Community Services
Denise Park	Partner Member, Local Authorities

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

Regular Participants

Participants are individuals who the Board invite to make an informal contribution to their discussions on a regular basis. These individuals were invited to all meetings, received copies of the meeting papers and took part in discussions. Because they were not members, they could not vote, and they have no accountability for decisions made by the Board. Throughout 2025/26, the Board invited the following regular participants to each of its Board meetings:

ICB Officers:

- Chief Commissioning Officer
- Chief Digital Officer
- Chief People Officer
- Company Secretary / Director of Corporate Governance
- Director of Communications and Engagement

Sector representatives and other professionals:

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

The Board has met in public on six occasions between 1 April 2025 and 31 March 2026. All meetings were quorate, were held in public and were livestreamed.

Attendance at Board Meetings for the period 1 April 2025 to 31 March 2026:

MEMBER	22 MAY 2025 (PUBLIC BOARD)	24 JULY 2025 (PUBLIC BOARD)	25 SEP 2025 (PUBLIC BOARD)	27 NOV 2025 (PUBLIC BOARD)	22 JAN 2026 (PUBLIC BOARD)	19 MAR 2025 (PUBLIC BOARD)
Emma Woollett	✓	✓	✓	✓	✓	✓
Sheena Cumiskey	✓	✓	✓	✓	✓	x
Roy Fisher	x	✓	✓	✓	✓	✓
Jane O'Brien	✓	✓	x	✓	✓	✓
Debbie Corcoran	x	✓	✓	x	✓	✓
Steve Igoe	✓	✓	x	✓	✓	✓
Stephen Spill	N/A	N/A	N/A	N/A	✓	✓
James Birrell	✓	✓	✓	✓	N/A	N/A
Mark Bakewell	N/A	N/A	N/A	✓	✓	✓
Stephen Downs	✓	✓	✓	N/A	N/A	N/A
Aaron Cummins	N/A	N/A	N/A	✓	✓	✓
Samantha Proffitt	✓	✓	✓	N/A	N/A	N/A
Dr Andy Knox	✓	✓	✓	✓	✓	✓
Jane Scattergood	N/A	N/A	x	✓	✓	✓
Sarah O'Brien	✓	x	N/A	N/A	N/A	N/A
Chris Oliver	✓	✓	✓	✓	✓	✓
Silas Nicholls	N/A	N/A	N/A	✓	✓	✓
Denise Park	x	✓	x	x	x	x
Dr Julie Colclough	✓	✓	✓	✓	✓	✓
Aaron Cummins (as partner member)	✓	✓	N/A	N/A	N/A	N/A

Board Performance

Each meeting held in public includes a patient story that allows the Board to reflect on where both learning and good practice can be contextualised during the course of the meeting. At each meeting regular reports are received from the Chair and Chief Executive to provide context of national, system and local key messages to Board members. Updates are also regularly provided in relation to the Board Assurance Framework, financial performance and system recovery and performance. Each meeting also includes a report which describes the insights captured from proactive engagement and involvement activity and how this has been used to inform and develop key areas of work in the ICB including the five-year commissioning strategy.

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

Plans to mitigate the financial risk during the year has been overseen by the Board which agreed a number of mitigating plans and actions to address the challenging financial position. Regular private sessions have also been held with the Board over this period to focus on plans to address the risk to the year-end financial outturn position and plans for 2026/27.

A summary of items considered from private board meetings are presented to each public board meeting through a report of matters discussed in private.

During 2025/26, the Board has considered and approved significant areas of business including:

- High-level budget and Financial Plan for 2025/26.
- Exit criteria against the enforcement undertakings and a Single Improvement plan to address recommendations as agreed with the Recovery Support Programme.
- The Future of community services.

Progress against the Integrated Care Strategy and development of the Integrated Care Partnership.

- *Joint Capital Resource Use Plan 2025/26.
- Equality, Diversity, and Inclusion Annual Report 2025-2026.
- Equality Delivery System (EDS2022) Grading Assessment Report 2025-26.
- ICB Annual Report and Board Assurance Statement.
- Urgent and Emergency Care (UEC) Delivery and Winter Planning 2025/26.
- Board Assurance Framework.
- Risk Appetite Statement.
- Strategic Objectives.
- Strategic Commissioning Framework Response.
- Voluntary, Community, Faith and Social Enterprise Alliance/ ICB Partnership Agreement.
- Annual Review and publication of the ICB's Registers of Interests including Gifts and Hospitality.
- 3 Year Medium Term Plan (2026/2029) and a 5 Year Strategic Commissioning Plan (2026/2031).
- ICB Target Operating Model and plans to transition to the Model ICB Blueprint.
- 2026/27 Annual Budget and Operational Plan.
- 2026/27 Commissioning Intentions.
- Cases for change to reconfigure services.
- Governance and Committee Review.
- Constitution and Board Composition.
- Emergency Preparedness, Resilience and Response Core Standards.

The Board has also met informally on a regular basis over the reporting period with a focus on a programme of board seminars, including board development, strategy and education. These seminars focused on the following key themes:

- Board Well Led Self-Assessment and Improvement Plan.
- Board Assurance Framework, Strategic Objectives and Risk Appetite.
- Community Service in the context of strategic commissioning.
- Board Development.

- Strategic Commissioning Framework.
- 5 Year Strategy.
- Equality, Diversity and Inclusion (EDI).

Over 2025/26 NHS England have published a number of frameworks including a new NHS Planning Framework and Strategic Commissioning Framework that sees the ICB moving to a three-year finance, activity and workforce plan and a 5-Year Strategic Commissioning Plan. On publication of the Medium-Term Planning Framework and Strategic Commissioning Framework, the Board received an update on the requirements and implications for the LSC system, key milestones, deliverables, and assurance expectations, progress to date and areas requiring Board oversight or decision at its meeting in November. Subsequently the Board and its assurance committees have undertaken a key role in receiving assurance against the progress of this response prior to the national submission deadline in February, with the final submission presented to the Board in public in March 2026.

On 16 June 2025, a meeting of the Board was held to approve the submission of the annual report and accounts for the period 1 April 2024 to 31 March 2025.

The ICB held an Annual General Meeting on 25 September 2025 at which the Annual Report and Accounts were presented from 2024/25. Presentations at this meeting shared key achievements and challenges during the year, with a forward view to 2025/26. Members of the public were given the opportunity at the meeting to ask questions directly to the Board.

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

*ICBs are required to publish a Joint Forward Plan (14Z52) and a Joint Capital Resource Use Plan (14Z56) and report against them within this annual report. The Joint Forward Plan is referenced in more detail in the report at NHS Medium Term Planning and the 5 Year Strategic Commissioning Plan.

The Annual Joint Capital Resource Use Plan was approved by the Board and published in July 2025. Lancashire and South Cumbria ICB has an ICS-wide Infrastructure Strategy 2024 – 2040 that sets out the longer-term vision of the infrastructure / estate. It was endorsed by the ICB Board and published in January 2024. LSC Integrated Care Board :: Infrastructure Strategy 2024-2040 (icb.nhs.uk).

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

Committees of the Board

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

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

each committee and allows for the Board to have timely oversight of the decisions taken, the assurances gained, and any areas of concern.

The committees of the Board are:

Statutory committees

- Audit Committee
- Remuneration Committee

Non-statutory committees

- Quality and Outcomes Committee
- Finance and Contracting Committee
- People and Culture Committee
- Executive Committee
- Transition committee

Joint Committees

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

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

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

Committee Effectiveness

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

A robust process is in place whereby a committee can refer business or an action to another committee where findings or concerns overlap. These referrals are reported to the Audit Committee bi-annually which provides a summary of the focus of each committee over the period and assurance that the committees are remaining within their agreed terms of reference and interacting within the governance structure. The first report this year was presented to the Audit Committee in July 2025 which provided some early assurance against the revised committee structure implemented in April 2025 that this was delivering against the respective terms of reference. A further report was presented to the Audit Committee in March 2026 to provide additional assurance that this has continued throughout the year.

In January 2026, the Board undertook a review of its committee structure. This review was informed by the publication of NHS England's Strategic Commissioning Framework in November 2025 and the transition to the Model ICB Blueprint. As a result, strategic commissioning functions have been aligned within the committee structure and terms of reference, with the revised arrangements approved by the Board in March 2026 and implemented from April 2026.

The Quality and Outcomes and Finance and Contracting committees have undertaken a self-assessment of committee effectiveness in March 2026. The People and Culture Committee also

undertook this assessment in April 2026 to inform the future planning of the committee in a new form for 2026/27 aligned to the model ICB blueprint.

The self-assessment was undertaken against some key areas informed by the NHS England publication 'The Insightful ICB Board'. This publication was designed to help ICBs to assess the effectiveness of the information they collect and use, which was therefore pertinent to assess against the business of the committee. The assessment enabled the committee members to respond to five key statements concerning the following:

- Reporting to the board
- Receipt of the level of assurance required in line with the terms of reference
- Member confidence to ask uncomfortable questions
- The appropriate granularity and transparency of information
- Balance of assurance and reassurance in the papers received

The responses will be used to further drive those areas identified as functioning well and to refine those areas identified for development in 2026/27 committee business.

Audit committee

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

The Audit Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, including quality governance, risk management and internal control processes within the ICB. The Audit Committee is required to produce an annual report, a mid-year report was presented to the committee at the December 2025 meeting, with a concluding report scheduled to the June 2026 meeting. The duties of the committee are driven by the organisation's objectives and the associated risks. The committee agreed an annual internal audit plan with sufficient flexibility to be able to respond to new and emerging priorities and risks. Regular updates are received against this plan and any amendments are presented to the committee.

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

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

The Audit Committee agreed a business plan for 2025/26 which was regularly monitored and aligned to the meeting's agendas.

Audit Committee Membership

MEMBER	POSITION
James Birrell	Non-Executive Member (Chair until 31.12.2025)
Stephen Spill	Non-Executive Member (Chair from 01.01.2026)
Sheena Cumiskey	Non-Executive Member

Debbie Corcoran	Non-Executive Member
Roy Fisher	Non-Executive Member

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

The committee met on five occasions between 1 April 2025 and 31 March 2026 including an extraordinary meeting to recommend the Annual Report and Accounts to the Board. All meetings were fully quorate and the quorum necessary for the transaction of business is two members.

Attendance at Audit Committee meetings for the period 1 April 2025 to 31 March 2026:

MEMBER	16 JUNE 2025	23 JULY 2025	24 SEPTEMBER 2025	10 DECEMBER 2025	18 MARCH 2025
James Birrell (Until 31.12.25)	✓	✓	✓	✓	
Stephen Spill (Associate NEM from 01.05.25, NEM and committee chair from 01.01.26)	✓	✓	✓	✓	✓
Sheena Cumiskey	x	✓	✓	x	✓
Roy Fisher	✓	✓	✓	✓	✓
Debbie Corcoran	x	✓	✓	✓	✓

Audit Committee Performance

The Audit Committee has an annual business plan that incorporates the review of reports and positive assurances from Executives, managers, Internal Audit and External Audit and counter fraud on the overall arrangements for governance, risk management and internal control. Significant items that were considered during 2025/26 are shown below:

Governance, risk management and internal control:

- ICB annual report and audit accounts 2024/25 for recommendation to the Board.
- Mental health investment standard.
- Annual report of the Audit Committee 2024/25.
- All Age Continuing Care.
- Data Protection and Security Toolkit (DPST), Information Governance and Artificial Intelligence.
- Assurance against delivery of the ICB strategic objectives.
- Updates against the implementation of the new finance system ISFE2 (The committee has received reporting of risks regarding the transition nationally to a new financial management system (ISFE2) from 1st October and how these risks have been mitigated pre and post transition).
- Committee Effectiveness: Assurance of key focus and escalation of issues.
- Freedom to Speak Up.
- ICB registers of interests, gifts and hospitality.
- Updated Anti Fraud Bribery and Corruption policy.
- Business continuity deep dive.
- Board Assurance Framework and risk management.

- Audit Committee mid-year report.
- Annual Report timetable & early assessment of the Annual Governance Statement.

Internal Audit (MIAA):

- Final Head of Internal Audit Opinion 2024/25 and annual report.
- Internal audit plan 2025/26.
- Progress reports against the internal audit plan 2025/26.
- The Internal Audit Network Insight Reports and Technology Risk briefings.
- Audit charter.
- Interim Head of Internal Audit Opinion 2025/26.
- Internal audit plan 2026/27.

External Audit (KPMG):

- Annual auditor reports relating to the ICB annual report and accounts 2024/25 and associated documents.
- Health technical updates and progress reports.
- Draft audit plan 2026/27 including value for money risk assessment.

Anti-fraud (MIAA):

- Anti-fraud Annual Report 2024/25.
- Progress reports against the annual workplan.
- Workplan 2026/27.

Committee Effectiveness

The committee committed to conducting deep dives into agreed areas of focus, and in-year this was undertaken into business continuity with a focus on the Business Impact Analysis (BIA) Process. The committee gained assurance that most teams had completed a BIA and that the quality and relevance of these would be assessed, with prioritisation given to clinical services namely AACC due to the team's direct impact on patient care. Further deep dive areas will be planned for 2026/27 meetings where determined by the committee.

Remuneration Committee

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

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

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

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

- Elements of the nominations and appointments process for Board members.

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

The committee meets in private at least twice a year and membership comprises of three Non-Executive Members of the Board. During 2025/26 the committee met on 17 occasions and was quorate for each meeting.

Remuneration Committee Membership

Member	Position
Roy Fisher	Non-Executive Member *(Chair)*
Professor Jane O'Brien	Non-Executive Member
Sheena Cumiskey	Non-Executive Member

Attendance at Remuneration Committee meetings for the period 1 April 2025 to 31 March 2026:

MEMBER	9 APR	24 APR	15 MAY	2 JUNE	10 JULY	21 JULY	7 AUG	21 AUG
Roy Fisher	✓	✓	x	✓	✓	✓	✓	✓
Sheena Cumiskey	✓	x	✓	✓	✓	✓	✓	x
Professor Jane O'Brien	✓	✓	✓	✓	x	✓	✓	✓

Member	30 SEPT	20 OCT	13 NOV	18 NOV	18 DEC	5 JAN	9 FEB	5 MAR	11 MAR
Roy Fisher	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sheena Cumiskey	✓	✓	✓	✓	✓	✓	✓	✓	x
Professor Jane O'Brien	✓	✓	✓	x	✓	✓	✓	✓	✓

Remuneration Committee Performance

During 2025/26, the Remuneration Committee reviewed and approved significant areas of business including:

- Arrangements for CEO Appointment.
- Remuneration for Very Senior Manager (VSM) positions.
- Updates to HR policies in the areas of; Recruitment and selection, Organisational Change, Retirement, Anti-Racism, Flexible Working and Retirement.
- New HR Policy ratification in the areas of Sexual Misconduct and ICB Menopause Policy.
- VSM annual review 2025/26.

- Executive restructure.
- Proposals for the launch of a Voluntary Redundancy Scheme.

The ICB has also established a Remuneration Panel to agree salaries of the ICB's Non-Executive Members. Members of the Panel are the ICB's Chair (whose salary is determined by NHSE), the Chief Executive and Chief People Officer. The panel met on one occasion during 2025/26.

Quality and Outcomes Committee

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

The committee provides the Board with assurance that the ICB is delivering its functions and meeting its statutory requirements with regard to continuous quality improvements and enabling a single understanding of and shared commitment to quality care across the system that is safe, effective, equitable, and that provides a personalised experience and improved outcomes with reduced health inequalities.

The remit of the Committee incorporates scrutiny of Primary Care Services (as set out within the Delegation Agreement between NHS England and the ICB), insofar as they relate to quality and safety, access to services and patient experience.

The Committee is also responsible for scrutinising ICB performance against mandated national and regional metrics as well as locally agreed indicators and metrics that ensure the ICB is meeting its defined objectives insofar as they relate to quality and safety, access to services and patient experience.

During 2025/26 the committee met on 8 occasions and was quorate at each meeting.

Quality and Outcomes Committee Performance

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

The committee received a series of regular reports for assurance throughout the year including updates in the areas of; Children and Young People and SEND, maternity and neonatal, patient and safety (including Patient Safety Incident Response Framework PSIRF), medicines optimisation and safety, safeguarding adults and children, infection prevention and control, learning disabilities and autism. The committee also received regular updates against AACC in the reporting period to provide assurance on progress already made and the plans in place to improve the quality of the AACC service alongside improved performance. The committee also received regular updates on; risk management, patient experience, and assurance against the process for Quality Impact Assessments and Equality Impact Assessments.

Furthermore, triple A reports from subgroups of the committee were reported from; the Clinical Effectiveness Group, the Primary Care Quality Group, the System Quality Group, and Prevention and the Health Inequalities Steering Group.

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

Committee Effectiveness

A key achievement of the committee in this period is the development and establishment of an integrated performance report. This integrated reporting of quality and outcomes including population health has supported the committee to obtain more focussed and triangulated assurance against a range of duties of the committee with increased focus on those areas identified as risks in the report.

The committee also received assurance at its January 2026 meeting regarding the development of the five-year Strategic Commissioning Plan, and how this will describe the ICB's vision for improving health outcomes, defining clear outcomes, actions and KPIs. This was presented ahead of the final ICB submission of the Medium-Term Plan in February 2026.

The committee made some amendments to the terms of reference in September to reduce quoracy from 5 members to 4 with only one executive required, and to reduce the frequency of meetings from monthly to bimonthly alternating between face to face and virtual.

Further amendments to the terms of reference were approved by the Board in March 2026 which included alignment of the committee's functions to the strategic commissioning framework.

System Quality Group

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

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

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

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

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

Finance and Contracting Committee

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

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

During 2025/26 the committee met on 12 occasions and was quorate at each meeting when taking decisions. On two occasions (April 2025 and February 2026) part of the meeting was not fully quorate and therefore no decisions were taken at these times.

Finance and Contracting Committee Performance

The committee received a series of regular reports for assurance throughout the year including in the following areas at each meeting; monthly system finance, Waste Reduction Plan (WRP), contract monitoring, and AACC. The committee also received a quarterly BAF and risk management update. In addition to regular reports the committee received additional key items including;

- Assurance on an update on the development and Delivery of the ICB Annual Budget and Waste Reduction Programme for 2025/26.
- Commissioning delivery and intentions.
- Digital and Data Strategy.
- Receipt of the Joint Capital Resource Plan 2025/26 which was recommended to the Board for approval.
- Approval of the Green Plan 2025-2030.
- System Wide Estates and Infrastructure Strategy.
- Provider Capital.
- Winter planning 2025/26.
- Primary care estate and statutory compliance.
- Local Enhanced Services updates.
- New finance system ISFE2.
- Prescribing.

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

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

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

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

Committee Effectiveness

The Committee received a series of assurance updates in advance of the ICB's submission of the 2026–2029 Medium-Term Plan. At its meeting on 21 November, the Committee received an update on the detailed 2026/27 planning guidance and provided assurance against the emerging draft plans. At the same meeting, the Committee also received an update on commissioning intentions and their alignment with the NHS planning and contracting cycle. At the meeting held on 7 January, the Committee was advised of progress with the plan submission, including confirmation that the ICB had successfully submitted its initial planning assumptions and templates in line with the December 2025 deadline. At its meeting on 30 January, the Committee received assurance on the final draft plan ahead of its consideration by the Board. Collectively, these updates enabled the Committee to provide effective oversight and assurance to the Board in advance of the Board's approval of the submission.

The committee has conducted significant oversight of the in-year delivery of the financial plan, with assurance reports provided to each meeting against ICB and system monthly financial position and forecast, with associated risks and mitigations. Focussed reporting has been made to each meeting regarding AACC in order to provide updates against the progress made in delivering the turn-around plan. Assurance received from the committee and those risks and mitigations identified have been reported to the Board via the 'triple A' report.

The committee reviewed its membership and quoracy arrangements in August and further amendments to the terms of reference were approved by the Board in March 2026 to align the committee's functions to the strategic commissioning framework and medium-term planning requirements.

People and Culture Committee

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

The committee has met on a quarterly basis throughout the year with four meetings taking place during 2025/26. All meetings were quorate.

People and Culture Committee Performance

The committee received reports at each meeting in the areas of risk management and Freedom to Speak Up.

Further significant items received during 2025/26 include:

- NHS Operational Planning 2025/26 (from a workforce perspective) and multi-year planning.
- Provider staff survey and pulse survey.
- Culture, values, and behaviours framework.
- Approval of the 12-month People Plan, and updates against transition plan.
- Local Maternity and Newborn System (LMNS) Workforce Report.
- Equality, Diversity and Inclusion Annual Report 2024-25 which the committee recommended to the Board for approval.
- Equality Delivery System (EDS2022) Grading Assessment Report 2024/25.
- Anti-Racism Policy and Guidance.
- Health and Wellbeing system and ICB reports.
- ICB Equalities Action Plan Q3/Q4 2025-26.
- ICB Combined Pay Gap report 2025.
- Research and Innovation.

The committee received updates from its subgroups: Strategic Training and Education Collaborative (STEC) and People and Culture Sub Committee across the reporting period.

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

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

Committee Effectiveness

The committee received assurance at its January 2026 meeting regarding the

numerical workforce figures and context of the workforce elements of the Medium -Term Plan. This was presented ahead of the final ICB submission of the Medium-Term Plan in February 2026.

The committee purpose and functions will be refined in 2026/27 in order to align to the model ICB blueprint.

Executive Committee

The ICB Executive Committee exists to support the Board to ensure that the ICB takes appropriate steps to meet all its statutory duties and meets legislative requirements and regulatory guidance. The duties of the committee are driven by the ICB's strategic objectives and the associated risks. The committee's business programme is flexible to accommodate and respond to new and emerging priorities and risks.

Due to the supporting nature of the committee, it receives a large volume of business throughout the year. This can be categorised into the following themes:

- Strategy and leadership
- Finance, performance and planning
- Strategic commissioning
- Operating model
- EPRR
- People and culture
- Risk management

The committee has a number of sub groups/committees, reporting has taken place from these across the reporting period:

- Commissioning Resource Group
- Specialised Commissioning Oversight Group
- Primary Care Contracts Sub Committee
- Incident Management Team
- Business and Sustainability Group
- Resource Mobilisation Group
- Non Pay Spend Panel
- Information Governance Oversight Group
- Health Safety and Security Group
- Medicines Management Group

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

The Committee reports updates to the Board via the Chief Executive report which is a standing item on the agenda.

Minor amendments were approved to the committee's terms of reference by the Board in March to reflect the new planning framework.

Other Committees

Transition Committee

The ICB established a time-limited Transition Committee in 2025/26 in response to the government announcement (13 March 2025) stating that ICBs must reduce their running costs and the subsequent publication of the 'Model ICB- Blueprint'.

The committee provides oversight of a robust programme in place to deliver the successful transition to the new operating model and achieve the delivery of the required running cost and programme cost reduction, whilst enabling the ICB to continue to deliver against its statutory responsibilities.

Further to the committee review received by the Board in March 2026, the business and functions of the committee will be reviewed in 2026/27 to ensure a continued focus on the safe transition to the new operating model.

Joint Committees

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

North-West Specialised Services Joint Committee

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

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

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

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

As a Joint Committee of the three ICBs, the Joint Committee is accountable to the respective Boards of NHS Lancashire and South Cumbria ICB, NHS Cheshire and Merseyside ICB and NHS Greater Manchester ICB. The committee has reported regularly to the Board via the 'alert assure advise' format to share those decisions taken and any risks and mitigations identified in the committees business.

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

The terms of reference for this joint committee can be viewed here.

Delegate One Services (single ICB)

The ICB has established a Specialised Commissioning Oversight Group to oversee the commissioning and delivery of the single-ICB specialised services that have been delegated from NHSE to LSC ICB. The group brings together the leadership of LSC ICB with the north west hub and subject matter experts, with a commitment to ensure that we commission effective, high-quality care in relation to delegated specialised commissioning functions with the resources available.

A specialised commissioning audit was included on the 2025/26 internal audit plan. The objective of this audit was to assess the effectiveness of the ICB's governance, risk management, financial control and operational delivery arrangements relating to specialised commissioning. The audit provided a 'substantial' assurance opinion.

Shaping Care Together Joint Committee

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

As the commissioners for the programme, NHS Cheshire and Merseyside Integrated Care Board (C&M ICB) and NHS Lancashire and South Cumbria ICB were required to approve the pre-consultation business case. To enable effective decision making, both Boards agreed to form a joint committee to take decisions for the SCT programme.

The committee has met in public during 2025/26, and approved the pre-consultation business case in July 2025. The public consultation followed from July to October. The committee then met in March 2026 to receive the decision-making business case which was approved. This agreed the future location of A&E services in Southport, Formby and West Lancashire. More information regarding this programme can be found here: Your Say Shaping Care Together.

The joint committee terms of reference can be viewed here.

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

Special Lead Roles

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

Senior Independent Risk Owner (SIRO)

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

Caldicott Guardian

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

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

The role of the FtSU lead is to oversee the systems and processes in place for ICB staff to raise concerns and ensure these are fit for purpose; enabling the organisation to be open and transparent and create a culture of learning. The Chief Digital Officer undertakes the executive lead role on behalf of the ICB, Professor Jane O'Brien undertakes the non-executive champion role on behalf of the ICB.

Equality, Diversity and Inclusion (EDI) Lead

It is important that the ICB ensure that its services and employment practices are fair, accessible, and inclusive for the diverse communities it serves and the workforce it employs. In recognition of this, the ICB has sought to have a named executive and non-executive lead for EDI. The Chief People Officer undertakes this role on behalf of the ICB

Conflicts of Interest Guardian

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

The role of the Conflicts of Interest Guardian is to strengthen the scrutiny and transparency of the organisation's decision-making processes. It is commonly considered best practice for the Conflicts of Interest Guardian to be the audit chair. The Non Executive Member and Audit Committee Chair undertake this role on behalf of the ICB.

Senior Independent Non-Executive Director

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

Health and Wellbeing Guardian

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

The role of the Health and Wellbeing Guardian is to support with oversight of the organisational culture to ensure that the health and wellbeing of the workforce is considered routinely across all organisational activities. Professor Jane O Brien, non-executive member of the Board undertakes this role on behalf of the ICB.

Other Population Groups and Functions

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

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

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

The guidance also includes the requirement of at least one member of the Board who has knowledge and experience in connection with services relating to the prevention, diagnosis, and treatment of mental illness. Mental health lead Board members for the ICB are the Medical Director and NHS Trust/ Foundation Trust partner member: mental health services.

UK Corporate Governance Code

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

Discharge of Statutory Functions

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

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

Risk management arrangements and effectiveness

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

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

- Improve quality, including safety, clinical outcomes, and patient experience

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

Throughout the reporting period the ICB has continued to build on the work undertaken during 2024/25 to strengthen and embed these arrangements, including embedding the ICB's risk management strategy and policy which complies with the main principles of The Orange Book: Management of Risk. This sets out the arrangements for the management and oversight of risks linked to the ICB's strategic aims and objectives and clearly describes the processes established to support the systematic identification, assessment, evaluation and control of risks, at different levels across the organisation.

In September 2025, the Board reviewed and approved a refreshed BAF and risk appetite for 2025/26. The revised framework was centred on eight principal risks identified by the Board as having the potential to significantly impact delivery of the ICB's objectives.

At an operational level, risks identified as having the potential to impact on the delivery of the ICB's plans and priorities are held on the ICB's operational risk register (ORR). Operational risks which are categorised as 'high' receive corporate oversight through the Executive Committee and the relevant assuring committee. Risks held on the ORR which are assessed as a 'medium' (or lower) level, with the potential to impact on the delivery of team plans and priorities, are monitored at functional level with named senior responsible officer (SRO) oversight.

A key development during the year was the successful transition of the ICB's operational and functional risk registers onto an integrated risk management system in August 2025. This strengthened consistency, transparency and control, and provided enhanced reporting and oversight to support timely review and escalation of risks.

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

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

Risks are identified from a number of sources, including the Board, its committees, staff at all levels, and internal and external sources. They can also arise from the development or implementation of strategies and plans, therefore the ICB has embedded its risk management arrangements throughout the operation of the ICB's activities to ensure risk management is integral to decision making within the ICB.

This can be demonstrated in a number of ways e.g. when planning or commissioning health services, the ICB must take into consideration the risks arising from the potential impact of those decisions on the population served, the ICB also has a duty to consider the environmental

impact of its plans, these risks are assessed through the completion of equality and health inequalities impact and risk assessments (EHIIRA) and sustainability impact assessments. These are undertaken before new services are commissioned, or when policies, plans, proposals or decisions are being considered which could have the potential to impact on health or widen health inequalities.

To support the above, a defined risk management reporting cycle has been in place throughout the reporting period. Monthly risk updates and exception reports are presented to the Executive Committee which includes risks held on the BAF and those operational risks which meet which meet the threshold for corporate oversight. These are also reported through the relevant assuring committees, to ensure full visibility and oversight of all risks held on the BAF and ORR.

The role of the Audit Committee is to review the adequacy and effectiveness of the ICB's risk management arrangements. To enable this, the committee has received a full update in July and December 2025 on risks being managed within the organisation and the development of risk management arrangements. The committee also received the findings of the internal audit reviews of those arrangements undertaken by Mersey Internal Audit Agency (MIAA) which provided 'substantial assurance'.

A copy of the ICB's Risk Management Policy can be found here.

Capacity to Handle Risk

The ICB's capacity to handle risk is demonstrated through the board's risk appetite statement and is integral to the ICB's policy for risk management.

During 2025/26 the overall risk profile has reflected the impact of the main risks facing the organisation including strategic commissioning, financial sustainability, workforce capacity, and the resilience of healthcare services. At an operational level, the highest scoring risks were those assessed at a score of 20 and were therefore escalated for Board oversight in line with the ICB's risk management policy. These included risks relating to the ICB's ability to meet its statutory SEND responsibilities, neurodevelopment pathways across Lancashire and South Cumbria, the ability to effectively identify and respond to quality and safety concerns in primary care, and Court of Protection Deprivation of Liberty applications not being completed within required timeframes. These risks were aligned to the ICB's strategic objectives and were subject to enhanced executive and committee oversight, with mitigating actions in place and progress monitored through routine reporting.

The responsibility for risk management is clearly defined at all levels within the organisation through the ICB's risk management strategy and policy. This outlines the roles and responsibilities of the Board, its committees, the Chief Executive Officer, the Chief Finance Officer and other staff within the ICB. Committee terms of reference include the review and monitoring of those risks on the BAF and ORR which relate to each committee (and if relevant, risks have been overseen by more than one committee).

During 2025/26, the frequency and quality of risk reporting were strengthened, with reporting to the Board increasing from biannual to quarterly, with the Board's assuring committees continuing to receive quarterly risk updates relevant to their remit. The Executive Committee received a monthly risk exception report which has now been developed into an integrated risk management report including summary dashboards of BAF and operational risks which supports consistent oversight and challenge at executive level.

The ICB's Executive Committee determine whether risks have the potential to impact the delivery of the ICB's strategic objectives and consequently reported on the BAF, or whether they are managed as operational risks and reported through the ORR.

The committees of the ICB all present timely escalation and assurance (advise, alert and assure) reports into the Board. From a risk perspective, these reports are used by committees to assure the Board that risks are being effectively managed and to formally 'alert' the Board to areas of concern.

The ICB has established effective arrangements to support the committees to work and oversee risks in a cohesive and methodical way, with risk reporting being centrally coordinated by the Corporate Governance Team which is underpinned by regular monthly risk reviews being undertaken by SROs/ Risks Leads.

Staff training has been provided to support the implementation of the revised systems and processes for risk management. There is also a dedicated risk management intranet page is established to enable all staff to have the information they need to adhere to the policy and processes. Furthermore, a series of interactive virtual training sessions on Quality Impact Assessments (QIAs) have also been delivered during the reporting period.

Risk appetite was actively embedded into decision-making during the reporting year. Enhancements included incorporating risk appetite by category into the risk assessment process, to demonstrate alignment with the Board's risk appetite, and strengthening the requirement for Board and committee reports to clearly articulate associated risks and how these were being managed to a level acceptable to the Board.

Risk Assessment

Risk assessments across the ICB have followed a consistent and systematic approach, supported by the risk management policy, a defined scoring matrix and Board approved risk appetite statements. Risks were assessed in terms of likelihood and consequence, recorded on the appropriate risk register, and reviewed regularly through established governance processes.

Strategic risks were assessed and monitored through the BAF, with progress and changes reported through the Executive Committee, assuring committees and the Board. During quarter 4 of 2025/26, several BAF risks remained rated as high, reflecting the scale and complexity of the challenges facing the organisation. In a number of cases, target risk scores remained above the Board's agreed risk appetite. These positions were explicitly acknowledged, with further reviews undertaken to determine whether additional controls or mitigations could reasonably be applied within available resources.

Operational risks were assessed and managed through the ORR. Risks meeting the threshold for corporate oversight were reviewed monthly by the Executive Committee and escalated to the Board where required. At the end of quarter 4, four operational risks were rated at 20; these were reported to the Board in accordance with the ICB's risk management policy. These risks were aligned to strategic objectives and were subject to enhanced oversight through the Quality and Outcomes Committee, with clear action plans and target risk scores in place.

Below are the principal risks to the achievement of the ICB's strategic objectives and a summary of the key actions and controls:

RISK AREA	STATUS UPDATE (INCLUDING KEY ACTIONS/ CONTROLS)
Strategic Commissioning	Work to finalise the medium-term commissioning plan, 5-year strategy and the refresh of the joint forward plan continues to progress, including the national planning submission and the ICB's commissioning intentions for 2026/27 which were approved by the board in March 2026.
Partnerships and Collaborative Working	Further work to establish the Joint Commissioning Board continues to progress, with planning meetings held in February between the ICB and Lancashire County Council to progress the Joint Commissioning Framework. This is expected to mobilise in Q1 2026/27. The partnership agreement with the VCFSE and ICB has been re-affirmed and work with the Provider Collaborative Board continues to ensure alignment of work programmes to support service change and planning into the next financial year. The 5 Year Strategic Commissioning Plan includes partnership arrangements including VCFSE arrangements.
Responsive and Resilient Healthcare Services	Work continues to develop the clinical strategy to ensure it informs and is aligned with the ICB's broader commissioning plans and intentions. A task and finish steering group has been established to oversee the development of the strategy; engagement sessions are planned with ICB colleagues and wider partners to connect with the work undertaken to date, review the draft and contribute to its further development.
Transition to Model ICB Blueprint	A Transition Programme Group and a transitional planning framework is now established. Directorates have provided business impact assessments (BIA) and risks to "business as usual" activities are managed through the transition framework. The ICB's workforce requirements continue to be modelled against the ICB's target operating model and these will be finalised in line with national running cost requirements.
Sustainable Workforce	A programme of organisational development support including leadership development has been established; collaborative discussions held with the senior leadership teams regarding the development of the ICB's operating model, including plans for strengthening the ICB's role as a strategic commissioner.
Financial Sustainability	The ICB continued to review its forecast outturn position throughout the year with regular reports to finance and contracting committee, with reporting continuing through weekly incident management team meetings on waste reduction programme (WRP) delivery. IAG meetings remained in place during Q4 and further senior 'improvement' support was secured in February to help deliver 2025/26 WRP and planning for 2026/27.
All Age Continuing Care	Sustained improvement in CHC timeliness and elimination of long waits and maintaining compliance with national standards have been reported. WRP governance has been strengthened, with enhanced financial validation and oversight. finance and contracting committee has received regular reporting in relation the progress and management of this risk.
Quality Framework (All Age Continuing Care)	Quality frameworks and systems within the ICB have matured and further actions taken to provide effective mechanisms for identifying and escalating quality issues.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the NHS Lancashire and South Cumbria ICB, to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The ICB's accountable officer is responsible for the system of internal control within the ICB. Responsibility for specific elements of the internal control framework is delegated to individual members of the executive team, who have established the controls relevant to the key business functions, in line with the risks implicit in those functions.

The ICB's internal and external auditors provide assurance on the adequacy of those controls both in their design and their performance. The Audit Committee is charged with receiving reports on the operation of key controls and ensuring that risks identified are appropriately mitigated and that actions are completed.

In addition, the Board assurance framework is the key document which provides an overview of the controls and assurances in place to ensure that the ICB can achieve its strategic objectives and manage the principal risks identified. All reports presented to the ICB Board include identified risks.

Control mechanisms are embedded within all aspects of the ICB's governance, with the oversight of risk management within the organisation being one of them.

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

The Governance Handbook includes key documents that underpin our constitution and governance framework, including our scheme of reservation and delegation (SoRD). The SoRD sets out those decisions that are reserved to the Board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. It clearly sets out the financial delegated limits for individual officers and functions.

Furthermore, the organisation has a suite of organisational policies and documents ensuring that the ICB is compliant with national and legal standards such as policies for health and safety, standards of business conduct, freedom to speak up, conflicts of interest and fit and proper persons.

The ICB has a Fit and Proper Persons Test policy and framework in place which was approved by the Remuneration Committee in February 2024. The ICB met the requirements of this policy with the annual submission made to NHSE regional director by 30 June 2025 confirming that

assurance had been received that all checks had been undertaken. The ICB is part way through the assurance cycle in this area for 2025/26 with submission to region due in June 2026.

A self-assessment has been undertaken during 2025/26 of the ICB's systems and processes to meet the duties of fit and proper persons against a benchmarking document produced by Mersey Internal Audit Agency (MIAA). The benchmarking included areas of good practice and areas for enhancement. Under all areas identified in both categories the ICB was able to self-assess and document associated evidence. The benchmarking also included a series of challenge questions of which the ICB was able to provide evidence in response. This area is included on the internal audit plan for 2026/27.

The Freedom to Speak Up policy is in line with the NHSE national template. The policy is underpinned by a standard operating procedure outlining how the policy is enacted across the ICB.

The ICB has an overarching health and safety policy which was updated and approved by the Health and Safety Oversight Group (HSOG) in October 2024; there are an additional seven specialist policies in place to ensure the health and safety of ICB's employees. Midlands and Lancashire CSU provide subject matter expertise and guidance for ICB health and safety systems and procedures. All health and safety business is overseen by the HSOG which is chaired by the ICB Chief Executive Officer or their representative.

The ICB has implemented systems and processes which have supported a proactive approach to the review of declarations of interests and the maintenance of the ICB's registers of interests including gifts and hospitality. The ICB has also mandated completion of NHSE's conflict of interests training modules. During 2025/26 the ICB enabled staff to access the NHS England's national e-learning modules (including the additional two modules aimed at decision makers and the ICB Chair) to support consistent understanding of conflicts of interest for its employees. Staff were reminded of the requirement to complete all relevant mandatory training via automated reminders issued via the ESR system when mandatory training becomes due. Additional communications are provided through the staff newsletters, staff briefings and information provided via the dedicated intranet page.

There is a clear process for reporting, management, investigation and learning from incidents. The ICB has a senior information risk owner (SIRO) to support the arrangements for managing and controlling risks relating to information/ data security. The Medical Director is the Caldicott guardian to ensure that patient confidentiality is protected.

The ICB engages the services of a counter fraud specialist, the work undertaken by this specialist in liaison with the ICB is described at section 'Counter Fraud Arrangements' section of this report. Updates have been made to the following policies in order to ensure all are in line with the new corporate offence 'failure to prevent fraud':

- Freedom to speak up
- Fit and proper persons test
- Standards of business conduct
- Conflict of interest management

Management of Conflicts of Interest

During 2025/26, Lancashire and South Cumbria ICB continued to strengthen its approach to transparency and accountability by reviewing and publishing its statutory registers of Interests, including declarations of gifts, hospitality and commercial sponsorship. These registers were maintained in accordance with the requirements of the Health and Care Act 2022, which placed a clear duty on integrated care boards to manage conflicts of interest effectively and to publish relevant policies within their governance handbooks, the policy is available at the following link:

LSCICB_Corp34_Conflicts_of_Interest_Policy_V5.pdf.

Throughout the year, the ICB ensured that robust systems and processes were in place to support staff and decision-makers to declare any interests that might influence, or be perceived to influence, their work. The Audit Committee received bi-annual assurance reports confirming that these arrangements were operating effectively, and that any gifts, hospitality or sponsorship were managed in line with national policy.

A revised system for submitting declarations was introduced in August 2025, improving consistency and ease of reporting. Guidance and resources have been made available on the staff intranet, helping colleagues understand when and how to submit declarations and report any changes.

The ICB has applied its responsibilities under the provider selection regime, introduced nationally in January 2024. A revised contracting and procurement policy was implemented to ensure that all procurement decisions were taken fairly, transparently and in accordance with the relevant procurement legislation, NHS England guidance and the ICB's policies and procedures. Oversight from the Audit Committee confirmed that conflicts of interest within procurement processes were appropriately managed and in accordance with the relevant procurement legislation. This is demonstrated through the requirement for the ICB to produce an annual summary of its contracting activity for the provision of relevant healthcare services and, publish a report no later than six months following the end of the financial year it relates to. The report for 2025/26 will be published on the ICB's website once approved by the Audit Committee.

Data Quality

The ICB recognises that good quality data is essential for the effective commissioning of services and that data quality is crucial. The availability of complete, relevant, accurate and accessible and timely data is important in supporting patient care, clinical governance, management and service agreements for healthcare planning and accountability. Information is generated, and processed, for a broad variety of uses, and therefore the ICB employs varied techniques in assuring data quality across those different contexts. Where the ICB receives datasets from its service providers or external parties, a culture of routine data validation is promoted. The ICB and its data processors endeavour to both ensure that timescales for submission of information are adhered to, and that the quality and accuracy of such submissions is monitored and any issues fed back to relevant forums as appropriate. To support this, the ICB has a data quality policy in place for ensuring data quality, validation and the escalation routes for any identified data quality issues.

The Board has received an integrated performance report at each of its meetings and nationally published data is used to ensure accurate information is provided and offer a benchmarked position. In instances where data is provided to offer a more real-time position, a caveat is

provided that the data is subject to validation. The ICB also has in place a digital and data strategy approved by the Board.

The Quality and Outcomes Committee receives an integrated performance report at every meeting. Reporting is continuously under review to provide greater assurance to the Board that actions are underway to improve performance where necessary.

The integrated performance report has been updated during 2025/26 to report using statistical process control (SPC) methodology. SPC charts are visual tools used to monitor, control, and improve process performance over time by plotting data in chronological order. They distinguish between natural, random variation and special-cause, non-random variation, helping to identify when a process is stable or requires intervention.

Information Governance

The NHS information governance framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS information governance framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The ICB achieved the required standards within the DSPT submission for 2024/25 and is working towards submission for the 2025/26 DSPT by the national deadline of 30 June 2026. Work continues throughout the year to collate and maintain evidence against the DSPT assertions, including areas such as staff information governance training compliance, oversight and assurance of information assets and systems, and maintenance of data flow mapping.

The ICB places high importance on ensuring robust information governance systems and processes are in place to protect patient and corporate information. A comprehensive suite of information governance policies is in place, including the information governance code of conduct, data security and protection policy and the information governance handbook, which outline the standards and expectations for staff in relation to the appropriate use and protection of information. These policies are available to staff via the ICB intranet and are subject to periodic review.

The Chief Digital Officer acts as the senior information risk owner (SIRO) and has overall responsibility for ensuring that effective information governance arrangements are embedded across the organisation. A governance structure is in place to support the delivery and oversight of the information governance agenda, including the Information Governance Operational Group and the Information Governance Oversight Group, which provide assurance through established reporting arrangements to the Audit Committee.

Mandatory annual information governance training and a new starter induction programme are in place to ensure that all staff understand their responsibilities for protecting personal information and that data protection principles are embedded within organisational processes by design and default.

Robust processes are in place to ensure that personal data breaches are reported, investigated and managed appropriately. During 2025/26 the ICB reported five data breaches to the Information Commissioner's Office (ICO), two of which were also reported to the Department of Health and Social Care (DHSC) and NHS England in line with national reporting requirements.

All incidents related to patient identifiable information being shared via email with an incorrect recipient. Each incident was investigated and corrective actions implemented to mitigate the risk of recurrence, and the ICO closed the cases following satisfactory assurance.

The ICB continues to recognise the importance of maintaining high standards of information governance and remains committed to strengthening data security, confidentiality and compliance across the organisation. In doing so the ICB was on track to meet the requirement of 'Standards Met' for the DSPT year 2025/26 by submission deadline of 30 June 2026 at the time of submitting this report.

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, we can confirm that an appropriate framework and environment is in place to provide quality assurance of business critical models.

A business continuity plan is in place for the ICB, and the development of business impact analyses is now completed. This has enabled the ICB to understand what its business critical activities and functions are. A full review of the corporate business continuity plan has been undertaken, including assessing and addressing gaps, risks and mitigations associated with the loss of critical information systems. Business continuity is reported through the emergency preparedness resilience and response (EPRR) Co-ordinating Group, chaired by the Chief Operating Officer who is the Accountable Emergency Officer (for EPRR).

A business continuity exercise was developed to test the Integrated Care Systems response to a cyber incident. This annual cyber incident resilience exercise, undertaken in March 2025, is due to be repeated in 2026/27, to ensure learning and good practice is embedded across those organisations involved. Any further proposed actions will be presented to a future Audit Committee.

Third party assurances

The ICB currently contracts with a number of external organisations for the provision of back-office services and functions. Assurances on the effectiveness of the controls in place for these services are received from a service auditor report from the relevant service sent upon request.

The organisations concerned are:

SERVICE	PROVIDER
Finance and Accounting Services	NHS Shared Business Services
Payroll Management	Lancashire Teaching Hospitals
IT Services	Blackpool Teaching Hospital
HR Services	East Lancashire NHS Trust
Various	MLCSU

In addition, internal and external audit provide assurance to the ICB.

Control Issues

In the Month nine governance statement return (January 2026), the ICB reported control issues in the categories set out below. If not addressed, these issues could risk the standards expected of the Accountable Officer, the delivery of priorities, and the integrity and reputation of the ICB and the wider NHS. They do not relate to fraud or national data integrity.

Quality and Performance – patient safety

Control issues were reported in relation to safeguarding statutory deliverables, deprivation of liberty, never events, prevention of future deaths notices and independent investigations. mitigation plans are in place for each theme.

Quality and Performance – Accident and Emergency & Ambulance Services

Control issues were reported across urgent and emergency care, reflecting challenges in meeting the four-hour standard and reducing 12-hour waits, alongside performance against ambulance response and handover standards. A range of strategies are being utilised to try and address these pressures. From 1 August 2025, NHS England's 45-minute ambulance handover initiative (release to rescue) commenced, with providers required to implement local processes to support safe delivery. Urgent and emergency care is described in further detail in the performance report.

Quality and Performance – Referral to Treatment Target

Control issues were reported due to challenges in meeting referral to treatment (RTT) standards, across adult and children and young people (CYP) services. System programmes are in place through planned care commissioning and elective reform initiatives. The ICB's CYP team is working with the LSC Provider Collaborative to ensure provider plans for 2026/27 align with NHS England medium term planning guidance (October 2025), including targeted actions to increase activity and improve performance. Diagnostic and planned care is described in further detail in the performance report.

Quality and Performance – Mental Health and Dementia

Control issues were reported due to a decline in the proportion of talking therapies patients achieving reliable recovery. The lead commissioner is working with providers on a recovery plan, including the use of digital initiatives to support self-referral and 'waiting well', improve productivity and reduce waiting times. Mental Health is described in further detail in the performance report.

Quality and Performance – Cancer

Control issues were reported due to breaches in cancer referral and treatment times. The ICB Cancer Board (with representation from all acute trusts, NHS England, Public Health and the Cancer Alliance) oversees early diagnosis, screening and secondary care delivery. Operational oversight is provided through monthly trust level reviews and fortnightly cancer manager meetings, focusing on variation, milestone tracking and sharing best practice. Cancer waiting times are described in further detail in the performance report.

Quality and Performance – Infection Prevention and Control

Control issues were reported due to trends in healthcare associated infections (HAI). The ICB is monitoring implementation of the national cleaning standards and has supported an enhanced influenza vaccination programme. Infection Prevention and Control is described in further detail in the performance report.

Quality and Performance – Maternity

Control issues were reported due to two providers remaining in the maternity safety support programme (MSSP). Progress against improvement plans and MSSP exit criteria is monitored regularly. The local maternity and neonatal system (LMNS) continues its programme of quality assurance visits for the maternity incentive scheme (MIS) and saving babies' lives (SBL), with a minimum of three visits per provider in 2025/26 to review progress and evidence of compliance. Maternity services are described in more detail in the performance report.

Quality and Performance – Continuing Healthcare

Control issues were reported in relation to continuing healthcare, including service backlogs, patient experience and financial performance. The service is delivering a turnaround plan with four integrated workstreams. The Quality and Outcomes Committee receives assurance on patient experience actions, and the waste reduction plan is reviewed weekly through the AACC and IPA governance meetings, with assurance reported through the ICB committee structure.

Quality and Performance – Children's services

Control issues were reported due to extended waits and a high number of children waiting 52 weeks for appointments, primarily for neurodevelopmental assessment. Pressures were also identified in parts of the speech and language therapy (SaLT) pathway. The ICB CYP team, working with contracting colleagues, has implemented a vulnerable services process with providers to oversee trajectories and recovery plans, including assurance on safety-netting and waiting well support. CYP services are described in more detail in the performance report.

Quality and Performance – diagnostics

Control issues were reported due to challenges in meeting the six-week diagnostic target. Recovery plans and trajectories are in place and are routinely monitored. Diagnostic and planned care is described in more detail in the performance report.

Quality and Performance – critical incidents

Control issues were reported following two critical incidents declared by a provider in 2025/26, both linked to operational pressures and system flow challenges (OPEL level 4). The ICB provided oversight and intervened as required to manage local and system impacts. Emergency planning is described in more detail in the governance statement.

Finance Governance and Control – Information Governance

A control issue was reported following five personal data breaches that were notified to the Information Commissioner's Office. All cases were closed following satisfactory assurance on corrective actions. Information Governance is described in more detail in the governance statement.

Finance Governance and Control – Finance

At Month eight, the year-to-date position and forecast outturn reported in the Month nine governance statement return was consistent with the ICB's breakeven plan. The year-end position is described further in the introduction and context section.

Review of economy, efficiency and effectiveness of the use of resources

The ICB is charged with ensuring that it achieves economy, efficiency and effectiveness in its use of resources, and continues to develop and strengthen the system of internal controls. The Chief Finance Officer has worked with the internal and external auditors to ensure that the ICB receives assurance in relation to the use of resources and that this is reported to the Board.

The ICB has a strategic objective to meet financial targets and deliver improved productivity, and there are three risks on the Board assurance framework in this regard related to:

- The ICB having in place a fully developed vison, strategy, intentions and implementation plans for strategic commissioning, as this will impact effective delivery of service transformation.
- The government three strategic shifts and achievement of financial sustainability, all age continuing care (AACC) in terms effectively implementing an affordable AACC framework and deliver the enhanced controls established through the turnaround plan.
- Failing to deliver against financial plan for 2025/26 to ensure statutory financial duties are met. Further details on these risks and the controls can be found in the risk management section of this report.

Monthly financial performance has been scrutinised by the Finance and Contracting Committee and reported to the Board. Internal and external audit arrangements give a view to the Audit Committee on the delivery of the ICB's statutory financial responsibilities and the achievement of value for money.

As described in the introduction and context and financial review sections of this report, the ICB was issued enforcement undertakings in 2024/25 by NHS England. During 2025/26 the ICB has continued to progress its plan to meet the agreed exit criteria and support de-escalation from enhanced oversight and associated removal of the NHSE undertakings.

Commissioning of delegated services (primary care services and specialised services)

NHS Lancashire and South Cumbria ICB has signed delegation agreements with NHS England for the commissioning of delegated primary care services and specialised services and held full commissioning responsibilities for delegated services during the 2025/26 reporting period.

To the best of the ICB leadership's knowledge, all delegated services were commissioned in accordance with 2025/26 delegation agreements and national service specifications.

The ICB leadership is able to provide the necessary evidence of compliance with the delegation agreements, any associated developmental requirements and national service specifications, and to show how effectively the delegated function is operating (either directly or via multi-ICB working arrangements) should NHS England or a third party (e.g. external auditors) ask for such evidence.

Delegation of ICB functions

The ICB keeps its governance structures under constant review with the aim of delegating decision-making responsibility where this enables the ICB Board to devote more time to strategy and optimises the use of clinical leadership. All such arrangements are set out in the SORD.

The ICB has the following delegated functions from NHSE:

- primary medical care
- primary pharmacy services
- optometry services
- primary and secondary dental services; and
- specialised commissioning

The decision making of delegated services is described in further detail in the committees of the board section of this statement, and the performance of primary care is described in the annual report at primary care. In line with NHSE Statutory Guidance, the ICB has not delegated any of its functions during 2025/26.

Counter fraud arrangements

The ICB Chief Finance Officer (CFO) is responsible for ensuring appropriate arrangements are in place to comply with the government functional standard 013: counter fraud within the NHS. An Accredited counter fraud specialist is assigned to design and undertake counter fraud work proportionate to identified fraud risks via the contract the ICB holds with Mersey Internal Audit Agency (MIAA).

The ICB Audit Committee receives regular progress reports against each of the government functional standard 013: counter fraud and a final one within an annual report. The CFO provides executive oversight, and a proactive anti-fraud work plan is in place to address identified fraud risks. The CFO is proactively and demonstrably responsible for leading the ICB's approach to tackling fraud, bribery and corruption. Regular meetings are held with the anti-fraud specialist and the CFO throughout the year. The ICB's nominated counter fraud champion also provides support to the anti-fraud specialist.

Appropriate action is taken regarding any fraud issues identified by the NHS Counter Fraud Authority or MIAA, via their communications such as alerts, fraud prevention notices or local proactive exercises, which are cascaded to the relevant departments within the ICB for action.

In the year to date the anti-fraud specialist has received a total of 45 fraud referral queries. Ten referrals have been converted into formal fraud investigations, with six ongoing and the remaining 29 investigations having been closed. One investigation was brought forward from 2024/25, 10 were opened, and seven remain open for further investigation. The remainder were closed, as no fraud was identified, or other sanctions were considered more appropriate, after further checks conducted by the ICB / AFS.

The anti-fraud annual work plan, which is approved by the Audit Committee, is risk based. The anti-fraud specialist provides regular updates on the progress of the anti-fraud plan to the Audit Committee via progress reports, which details the ongoing self-assessment against the 12 components of the government functional standard 013 counter fraud. The workplan for 2025/26 has included fraud awareness presentations delivered to key groups of staff including; primary care networks, and the AACC team. In addition, in responding to an issue relating to a referral, three presentations were delivered to the Urgent Care team.

During this year, as there has been new fraud legislation (corporate offence of 'failure to prevent fraud' as part of the Economic Crime and Corporate Transparency Act 2023), the AFS has worked with the ICB to ensure measures are in place in order to ensure compliance. This has included a statement from the Chief Executive, updating of relevant policies to include reference

to the legislation's impact, the delivery of webinars to senior leaders, and communications issued to staff.

The government counter fraud standards has 12 components which are regularly monitored and scored by the anti-fraud specialist within the year and an update is provided to the Audit Committee on the current scoring via anti-fraud progress reports. For the year to date, the ICB assessed itself as being green overall (with 11 of the 12 components scoring 'green' individually). The return was provided to the NHS Counter Fraud Authority on 3 June 2026.

Freedom to Speak Up

Freedom to speak up (FtSU) is an important part of creating a safe and open culture within the ICB and wider ICS and of ensuring staff feel listened to and valued in order to confidently share concerns where patient safety or quality of care is below the standards the ICB expect, or when behaviours or working practices do not reflect the values of the organisation.

The ICB has two FtSU Guardians, a lead executive and a named non-executive champion. The speaking up service works to robust processes that are fit for purpose and promote an open culture. The guardians have conducted a series of proactive sessions with a range of staff groups to encourage accessing the FtSU service including via organisation wide briefings and attendance at corporate induction.

The Board received an annual FtSU report when it met in November 2025 and the People and Culture Committee has received quarterly updates at each meeting.

Between April 2025 and March 2026, 24 concerns eligible for reporting were raised with the ICB speaking up service, two of which were from primary care providers. This compares with a total of 25 reported in the 2024/25 annual report. Each concern is considered in line with the ICB's freedom to speak up policy and for each concern raised the guardian will ensure that the concern is heard, and that positive actions, support and signposting are agreed where appropriate.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2025 to 31 March 2026 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

The overall opinion for the period 1 April 2025 to 31 March 2026 provides moderate assurance, can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.

This opinion is provided in the context that the ICBs like other organisations across the NHS is continuing to face a number of challenging issues and wider organisational factors particularly with regards to the changes to national and local bodies and the corresponding uncertainty this causes, ongoing elective recovery response, workforce challenges, financial challenges and increasing collaboration across organisations and systems.

In 2024/25 the ICB was placed into NHS Oversight Framework (NOF) Segment 4 and has been receiving intensive support from the National Recovery Support Programme (RSP) throughout 2025/26. The financial sustainability of the Lancashire & South Cumbria system has remained challenged during 2025/26 with the financial position continuing to be monitored through the System Improvement and Assurance Group (IAG) monthly meetings as part of the turnaround measures. The ICB's reported outturn position was a surplus of £9.676m to 31 March 2026 after mitigations and use of reserves.

The ICB has also been impacted by the national reorganisation of ICB's during 2025/26; in addition, there have been a key of changes to the Board including the appointment of a new Chief Executive Officer as well as appointment of two Chief Finance Officers, interim Chief Nurse and interim Chief Medical Officer. The Chief People Officer also left the ICB in March 2026.

Last year we issued a split Limited/Moderate Head of Internal Audit Opinion. The 'Limited' element related to the assurance level and outcomes following our continuous review of the ICB's Continuing Healthcare (CHC) processes. During 2025/26 our focus has been on reviewing the implementation of our previous CHC audit recommendations which has identified that good progress had been made, noting there is still work to do to ensure actions are sustained.

This year we have provided an overall moderate Head of Internal Audit Opinion, recognising the improvements in the ICB's internal control environment. We acknowledge that the ICB directs internal audit activity towards known areas of risk, reflecting management engagement and an appropriate level of risk awareness, and supporting the effective prioritisation of internal audit resource.

The ICB has continued to maintain and strengthen its systems and processes regarding the Board Assurance Framework and strategic risk management. This is a key element in informing our overall opinion together with the outcomes from core, mandatory and risk based reviews and the ICBs response to the implementation of internal audit recommendations.

The profile of risk-based internal audit reviews completed during the year presents a varied picture, with assurance opinions broadly split across Substantial, Moderate and Limited, together with a High Risk outcome arising from the Data Security and Protection Toolkit assessment. Across the reviews undertaken, this has highlighted challenges with the effective and consistent operation of controls.

There has been a continued focus by the ICB during the year on implementing prior-year audit recommendations, resulting in a reduction in the overall number of outstanding recommendations. Continued management attention is required to ensure actions are completed on a timely and consistent basis.

The totality of this position has underpinned and informed our assessment of the overall opinion.

The consistent and timely implementation of agreed audit recommendations, including a focus and prioritisation on critical and high risk recommendations, together with sustained improvement in internal control arrangements will be key to improving the ICB's overall assurance opinion.

We have reviewed the Service Auditor reports that have been issued to the ICB in producing our final Head of Internal Audit Opinion.

Compliance with professional standards: In providing this opinion we can confirm continued compliance with the definition of internal audit (as set out in your Internal Audit Charter), code of ethics and professional standards. We also confirm organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

Purpose: The purpose of our Head of Internal Audit (HoIA) Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. As such, it is one component that the Board takes into account in making its Annual Governance Statement (AGS).

During the period, Internal Audit issued the following audit reports:

AREA OF AUDIT	LEVEL OF ASSURANCE GIVEN
Assurance framework	NHS requirements met
Risk management	Substantial assurance
Data Security and Protection Toolkit	Overall assurance rating – high risk Veracity of self assessment – high confidence
IT business continuity	Limited assurance
IT asset management	Substantial assurance
Waste reduction programme	Moderate assurance
Quality and Equality Impact Assessments	Moderate assurance
Delegated Primary Care Functions – Review of Annual Self Declaration	Substantial assurance
Special educational needs and disabilities (send) review	Moderate assurance
Continuing Healthcare – Follow up (3 follow up reports)	Not applicable
All age continuing care prior year invoices	Not applicable
Specialised commissioning	Substantial assurance
Key financial systems	Moderate assurance
Primary care contracting	Moderate assurance
Financial governance	Limited assurance
Equality, Diversity and Inclusion	Substantial assurance
Quality of Commissioned services – Neurology	Moderate assurance

Further Details on Limited Assurance Audits

The IT business continuity audit identified one 'high priority' action for a Business Continuity Plan template to be implemented across all teams. The audit also identified 4 'medium priority' actions to; detail mitigations for systems that are cloud hosted, to assign information asset owners across the ICB, undertake annual testing of disaster recovery plans, and further testing of the Incident Response Plan. All actions are in progress and due for completion in totality by September 2026.

The financial governance audit identified one ‘high priority’ action for budget holders to continue to be fully engaged in the budget setting process and that a timely record of their acceptance is kept. The audit also identified 6 ‘medium priority’ actions to; further enhance budget holder meetings, ensure validity of WRP schemes, work closely with budget holders throughout each month to help inform the monthly reporting and forecasting, develop a programme of budget holder training, inclusion of reporting on ICB’s financial statutory duties as part of monthly finance reports, and to change process with reporting being provided on a consistent basis. All actions are due for completion in totality by August 2026.

Review of the effectiveness of governance, risk management and internal control and conclusion of statement

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our Board Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

While the Board, its committees and the executive team have had good oversight of the principal risks and issues impacting on the ICB’s ability to deliver its objectives, and the financial risks have been reported to the board thorough the year, the ICB has faced significant risk in controlling its expenditure to stay within its allocated resource limit. This has resulted in the ICB receiving deficit support funding; being placed in the highest segment of NHSE’s new one-year oversight framework and the enforcement undertakings issued in February 2024 have remained in place in relation to financial governance. The ICB has made positive progress in respect of exiting the recovery support programme in December, and further work is required to fully meet the agreed exit criteria and support de-escalation from enhanced oversight and associated removal of the NHSE undertakings. The focus for the coming financial year is to address the underlying financial position for the ICB to establish a strong foundation for the successful delivery of the 10 Year Health Plan and successfully transitioning to the ICB’s new operating model and its role as a strategic commissioner. This is vital to ensure the future financial sustainability of the Lancashire and South Cumbria system and to allow for transformation of services and delivery of the Integrated Care System’s joint aim to driving improvements in population health, reducing health inequalities, and ensuring more consistent access to high-quality care for the population we serve.

Aaron Cummins

Accountable Officer

15 June 2026

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

Details of the ICB's Remuneration Committee can be found in the Governance Statement.

Percentage change in remuneration of highest paid director – subject to audit

Reporting bodies are required to disclose the percentage change from the previous financial year in respect of the highest paid member and the average percentage change from the previous financial year in respect of employees of the reporting body, taken as a whole:

2025/26	SALARY AND ALLOWANCES	TOTAL REMUNERATION
The percentage change from the previous financial year in respect of the highest paid director	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	-4%	-4%

The highest paid director was only in post for the period 01/04/2025 to 30/04/2025, the above reflects the annual salary payable to this individual at that point. The average percentage change for employees of the entity reflects the reduction in staff due to the Voluntary Redundancy Scheme.

The prior year comparatives in respect of the above percentage changes are as follows:

2024/25	SALARY AND ALLOWANCES	TOTAL REMUNERATION
The percentage change from the previous financial year in respect of the highest paid director	4%	4%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	5%	5%

In 2024/25 the average percentage change for employees of the entity broadly reflected the effect of the 2024/2025 pay award and the government decision to add intermediate pay points in each of pay bands 8a and above with effect from 1 April 2024.

Pay ratio information – subject to audit

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in NHS Lancashire and South Cumbria ICB in the reporting period 1 April 2025 to 31 March 2026 was £280,000 - £285,000

(annual salary, this individual was only in post for the period 01/04/2025 to 30/04/2025) (prior year £280,000 – £285,000).

The relationship to the remuneration of the organisation's workforce is disclosed in the below table:

2025/26	25TH PERCENTILE PAY RATIO	MEDIAN PAY RATIO	75TH PERCENTILE PAY RATIO
Total remuneration (£)	£37,796	£50,273	£62,682
Salary component of total remuneration (£)	£37,796	£50,273	£62,682
Pay ratio information	7.47:1	5.62:1	4.51:1

2024/25	25TH PERCENTILE PAY RATIO	MEDIAN PAY RATIO	75TH PERCENTILE PAY RATIO
Total remuneration (£)	£37,338	£48,526	£62,215
Salary component of total remuneration (£)	£37,338	£48,526	£62,215
Pay ratio information	7.57:1	5.82:1	4.54:1

The calculations for the above figures include the costs of any agency staff engaged by the ICB in the financial period.

The reduction in the pay ratios is a reflection of decrease in WTE for the ICB as a result of the Voluntary Redundancy Scheme.

During the reporting period 2025/26, no employees received remuneration in excess of the highest-paid director/member (2024/25: nil). Remuneration ranged from £15,000 - £20,000 to £280,000 - £285,000 (this reflects the annual salary, the highest paid director was only in post for the period 01/04/2025 to 30/04/2025) (2024/25 £15,000 - £20,000 to £280,000 - £285,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers

Remuneration of senior managers, up to and including Band 9, is undertaken in accordance with Agenda for Change, and guided and advised by the ICB's HR function.

Remuneration of Very Senior Managers

We are obliged to review the remuneration of all our Senior Executives (non-agenda for change) on an annual basis and in accordance with NHS England's (NHSE) Guidance on ICB Executive Director pay. NHSE has ranked all Integrated Care Systems in size order according to weighted population, with four categories, A,B,C and D, with A being the smallest and D the largest. This pay framework determines the pay range for the Chief Executive, and the proportionate minimum and operational maximum of statutory executive Board roles and other Board level executives. LSC ICB is ranked as band D, meaning that the Remuneration

Committee can make decisions on Board level executive pay, subject to this remaining in line with the parameters. The ICB has also adopted a local pay framework for other VSM roles, and all VSM pay is considered and agreed by the ICB's Remuneration Committee.

Senior manager remuneration (including salary and pension entitlements) – subject to audit

NAME AND TITLE	1 APRIL 2025 TO 31 MARCH 2026 (A) SALARY (BANDS OF £5,000) £000	(B) EXPENSE PAYMENTS (TAXABLE) TO NEAREST £100** £	(C) PERFORMANCE PAY AND BONUSES (BANDS OF £5,000) £000	(D) LONG TERM PERFORMANCE PAY AND BONUSES (BANDS OF £5,000) £000	(E) ALL PENSION- RELATED BENEFITS (BANDS OF £2,500) £000	(F) TOTAL (A TO E) (BANDS OF £5,000) £000
Kevin Lavery *Chief Executive Officer – from 01/04/2025 to 30/04/2025*	20 – 25	0	0	0	0	20 – 25
Samantha Proffitt *Chief Finance Officer – from 01/04/2025 to 30/04/2025* *Chief Executive Officer – from 01/05/2025 to 31/10/2025*	145 – 150	0	0	0	0	145 – 150
Aaron Cummins *Chief Executive Officer – from 01/11/2025 to 31/03/2026*	105 – 110	0	0	0	292.5 – 295	400 - 405
Stephen Downs *Acting Chief Finance Officer – from 01/05/2025 to 30/09/2025*	70 – 75	0	0	0	485 - 487.5	555 - 560
Mark Bakewell *Chief Finance Officer – from 01/10/2025 to 31/03/2026*	85 – 90	0	0	0	77.5 – 80	160 - 165
Andrew Knox *Interim Chief Medical Officer*	165 – 170	100	0	0	417.5 – 420	585 – 590
Sarah O'Brien *Chief Nursing Officer – from 01/04/2025 to 29/06/2025*	40 – 45	0	0	0	25 – 27.5	70 – 75
Jane Scattergood *Chief Nursing Officer – from 18/08/2025 to 31/03/2026*	95 – 100	0	0	0	785 – 787.5	880 – 885
Debbie Eyitayo *Chief People Officer – from 01/04/2025 to 31/01/2026*	140 – 145	0	0	0	417.5 – 420	560 – 565

NAME AND TITLE	1 APRIL 2025 TO 31 MARCH 2026 (A) SALARY (BANDS OF £5,000)	(B) EXPENSE PAYMENTS (TAXABLE) TO NEAREST £100**	(C) PERFORMANCE PAY AND BONUSES (BANDS OF £5,000)	(D) LONG TERM PERFORMANCE PAY AND BONUSES (BANDS OF £5,000)	(E) ALL PENSION- RELATED BENEFITS (BANDS OF £2,500)	(F) TOTAL (A TO E) (BANDS OF £5,000)
	£000	£	£000	£000	£000	£000
Debbie Herring *Interim Chief People Officer – from 01/02/2026 to 31/03/2026*	15 – 20	0	0	0	0	15 – 20
Asim Patel *Chief Digital Officer*	155 – 160	0	0	0	22.5 – 25	175 – 180
Craig Harris *Chief Commissioning Officer*	170 – 175	0	0	0	27.5 – 30	200 – 205
Emma Woollett *Chair*	70 – 75	0	0	0	0	70 – 75
Debbie Corcoran *Non-Executive Member*	10 – 15	0	0	0	0	10 – 15
Jim Birrell *Non-Executive Member – from 01/04/2025 to 31/12/2025*	10 – 15	100	0	0	0	10 – 15
Sheena Cumiskey *Non-Executive Member*	15 – 20	0	0	0	0	15 – 20
Roy Fisher *Non-Executive Member*	15 – 20	100	0	0	0	15 – 20
Jane O'Brien *Non-Executive Member*	10 - 15	100	0	0	0	10 – 15
Stephen Igoe *Non-Executive Member*	15 – 20	100	0	0	0	15 – 20
Stephen Spill *Non-Executive Member – from 01/05/2025 to 31/03/2026*	10 – 15	200	0	0	0	10 – 15
Julie Colclough *Partner Member – Primary Medical Services*	25 – 30	0	0	0	0	25 – 30

**Note: Taxable expenses and benefits in kind are expressed to the nearest £100.

Notes:

Expense payments (taxable) to the nearest £100 relate to the net taxable benefit of the use of lease cars. In addition, the table above includes the taxable benefit relating to payments in respect of mileage claims where the payment is above the HMRC allowable rate of £0.45 per mile.

The salary figure for the Chief Commissioning Officer includes a one-off payment of £3,500 to “buy back” 5 days’ annual leave which, due to operational pressures, he has been unable to take. This payment was approved by the Chief Executive under section 7.15 of the scheme of reservation and delegation, this decision being endorsed by the Remuneration Committee at the meeting held on 5 March 2026.

The ICB does not have a performance-related pay scheme; the performance of staff is measured through the ICB’s annual appraisal process. There is therefore no reference to performance-related bonuses.

Pension-related benefits are calculated as follows:

((20 x PE) + LSE) – ((20 x PB) + LSB) – Employee contribution

Where:

PE = the annual rate of unreduced pension that would be payable to the senior manager if they became entitled to it at the end of the financial year.

LSE = the amount of unreduced lump sum that would be payable to the senior manager if they became entitled to it at the end of the financial year.

PB = the annual rate of unreduced pension, adjusted for inflation, that would be payable to the senior manager if they became entitled to it at the beginning of the financial year.

LSB = the amount of unreduced lump sum, adjusted for inflation, that would be payable to the senior manager if they became entitled to it at the beginning of the financial year.

Ees cont = employee pension contributions for the financial year.

To adjust PB and LSB for inflation the Consumer Prices Index (CPI) of 1.7% has been used.

In summary, the value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

The following page includes 2024/2025 comparative figures:

1 APRIL 2024 TO 31 MARCH 2025

NAME AND TITLE	(A) SALARY (BANDS OF £5,000)	(B) EXPENSE PAYMENTS (TAXABLE) TO NEAREST £100**	(C) PERFORMANCE PAY AND BONUSES (BANDS OF £5,000)	(D) LONG TERM PERFORMANCE PAY AND BONUSES (BANDS OF £5,000)	(E) ALL PENSION-RELATED BENEFITS (BANDS OF £2,500)	(F) TOTAL (A TO E) (BANDS OF £5,000)
	£000	**£**	**£000**	**£000**	**£000**	**£000**
Kevin Lavery* *Chief Executive Officer*	280 – 285	1,700	0	0	67.5 – 70	350 – 355
Samantha Proffitt *Chief Finance Officer*	190 – 195	0	0	0	22.5 – 25	215 – 220
David Levy *Chief Medical Officer – from 01/04/2024 to 28/02/2025*	155 – 160	100	0	0	0	155 – 160
Sarah O'Brien *Chief Nursing Officer*	175 – 180	0	0	0	40 – 42.5	215 – 220
Debbie Eyitayo *Chief People Officer – from 18/09/2024 to 31/03/2025*	85 – 90	0	0	0	100 – 102.5	190 - 195
Asim Patel *Chief Digital Officer*	155 – 160	1,200	0	0	25 – 27.5	180 – 185
Craig Harris *Chief Operating Officer*	170 – 175	0	0	0	32.5 – 35	205 – 210
Emma Woollett *Chair – from 01/09/2024 to 31/03/2025*	40 – 45	0	0	0	0	40 – 45
Debbie Corcoran *Non-Executive Member*	10 – 15	0	0	0	0	10 – 15

1 APRIL 2024 TO 31 MARCH 2025

NAME AND TITLE	(A) SALARY (BANDS OF £5,000)	(B) EXPENSE PAYMENTS (TAXABLE) TO NEAREST £100**	(C) PERFORMANCE PAY AND BONUSES (BANDS OF £5,000)	(D) LONG TERM PERFORMANCE PAY AND BONUSES (BANDS OF £5,000)	(E) ALL PENSION-RELATED BENEFITS (BANDS OF £2,500)	(F) TOTAL (A TO E) (BANDS OF £5,000)
	£000	**£**	**£000**	**£000**	**£000**	**£000**
Geoff Jolliffe *Partner Member – Primary Medical Services – from 01/04/2024 to 30/06/2024*	0 – 5	0	0	0	0	0 – 5
Jim Birrell *Non-Executive Member*	15 – 20	100	0	0	0	15 – 20
Sheena Cumiskey *Non-Executive Member*	15 – 20	0	0	0	0	15 – 20
Roy Fisher *Acting Chair – from 01/04/2024 to 31/08/2024* *Non-Executive Member – from 01/09/2024 to 31/03/2025*	40 – 45	100	0	0	0	40 – 45
Jane O'Brien *Non-Executive Member*	10 - 15	100	0	0	0	10 – 15
Julie Colclough Partner Member – Primary Medical Services – from 01/07/2024 to 31/03/2025	20 - 25	0	0	0	0	20 – 25

*Note: Kevin Lavery stepped down from the position of Chief Executive Officer of the ICB in April 2025. His last working day was 30/04/25.

**Note: Taxable expenses and benefits in kind are expressed to the nearest £100.

Notes:

David Levy was seconded into NHS England from 1 March 2025 but continued to be paid in full by the ICB and therefore the costs shown above relate to the period 1 April 2024 to 31 March 2025.

Expense payments (taxable) to the nearest £100 relate to the net taxable benefit of the use of lease cars. In addition, the table above includes the taxable benefit relating to payments in respect of mileage claims where the payment is above the HMRC allowable rate of £0.45 per mile.

The ICB does not have a performance-related pay scheme; the performance of staff is measured through the ICB's annual appraisal process. There is therefore no reference to performance-related bonuses.

Pension-related benefits are calculated as follows:

((20 x PE) + LSE) – ((20 x PB) + LSB) – Employee contribution

Where:

PE = the annual rate of unreduced pension that would be payable to the senior manager if they became entitled to it at the end of the financial year.

LSE = the amount of unreduced lump sum that would be payable to the senior manager if they became entitled to it at the end of the financial year.

PB = the annual rate of unreduced pension, adjusted for inflation, that would be payable to the senior manager if they became entitled to it at the beginning of the financial year.

LSB = the amount of unreduced lump sum, adjusted for inflation, that would be payable to the senior manager if they became entitled to it at the beginning of the financial year.

Ees cont = employee pension contributions for the financial year.

To adjust PB and LSB for inflation the Consumer Prices Index (CPI) of 6.7% has been used.

In summary, the value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of

the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Pension benefits – subject to audit

NAME AND TITLE	(A) REAL INCREASE IN PENSION AT PENSION AGE (BANDS OF £2,500)	(B) REAL INCREASE IN PENSION LUMP SUM AT PENSION AGE (BANDS OF £2,500)	(C) TOTAL ACCRUED PENSION AT PENSION AGE AT 31 MARCH 2026 (BANDS OF £5,000)	(D) LUMP SUM AT PENSION AGE RELATED TO ACCRUED PENSION AT 31 MARCH 2026 (BANDS OF £5,000)	(E) CASH EQUIVALENT TRANSFER VALUE AT 1 APRIL 2025	(F) REAL INCREASE IN CASH EQUIVALENT TRANSFER VALUE	(G) CASH EQUIVALENT TRANSFER VALUE AT 31 MARCH 2026	(H) EMPLOYERS CONTRIBUTION TO PARTNERSHIP PENSION
	£000	£000	£000	£000	£000	£000	£000	£000
Kevin Lavery *Chief Executive Officer – from 01/04/2025 – 30/04/2025*	0 – 2.5	0 – 2.5	10 – 15	0 - 5	215	2	239	0
Samantha Proffitt *Chief Finance Officer – from 01/04/2025 – 30/04/2025* *Chief Executive Officer – from 01/05/2025 – 31/10/2025*	0 – 2.5	0 – 2.5	60 – 65	180 – 185	1,795	0	0	0
Aaron Cummins *Chief Executive Officer – from 01/11/2025 – 31/03/2026*	12.5 – 15	37.5 – 40	30 – 35	90 – 95	0	292	719	0
Stephen Downs *Acting Chief Finance Officer – from 01/05/2025 – 30/09/2025*	22.5 – 30	52.5 – 55	50 – 55	125 – 130	0	458	1,111	0
Mark Bakewell *Chief Finance Officer – from 01/10/2025 – 31/03/2026*	2.5 – 5	5 – 7.5	50 – 55	120 – 125	893	69	1,042	0
Andrew Knox *Interim Chief Medical Officer*	20 – 22.5	32.5 – 35	20 – 25	30 – 35	0	328	349	0
Sarah O'Brien *Chief Nursing Officer – from 01/04/2025 – 29/06/2025*	0 – 2.5	2.5 – 5	70 – 75	185 – 190	1,527	35	1,676	0

NAME AND TITLE	(A) REAL INCREASE IN PENSION AT PENSION AGE (BANDS OF £2,500)	(B) REAL INCREASE IN PENSION LUMP SUM AT PENSION AGE (BANDS OF £2,500)	(C) TOTAL ACCRUED PENSION AT PENSION AGE AT 31 MARCH 2026 (BANDS OF £5,000)	(D) LUMP SUM AT PENSION AGE RELATED TO ACCRUED PENSION AT 31 MARCH 2026 (BANDS OF £5,000)	(E) CASH EQUIVALENT TRANSFER VALUE AT 1 APRIL 2025	(F) REAL INCREASE IN CASH EQUIVALENT TRANSFER VALUE	(G) CASH EQUIVALENT TRANSFER VALUE AT 31 MARCH 2026	(H) EMPLOYERS CONTRIBUTION TO PARTNERSHIP PENSION
	£000	£000	£000	£000	£000	£000	£000	£000
Jane Scattergood *Interim Chief Nursing Officer – from 18/08/2025 – 31/03/2026*	35 – 37.5	92.5 – 95	55 – 60	150 – 155	0	99	179	0
Debbie Eyitayo *Chief People Officer – from 01/04/2025 – 31/01/2026*	17.5 – 20	60 – 62.5	60 – 65	165 – 170	924	0	120	0
Debbie Herring *Interim Chief People Officer – from 01/02/2026 – 31/03/2026*	0 – 2.5	0 – 2.5	0 – 5	0 – 5	0	0	0	0
Asim Patel *Chief Digital Officer*	0 – 2.5	0 – 2.5	50 – 55	120 – 125	1,004	22	1,044	0
Craig Harris *Chief Operating Officer*	2.5 – 5	0 – 2.5	55 – 60	125 – 130	1,062	24	1,108	0

Notes:

The payments made to the Lay Members do not include pension contributions. These persons have therefore been excluded from the above table.

Any Officers who are not members of the pension scheme have been excluded from the above table.

For comparative purposes the CETV figures at 31 March 2025 have been inflated by 1.7%. The real increase in CETV is calculated as follows:

CETV at 31/03/2026 – (CETV at 31/03/2025 + 1.7%) - 2025/2026 Employee superannuation contributions

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

The ICB made no payments for early retirement or for loss of office during the financial year (zero, 2024/25).

Payments to past directors

The ICB has made no payments to past Directors in the period 1 April 2025 to 31 March 2026 (zero, 2024/25).

Staff Report

Number of senior managers

The following table details the breakdown of ICB-employed staffing by pay band as at 31 March 2026, including the number of senior managers (represented as 'very senior managers'):

PAY BAND	HEADCOUNT	2024/25 HEADCOUNT
Apprentice	0	0
Band 1	0	0
Band 2	1	1
Band 3	23	30
Band 4	81	86
Band 5	121	116
Band 6	158	161
Band 7	136	144
Band 8a	139	143
Band 8b	80	73
Band 8c	46	47
Band 8d	32	36
Band 9	24	26
VSM	21	20
Medical	23	46
NEDS	9	6
Grand Total	**894**	**935**

Staff numbers and costs

Number of people (average whole time equivalent) employed by NHS Lancashire and South Cumbria ICB (subject to audit):

	TOTAL NUMBER	PERMANENTLY EMPLOYED NUMBER	OTHER NUMBER	2024/25 TOTAL NUMBER
Total	803.41	790.28	13.13	776.62
Costs:	£'000	£'000	£'000	£'000
Salaries and wages	45,602	44,307	1,295	43,248
Social security cost	6,185	6,185	0	4,783
NHS pension cost	9,976	9,976	0	9,240

Other pension cost	0	0	0	0
Apprenticeship levy	220	220	0	202
Recoveries in respect of employee benefits	0	0	0	0
Termination benefits	14,698	14,698	0	65
Total costs	76,681	75,385	1,295	57,538
Of the above, number of whole time equivalent people engaged on capital projects	0	0	0	0

There has been an increase in permanent whole-time equivalents employed by the ICB in 2025/26. The increase is due to movement of staff into the ICB under the Transfer of Undertakings (Protection of Employment) regulations (TUPE), for the Medicines Management team.

Staff composition

As an ICB, we recognise the need for our workforce to be representative of our resident population. Furthermore, we recognise that we need to do far more to attract and retain a workforce that is representative of the communities we serve, retain the existing diversity within our workforce, and improve the experiences of our diverse staff.

Throughout 2025/26, our internal workforce has fluctuated starting at 922 in March 2025, peaking at 942 in July 2025, reducing to 894 as of 31 March 2026. Please note that there were 145 VR leavers on 31 March 2026 that are still included in the headcount for 31 March 2026 as they were employed until midnight on that date.

While we have seen some improvements, there are still significant issues with under-representation of specific protected characteristics and under-reporting of diversity monitoring data via the national NHS Electronic Staff Record (ESR). This means we need to continue to make further efforts to ensure that our people are comfortable with, and understand the importance of, sharing their personal information with us so that we are better able to understand their needs and the challenges they may face, and improve the workplace experience for all employees regardless of their background or protected characteristics. This has been reflected in our ICB Equality Diversity and Inclusion objectives for 2026/2027.

The following sections provide an overview of diversity within our existing ICB workforce at 31st March 2026. Please note – due to relatively low workforce numbers, we are unable to report on pregnancy and maternity, or marriage and civil partnership as there is a risk of identifying individual members of staff through the publication of this data. Furthermore, we are unable to report on gender reassignment as this data is not routinely collected via the national NHS Electronic Staff Record.

Gender

In Lancashire and South Cumbria, the population has nearly the same number of males (**49.2%**) as females (**50.8%**). As of 31 March 2026, Lancashire and South Cumbria ICB's full

time equivalent (**FTE**) workforce comprises of **20%** male staff and **80%** female staff. The following table details the breakdown of total ICB staffing by gender as at the 31 March 2026:

GENDER	FTE	HEADCOUNT
Female	652.2	715
Male	163.8	179
Grand Total	816.0	894

The following table details the gender split of the ICB Executive Director team (those who are directly employed by the ICB) as at the 31st March 2026:

GENDER	FTE	HEADCOUNT
Female	1.60	2
Male	5.00	5
Grand Total	6.60	7

Disability

Census 2021 data tells us that 19.7% of the total resident population of Lancashire and South Cumbria are disabled under the Equality Act, and 8.8% of those individuals, report that their disability limits their day-to-day activities. In total, 9.4% of Lancashire and South Cumbria ICB's workforce has declared that they are disabled. However, 31.1% of the workforce has not declared their disability status which means that the actual number of disabled staff is likely to be higher. This is further supported by the fact that there are a significantly higher number of staff members who have required reasonable adjustments in the workplace due to a disability or long-term condition. Staff are also encouraged to discuss any needs or requests for reasonable adjustments as part of their health and wellbeing conversations with line managers.

Ethnicity

The proportion of Lancashire and South Cumbria's resident population who are from an ethnically diverse background (i.e., non-White British) is currently 12.3%. In comparison, 8.7% of Lancashire and South Cumbria ICB's workforce self-reported as coming from ethnically diverse backgrounds. It should also be noted that 3.8% of the workforce has not stated their ethnicity.

Religion and Belief

The following table provides an overview of the most prevalent religions and beliefs within the ICB workforce compared to our resident populations in Lancashire and South Cumbria. Please note that it has not been possible to report on the religion of some of our people due to the risk of identifying individual members of staff.

RELIGION & BELIEF	% ICB WORKFORCE	% POPULATION OF LANCASHIRE AND SOUTH CUMBRIA
Atheism	12.0%	32.0%
Christianity	44.9%	52.8%
Islam	4.5%	8.3%
Other	5.0%	1.4%
Unspecified	4.6%	
Not declared	29.1%	5.4%

Sexual Orientation

The following table provides an overview of sexual orientation within our workforce compared to our resident populations in Lancashire and South Cumbria.

SEXUAL ORIENTATION	% ICB WORKFORCE	% POPULATION OF LANCASHIRE AND SOUTH CUMBRIA
Bisexual	0.7%	
Gay or Lesbian	2.8%	1.5%
Heterosexual or straight	66.7%	90.2%
Other	0.2%	1.4%
Unspecified	4.4%	
Not declared	25.2%	6.9%

Sickness absence data

The following table details the monthly ICB sickness absence rate between 1st April 2025 and 31st March 2026 including a 12-month cumulative percentage:

MONTH	ABSENCE FTE %	ROLLING ABS FTE %
April-25	5.03%	4.74%
May-25	4.59%	4.74%
June-25	5.16%	4.85%
July-25	5.84%	5.01%
August-25	5.93%	5.24%

MONTH	ABSENCE FTE %	ROLLING ABS FTE %
September-25	5.93%	5.44%
October-25	6.64%	5.60%
November-25	6.42%	5.65%
December-25	6.98%	5.72%
January-26	6.46%	5.81%
February-26	6.74%	5.92%
March-26	5.72%	5.95%

Staff turnover percentages

Staff turnover percentage

The staff turnover rate across the ICB between 1st April 2025 and 31st March 2026 was 24.61%. There were 238 leavers during that time, six of which were compulsory redundancies. Please note that this figure includes the leavers up to and including midnight on 31st March 2026.

Staff engagement percentages

The ICB participated in the National Staff Survey from 15 September to 28 November 2025 using the online survey.

The ICB reforms announcement in March 2025 and subsequent model redesign work has had a significant impact on the ICB workforce to date.

932 staff members were eligible to complete the survey by the end of the survey period. 62% (581) of the workforce completed the survey in comparison to average ICB (ICBs that use Picker for the staff survey) responses at 66%. In 2023 LSC ICB response rate was 75%.

The 2025 ICB staff survey results demonstrate a low period for staff satisfaction and experience. The results are not drastically different from 2023. The ICB also entered a period of significant change from March 2025 which has affected staff wellbeing due to the potential impact on their roles.

Feedback from the NHS Staff Survey has been formally considered by the ICB Executive Team, Senior Leadership Team, and a range of established staff engagement forums. This collective review is informing the development of a structured action plan, which is designed to recognise areas of strong performance, address identified areas of concern and identify further opportunities to enhance organisational support for staff.

Staff policies

The following staff policies have been applied during the financial year.

Policies are reviewed and Equality Impact Assessed in line with the policy schedule

- Absence Management Policy
- Adoption Policy
- Annual Leave Policy
- Career Break Policy
- Disciplinary Policy
- Domestic Abuse and the Workplace Policy
- Equality and Inclusion Policy
- Flexible Working
- Grievance Policy
- Harassment and Bullying at Work Policy
- Induction Policy
- Agenda for Change Job Evaluation and Re-banding Policy
- Managing Work Performance Policy
- Maternity Policy
- Appraisal objectives and performance review (including pay progression) policy
- Organisational Change Policy
- Special Leave
- Parental Leave Policy
- Paternity Leave Policy
- Professional Registration Policy
- Recruiting Ex-Offenders Policy
- Recruitment and Selection Policy
- Retirement Policy
- Shared Parental Leave Policy
- Substance Misuse Policy
- Training and Development Policy
- Secondment Policy
- Temporary Promotion Policy
- Freedom to Speak up Policy (Whistleblowing / Raising Concerns)
- Human Rights Policy
- Lone Worker Policy and Procedure

Other employee matters

We are fully committed to providing a safe working environment that values wellbeing and diversity. We recognise our wider legal and moral obligation to provide a safe and healthy working environment for our employees, visitors and members of the public that may be affected by our activities. We have adapted a Health and Safety Management System based on the HSG65 model and are adopting a positive, proactive stance on health and safety. We aim to promote an accountable culture which is just and fair to its employees and enables us to learn from incident reports and risk assessments in order to continuously improve our health and safety management, and, where necessary, change policies/procedures to enable this to happen.

It is a statutory requirement to keep a record of all accidents, incidents and near misses that occur out of work activities. There were 2 RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reportable accidents relevant to our organisation during the reporting period.

Expenditure on consultancy

During the 2025/26 financial year we have spent £9,218k on external consultancy services (2024/25 £3,601k). The majority of this expenditure is in connection with the ICB's external enhanced intervention and turnaround support, along with costs relating to work undertaken to assist the ICB in recovering continuing healthcare costs.

Off-payroll engagements

There is a Treasury requirement for public sector bodies to report arrangements whereby individuals are paid through their own companies and so are responsible for their own tax and National Insurance arrangements.

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2026, for more than £245[(1)] per day:

	Number
Number of existing engagements as of 31 March 2026	**2**
Of which, the number that have existed:	
for less than one year at the time of reporting	**2**
for between one and two years at the time of reporting	**0**
for between two and three years at the time of reporting	**0**
for between three and four years at the time of reporting	**0**
for four or more years at the time of reporting	**0**

Notes:

The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual pays the right amount of Income Tax and National Insurance and, where necessary, that assurance has been sought.

Of the 11 individuals outlined above, 10 individuals are employed by and on the payroll of an agency and therefore the off-payroll legislation does not apply.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2025 to 31 March 2026, for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2025 and 31 March 2026	13
Of which:	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	0
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	13
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

Notes:

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

(2) A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll Board member / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026:

Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during reporting period	0
Total no. of individuals on payroll and off-payroll that have been deemed “Board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements.	10

Exit packages, including special (non-contractual) payments – subject to audit

Table 1: Exit Packages

Exit package cost band (inc. Any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s
Less than £10,000	5	7,189	6	39,641	11	46,830	0	0
£10,000 - £25,000	0	0	19	350,214	19	350,214	0	0
£25,001 - £50,000	1	48,195	32	1,180,170	33	1,228,365	0	0
£50,001 - £100,000	0	0	55	3,983,249	55	3,983,249	0	0
£100,001 - £150,000	0	0	39	4,777,184	39	4,777,184	0	0
£150,001 – £200,000	0	0	25	4,328,151	25	4,328,151	0	0
TOTALS	6	55,384	176	14,658,609	182	14,713,993	0	0

Redundancy and other departure cost have been paid in accordance with the provisions of Agenda for Change. Exit costs in this note are accounted for in full in the year of departure.

Where the NHS Lancashire and South Cumbria ICB has agreed early retirements, the additional costs are met by the NHS Lancashire and South Cumbria ICB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

As the above table indicates, there are 176 other (non-compulsory) departures agreed in 2025/26. These relate to the Voluntary Redundancy scheme which the ICB ran during the financial year, in response to the publication of the NHS England model blueprint for ICBs and resulting reduction in allocation of c£36m from 1 April 2026.

Outside of this, there are no departures where special payments have been made.

Table 2: Analysis of Other Departures

	AGREEMENTS	TOTAL VALUE OF AGREEMENTS
	Number	£s
Voluntary redundancies including early retirement contractual costs	169	14,642,961
Contractual payments in lieu of notice	7	15,648
TOTAL	**176**	**14,658,609**

Aaron Cummins

Accountable Officer

15 June 2026

Parliamentary Accountability and Audit Report

NHS Lancashire and South Cumbria ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report are also included in this Annual Report.

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS LANCASHIRE & SOUTH CUMBRIA INTEGRATED CARE BOARD

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Lancashire & South Cumbria Integrated Care Board ("the ICB") for the year ended 31 March 2026 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2026 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 23 April 2025 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under and are independent of the ICB in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements of the ICB on the going concern basis, as they have not been informed by the relevant national body of the intention to either cease the ICB's services or dissolve the ICB without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements of the ICB ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or

collectively, may cast significant doubt on the ICB's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the ICB will continue in operation.

Fraud and breaches of laws and regulations – ability to detect
Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit as to the high-level policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls, in particular the risk that management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. We therefore assessed that there was limited opportunity for manipulation of the income that was reported.

We did not identify any additional fraud risks.

In determining the audit procedures, we took into account the results of our evaluation of some of the -wide fraud risk management controls.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual double entries to cash account codes.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board and other management (as required by auditing standards), and from inspection of the ICB's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, there are laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the ICB is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, antibribery, employment law, recognising the nature of the 's activities and its legal form. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management and inspection of regulatory and legal correspondence, if any. Therefore, if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect noncompliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer of the ICB is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2025/26.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 59, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the ICB or dissolve the ICB without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

The Accountable Officer is responsible for ensuring the regularity of expenditure and income.

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Basis for opinion on regularity

We conducted our work on regularity in accordance with Statement of Recommended Practice - Practice Note 10: *Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024)* issued by the FRC. We planned and performed procedures to obtain sufficient appropriate evidence to give an opinion over whether the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. The procedures selected depend on our judgement, including the assessment of the risks of material irregular transactions. We are required to obtain sufficient appropriate evidence on which to base our opinion.

Report on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

Significant weakness – financial sustainability

In line with the prior year work, the ICB faces significant difficulties in controlling its expenditure in order to stay within its Revenue Resource Limit, driven by challenges in forecasting & modelling All Age Continuing Care expenditure, linked to previously unknown prior year costs. This is evidenced by the continued use of non-recurrent mitigations to meet the final year end position.

Recommendation

Our recommendation is repeated from our prior year findings on which we recommended that the ICB continues its work to ensure that it is not a national outlier on fast-track referrals and conversion rates, through a stricter screening process at the clinical level for referrals, as well as working to reduce inappropriate referrals. We also recommend the ICB clarifies its statutory responsibilities regarding packages of care and reaches robust agreement with local authorities to ensure it can appropriately forecast costs.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 59, the Accountable Officer is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the ICB has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the ICB had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the ICB under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS Lancashire & South Cumbria Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the ICB's accounts consolidation template for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of NHS Lancashire & South Cumbria Integrated Care Board for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.

Timothy Cutler

for and on behalf of KPMG LLP
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE
17 June 2026

ANNUAL ACCOUNTS

Data entered below will be used throughout the workbook:

Entity name:	NHS Lancashire and South Cumbria Integrated Care Board
This year	2025-26
Last year	2024-25
This year ended	31 March 2026
Last year ended	31-March-2025
This year commencing:	01-April-2025
Last year commencing:	01-April-2024

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Income from sale of goods and services	3	(58,806)	(52,550)
Other operating income	3	(2,334)	(2,461)
Total operating income		**(61,140)**	(55,011)
Staff costs	5	76,681	57,538
Purchase of goods and services	6	5,672,518	5,354,455
Depreciation and impairment charges	6	371	362
Other operating expenditure	6	1,126	23,567
Total operating expenditure		**5,750,696**	5,435,922
Net Operating Expenditure		**5,689,556**	5,380,911
Finance expense	8	24	27
Net expenditure for the Year		**5,689,580**	5,380,938
Comprehensive Expenditure for the year		**5,689,580**	5,380,938

Statement of Financial Position as at 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Non-current assets:			
Right-of-use assets	9	2,316	2,659
Total non-current assets		**2,316**	2,659
Current assets:			
Inventories	10	7,066	7,669
Trade and other receivables	11	64,295	59,174
Cash and cash equivalents	12	129	1,089
Total current assets		**71,490**	67,932
Total assets		**73,806**	70,591
Current liabilities			
Trade and other payables	13	(284,027)	(225,140)
Lease liabilities	9	(350)	(346)
Total current liabilities		**(284,377)**	(225,486)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(210,571)**	(154,895)
Non-current liabilities			
Lease liabilities	9	(1,996)	(2,332)
Total non-current liabilities		**(1,996)**	(2,332)
Assets less Liabilities		**(212,567)**	(157,227)
Financed by Taxpayers' Equity			
General fund		(212,567)	(157,227)
Total taxpayers' equity:		**(212,567)**	(157,227)

The notes on pages 5 to 30 form part of this statement

The financial statements on pages 1 to 4 have been approved by the Board on 15 June 2026 and signed on its behalf by:

Aaron Cummins
Chief Accountable Officer

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2026

	General fund £'000	**Total reserves £'000**
Changes in taxpayers' equity for 2025-26		
Balance at 01 April 2025	**(157,227)**	**(157,227)**
Changes in NHS Integrated Care Board taxpayers' equity for 2025-26		
Net operating expenditure for the financial year	(5,689,580)	(5,689,580)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	(5,689,580)	(5,689,580)
Net funding	5,634,240	5,634,240
Balance at 31 March 2026	**(212,567)**	**(212,567)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 01 April 2024	(134,066)	(134,066)
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25		
Net operating expenditure for the financial year	(5,380,938)	(5,380,938)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	(5,380,938)	(5,380,938)
Net funding	5,357,777	5,357,777
Balance at 31 March 2025	(157,227)	(157,227)

The notes on pages 5 to 30 form part of this statement

Statement of Cash Flows for the year ended
31 March 2026

	Note	**2025-26** **£'000**	2024-25 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(5,689,580)	(5,380,938)
Depreciation and amortisation	6	371	362
Interest paid / received		24	27
(Increase)/decrease in inventories		603	(367)
(Increase)/decrease in trade & other receivables	11	(5,121)	57,197
Increase/(decrease) in trade & other payables	13	58,887	(34,191)
Net Cash Inflow (Outflow) from Operating Activities		**(5,634,816)**	(5,357,910)
Net Cash Inflow (Outflow) before Financing		**(5,634,816)**	(5,357,910)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		5,634,240	5,357,777
Repayment of lease liabilities		(384)	(383)
Net Cash Inflow (Outflow) from Financing Activities		**5,633,856**	5,357,394
Net Increase (Decrease) in Cash & Cash Equivalents	12	**(960)**	(516)
Cash & Cash Equivalents at the Beginning of the Financial Year		**1,089**	1,605
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**129**	1,089

The notes on pages 5 to 30 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Integrated Care Boards (ICBS) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2025-26 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2026, on a going concern basis.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, inventories and certain financial assets and financial liabilities.

1.3 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Joint arrangements**

Joint operations are arrangements in which the ICB has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The ICB includes within its financial statements its share of the assets, liabilities, income and expenses.

The ICB's pooled budget arrangements are considered to fall under the provisions of a joint operation.
Joint ventures are arrangements in which the ICB has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.
The ICB does not consider itself to be involved in any joint ventures.

1.5 **Pooled Budgets**

The ICB has entered into pooled budget arrangements with local authorities in Lancashire and Cumbria. Under the arrangements, funds are pooled in respect of services for adults with learning disabilities, services to support integrated hospital discharges and the Better Care Fund (BCF) initiative. The BCF is designed to create a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.
Note 17 to the accounts provides details of the ICB's share of the assets, liabilities, income and expenditure for the ICB's pooled fund arrangements.

1.6 **Operating Segments**

The ICB considers itself to have one operating segment which is healthcare for its population.

1.7 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government’s apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Notes to the financial statements

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 **Other Expenses**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.10 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Notes to the financial statements

1.12 **Intangible Assets**

1.12.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

From 1 April 2025, intngible assets are carried at cost. Where intangible assets have been carried historically under a revaluation approach following initial recognition, the carrying net amount as 31 March 2025 will be considered to be the deemed historic cost. In accordance with the GAM this change in valuation is being applied prospectively.

1.12.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.13 **Donated Assets**

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 **Non-current Assets Held For Sale**

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

Notes to the financial statements

1.16 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.16.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.16.2 **The ICB as Lessor**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.
When the group is an intermediate lessor, it accounts for the head lease and the sub-lease as two separate contracts. The sub-lease classification is assessed with reference to the right-of-use asset arising from the head lease.
Amounts due from lessees under finance leases are recognised as receivables at the amount of the ICB's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the net investment in the lease.
Rental income from operating leases is recognised on a straight-line basis over the term of the relevant lease.

1.17 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

1.18 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.19 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 3.64% (2024-25: 4.03%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 4.22% (2024-25: 4.07%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 5.32% (2024-25: 4.81%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 5.07% (2024-25: 4.55%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

Notes to the financial statements

1.20 **Clinical Negligence Costs**
NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

1.21 **Non-clinical Risk Pooling**
The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.22 **Contingent liabilities and contingent assets**
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.23 **Financial Assets**
Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:
- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.23.1 **Financial Assets at Amortised cost**
Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.23.2 **Financial assets at fair value through other comprehensive income**
A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

1.23.3 **Financial assets at fair value through profit and loss**
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.23.4 **Impairment of financial assets**
For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.
The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).
HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.24 **Financial Liabilities**
Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.24.1 **Financial Liabilities at Fair Value Through Profit and Loss**
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.24.2 **Other Financial Liabilities**
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Notes to the financial statements

1.25 **Value Added Tax**
Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.26 **Foreign Currencies**
The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB's surplus/deficit in the period in which they arise.

1.27 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the ICB has no beneficial interest in them.

1.28 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.29 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.29.1 **Critical accounting judgements in applying accounting policies**
There are no critical accounting judgements that management has made in the process of applying the ICB's accounting policies that would have a significant effect on the amounts recognised in the financial statements.

1.29.2 **Sources of estimation uncertainty**
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.
There are a number of accruals within the Statement of Financial Position where estimation techniques are applied. This is because the outturn information is not available at the time of preparation of the financial statements. Examples of significant accruals in the ICB's accounts involving estimates are prescribing and dental costs and all age continuing care costs.

1.30 **Gifts**
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.31 **New and revised IFRS Standards in issue but not yet adopted**

● IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
● IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective
for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted
● IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective
for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

2 Financial performance targets

The Integrated Care Board has a number of financial duties under the NHS Act 2006 (as amended).
Performance against those duties was as follows:

	2025-26 Target £000s	2025-26 Performance £000s	Target Achieved
Expenditure not to exceed income	5,760,396	5,750,720	Yes
Capital resource use does not exceed the amount specified in Directions	30	29	Yes
Revenue resource use does not exceed the amount specified in Directions	5,699,256	5,689,580	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	30	29	Yes
Revenue administration resource use does not exceed the amount specified in Directions	38,821	37,772	Yes

	2024-25 Target £000s	2024-25 Performance £000s	Target Achieved
Expenditure not to exceed income	5,435,949	5,435,949	Yes
Revenue resource use does not exceed the amount specified in Directions	5,380,938	5,380,938	Yes
Revenue administration resource use does not exceed the amount specified in Directions	32,922	29,720	Yes

There was no capital resource allocated to the ICB for its own capital projects in 2024-25.

3 Other Operating Revenue

	2025-26 Total	2024-25 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**3,798**	1,041
Prescription fees and charges	**25,154**	25,643
Dental fees and charges	**29,291**	25,702
Other Contract income	**563**	164
Total Income from sale of goods and services	**58,806**	**52,550**
Other operating income		
Other non contract revenue	**2,334**	2,461
Total Other operating income	**2,334**	**2,461**
Total Operating Income	**61,140**	**55,011**

4.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	6	0	0	39
Non NHS	3,792	25,154	29,291	524
Total	**3,798**	**25,154**	**29,291**	**563**

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	3,798	25,154	29,291	563
Total	**3,798**	**25,154**	**29,291**	**563**

4.2 Fees and Charges

NHS England certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. The following table provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

2025/26	Note	Income £000	Full Cost £000	Surplus/ (deficit) £000
Dental	3 & 6	29,291	(137,499)	(108,208)
Prescription	3 & 6	25,154	(446,734)	(421,580)
Total fees and charges		**54,445**	**(584,233)**	**(529,788)**

2024/25	Note	Income £000	Full Cost £000	Surplus/ (deficit) £000
Dental	3 & 6	25,702	(135,528)	(109,826)
Prescription	3 & 6	25,643	(420,182)	(394,539)
Total fees and charges		**51,345**	**(555,710)**	**(504,365)**

The fees and charges information in this note is provided in accordance with the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for International Financial Reporting Standards (IFRS) 8 purposes.

The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. From 1 April 2025, the NHS prescription charge for each medicine or appliance dispensed has remained at £9.90 (2024/25 £9.90). However, around 95% of prescription items are dispensed free each year where patients are exempt from charges or hold a pre-payment certificate*. In addition, patients who were eligible to pay charges could purchase pre-payment certificates from 1 April 2025 at £32.05 (2024/25 £32.05) for 3 months or £114.50 (2024/25 £114.50) for a year. A number of other charges were payable for wigs and fabric supports.

Those who are not eligible for exemption are required to pay NHS dental charges which fall into 3 bands depending on the level and complexity of care provided. In 2024/25, the charge for Band 1 treatments was £27.40 (2024/25 £26.80), for Band 2 was £75.30 (2024/25 £73.50) and for Band 3 was £326.70 (2024/25 £319.10).

**https://www.nhsbsa.nhs.uk/statistical-collections/prescription-cost-analysis-england/prescription-cost-analysis-england-202425, "Additional Tables", "Table 4A"*

5. Employee benefits and staff numbers

5.1 Employee benefits

	2025-26		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	44,307	1,295	**45,602**
Social security costs	6,185	0	**6,185**
Employer Contributions to NHS Pension scheme	9,976	0	**9,976**
Apprenticeship Levy	220	0	**220**
Termination benefits	14,698	0	**14,698**
Gross employee benefits expenditure	**75,386**	**1,295**	**76,681**
Net employee benefits excluding capitalised costs	**75,386**	**1,295**	**76,681**

	2024-25		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	41,244	2,004	**43,248**
Social security costs	4,783	0	**4,783**
Employer Contributions to NHS Pension scheme	9,240	0	**9,240**
Apprenticeship Levy	202	0	**202**
Termination benefits	65	0	**65**
Gross employee benefits expenditure	55,534	2,004	**57,538**
Net employee benefits excluding capitalised costs	**55,534**	**2,004**	**57,538**

5.2 Average number of people employed

	Permanently employed Number	Other Number	Total Number
2025-26 Total	**790.28**	**13.13**	**803.41**
2024-25 Total	**755.88**	**20.74**	**776.62**

There has been an increase in permanent whole-time equivalents employed by the ICB in 2025/26 and a reduction of whole-time equivalent staff not employed on permanent contracts, classified as 'Other'. The increase in permanent whole time equivalents is due to movement of staff into the ICB from the Commissioning Support Unit (CSU) under the Transfer of Undertakings (Protection of Employment) regulations (TUPE).

The above staff numbers do not reflect all departures agreed under the voluntary redundancy scheme run by the ICB in 2025/26.

A breakdown of termination benefits, including those associated with the 2025/26 voluntary redundancy scheme, is shown in Note 5.3 Exit Packages.

5.3 Exit packages agreed in the financial year

	2025-26 Compulsory redundancies		**2025-26 Other agreed departures**		**2025-26 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	5	7,189	6	39,641	11	46,830
£10,001 to £25,000	0	0	19	350,214	19	350,214
£25,001 to £50,000	1	48,195	32	1,180,170	33	1,228,365
£50,001 to £100,000	0	0	55	3,983,249	55	3,983,249
£100,001 to £150,000	0	0	39	4,777,184	39	4,777,184
£150,001 to £200,000	0	0	25	4,328,151	25	4,328,151
Total	**6**	**55,384**	**176**	**14,658,609**	**182**	**14,713,993**

	2024-25 Compulsory redundancies		2024-25 Other agreed departures		2024-25 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	9,716	0	0	1	9,716
£50,001 to £100,000	1	55,056	0	0	1	55,056
Total	2	64,772	0	0	2	64,772

Analysis of Other Agreed Departures

	2025-26 Other agreed departures		2024-25 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	169	14,642,961	0	0
Contractual payments in lieu of notice	7	15,648	0	0
Total	**176**	**14,658,609**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

Where entities have agreed early retirements, the additional costs are met by NHS Entities and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.
The ICB has had no early retirements on the grounds of ill-health during 2025-26 (0, 2024-25). The estimated resulting additional pension liability borne by the NHS Pension Scheme is nil (0k, 2024-25).

5.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

5.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

5.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

6. Operating expenses

	2025-26 Total £'000	2024-25 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	17,403	19,734
Services from foundation trusts	2,623,893	2,461,988
Services from other NHS trusts	1,019,092	961,812
Services from Other WGA bodies	169	0
Purchase of healthcare from non-NHS bodies	825,651	784,491
Purchase of social care	90,455	107,948
General Dental services and personal dental services	137,499	135,528
Prescribing costs	359,688	346,149
Pharmaceutical services	87,046	74,033
General Ophthalmic services	20,096	18,931
GPMS/APMS and PCTMS	442,525	404,066
Supplies and services – clinical	(1,170)	(1,466)
Supplies and services – general	10,780	7,342
Consultancy services	9,218	3,601
Establishment	7,421	6,836
Transport	1,635	119
Premises	16,961	18,198
Audit fees	254	247
Other non statutory audit expenditure		
· Internal audit services	154	148
· Other services	52	50
Other professional fees	2,713	3,332
Legal fees	636	1,153
Education, training and conferences	347	215
Total Purchase of goods and services	**5,672,518**	**5,354,455**
Depreciation and impairment charges		
Depreciation	371	362
Total Depreciation and impairment charges	**371**	**362**
Other Operating Expenditure		
Chair and Non Executive Members	229	213
Grants to Other bodies	285	357
Expected credit loss on receivables	0	22,936
Inventories consumed	603	0
Other expenditure	9	61
Total Other Operating Expenditure	**1,126**	**23,567**
Total operating expenditure	**5,674,015**	**5,378,384**

The Integrated Care Board's contract with its external auditors (KPMG LLP) provides for a limitation of the auditor's liability. The principal terms of this limitation are as follows:
Liability for all defaults resulting in direct loss or damage to the property of the other party shall be subject to a limit of £1m. In respect of all other defaults, claims, losses or damages the liability shall not exceed £1m.

7 Payment Compliance Reporting

7.1 Better Payment Practice Code

Measure of compliance	2025-26 Number	2025-26 £'000	2024-25 Number	2024-25 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	148,331	1,865,115	130,933	1,640,543
Total Non-NHS Trade Invoices paid within target	147,143	1,853,539	129,765	1,596,999
Percentage of Non-NHS Trade invoices paid within target	**99.20%**	**99.38%**	**99.11%**	**97.35%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,077	3,362,041	4,792	3,760,394
Total NHS Trade Invoices Paid within target	2,935	3,346,388	4,669	3,719,996
Percentage of NHS Trade Invoices paid within target	**95.39%**	**99.53%**	**97.43%**	**98.93%**

8 Finance costs

	2025-26 £'000	2024-25 £'000
Interest		
Interest on lease liabilities	24	27
Total finance costs	**24**	**27**

9 Leases

The ICB's right-of-use assets and associated lease liabilities reflect lease arrangements associated with ICB headquarters accommodation.

All right-of-use assets and associated lease liabilities are with external counterparties i.e. outside of the NHS and DHSC group.

9.1 Right-of-use assets

2025-26	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2025	3,385	3,385
Accumulated depreciation at 01 April 2025	(726)	(726)
Net Book Value at 01 April 2025	**2,659**	**2,659**
Lease remeasurement	28	28
Depreciation charged during the year	(371)	(371)
Cost/Valuation at 31 March 2026	**2,316**	**2,316**

9.2 Lease liabilities

	2025-26 £'000	2024-25 £'000
Lease liabilities at 01 April 2025	(2,678)	(3,034)
Interest expense relating to lease liabilities	(24)	(27)
Repayment of lease liabilities (including interest)	384	383
Lease remeasurement	(28)	0
Lease liabilities at 31 March 2026	**(2,346)**	**(2,678)**

9.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2025-26 £'000	2024-25 £'000
Within one year	(369)	(368)
Between one and five years	(1,427)	(1,427)
After five years	(726)	(1,083)
Balance at 31 March 2026	**(2,522)**	**(2,878)**

9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2025-26 £'000	2024-25 £'000
Depreciation expense on right-of-use assets	371	362
Interest expense on lease liabilities	24	27

9.5 Amounts recognised in Statement of Cash Flows

	2025-26 £'000	2024-25 £'000
Total cash outflow on leases under IFRS 16	384	383

10 Inventories

	Loan Equipment £'000	Total £'000
Balance at 01 April 2025	7,669	**7,669**
Inventories recognised as an expense in the period	(603)	**(603)**
Balance at 31 March 2026	**7,066**	**7,066**

11.1 Trade and other receivables

	Current 2025-26 £'000	Current 2024-25 £'000
NHS receivables: Revenue	7,179	8,044
NHS prepayments	251	345
NHS accrued income	3,270	1,016
Non-NHS and Other WGA receivables: Revenue	46,383	50,030
Non-NHS and Other WGA prepayments	1,935	894
Non-NHS and Other WGA accrued income	27,318	20,956
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	0	249
Expected credit loss allowance-receivables	(22,912)	(22,912)
VAT	710	538
Other receivables and accruals	161	14
Total Trade & other receivables	**64,295**	**59,174**

11.2 Receivables past their due date but not impaired

	2025-26 DHSC Group Bodies £'000	**2025-26 Non DHSC Group Bodies £'000**	2024-25 DHSC Group Bodies £'000	2024-25 Non DHSC Group Bodies £'000
By up to three months	402	8,774	329	7,587
By three to six months	643	140	931	1,537
By more than six months	3,170	37,065	62	39,383
Total	**4,215**	**45,979**	**1,322**	**48,507**

11.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	**Total**
	£'000	**£'000**
Balance at 01 April 2025	**(22,912)**	**(22,912)**
Total	**(22,912)**	**(22,912)**

12 Cash and cash equivalents

	2025-26	2024-25
	£'000	£'000
Balance at 01 April 2025	1,089	1,605
Net change in year	(960)	(516)
Balance at 31 March 2026	**129**	**1,089**
Made up of:		
Cash with the Government Banking Service	129	1,089
Cash and cash equivalents as in statement of financial position	**129**	**1,089**

13 Trade and other payables	**Current 2025-26 £'000**	Current 2024-25 £'000
NHS payables: Revenue	17,269	22,738
NHS accruals	42,410	11,182
Non-NHS and Other WGA payables: Revenue	29,829	76,741
Non-NHS and Other WGA accruals	167,591	102,212
Social security costs	696	596
Tax	672	668
Other payables and accruals	25,560	11,003
Total Trade & Other Payables	**284,027**	**225,140**

Other payables include £3,395k outstanding pension contributions at 31 March 2026 (31 March 2025: £2,996k).

14 Provisions

As at 31 March 2026, the ICB has no provisions to disclose (nil, 31 March 2025).

15 Contingencies

15.1 Contingent Liabilities

As at 31 March 2026, the ICB has a legal claim against it in respect of a multi-ICB procurement for the provision of healthcare waste collection and disposal services for primary care settings.

Any potential obligation or liability that may arise following legal proceedings is not yet confirmed.

This legal claim was identified in the ICB's 24-25 accounts as a contingent liability as at 31 March 2025.

16 Financial instruments

16.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the Integrated Care Board's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the Integrated Care Board and internal auditors.

16.1.1 Currency risk

The Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Integrated Care Board has no overseas operations and therefore has low exposure to currency rate fluctuations.

16.1.2 Interest rate risk

The Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Integrated Care Board therefore has low exposure to interest rate fluctuations.

16.1.3 Credit risk

Because the majority of the Integrated Care Board revenue comes from parliamentary funding, the Integrated Care Board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

16.1.4 Liquidity risk

The Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The Integrated Care Board draws down cash to cover expenditure, as the need arises. The Integrated Care Board is not, therefore, exposed to significant liquidity risks.

16.1.5 Financial Instruments

As the cash requirements of the Integrated Care Board are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the Integrated Care Board's expected purchase and usage requirements and the Integrated Care Board is therefore exposed to little credit, liquidity or market risk.

16 Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost 2025-26 £'000	**Total 2025-26 £'000**	Total 2024-25 £'000
Trade and other receivables with NHSE bodies	723	723	4,481
Trade and other receivables with other DHSC group bodies	9,725	9,725	5,147
Trade and other receivables with external bodies	73,862	73,862	70,682
Cash and cash equivalents	129	129	1,089
Total at 31 March 2026	**84,439**	**84,439**	81,399

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2025-26 £'000	**Total 2025-26 £'000**	Total 2024-25 £'000
Trade and other payables with NHSE bodies	1,782	**1,782**	2,034
Trade and other payables with other DHSC group bodies	57,897	**57,897**	31,917
Trade and other payables with external bodies	222,980	**222,980**	189,924
Right-of-use asset lease obligations	2,346	**2,346**	2,678
Total at 31 March 2026	**285,005**	**285,005**	226,553

17 Joint arrangements - interests in joint operations

The ICB has entered into pooled budget arrangements for services for adults with learning disabilities, services to support integrated hospital discharges and Better Care Fund (BCF). The BCF is an integrated commissioning approach between local authorities and the ICB to help jointly plan and deliver local services.
The ICB's share of the assets, liabilities, income and expenditure handled by the pooled budget in the accounting period were:

17.1 Interests in joint operations

			Amounts recognised in Entities books ONLY 2025-26				Amounts recognised in Entities books ONLY 2024-25			
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Assets**	**Liabilities**	**Income**	**Expenditure**	**Assets**	**Liabilities**	**Income**	**Expenditure**
			£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Learning Disabilities Pool	Lancashire County Council NHS Lancashire and South Cumbria Integrated Care Board	Services for Adults with Learning Disabilities	(3,073)	16,792	(512)	16,191	-	-	(480)	2,313
Better Care Fund	Lancashire County Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Lancashire County Council	-	-	(109,508)	126,333	-	-	(77,759)	113,768
Better Care Fund	Blackpool Borough Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Blackpool Borough Council	-	-	(10,123)	28,920	-	-	(8,695)	36,512
Better Care Fund	Blackburn with Darwen Borough Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Blackburn with Darwen Borough Council	(719)	-	(7,650)	17,164	(600)	-	(6,973)	17,151
Hospital Discharge Fund	Lancashire County Council NHS Lancashire and South Cumbria Integrated Care Board	Services to support integrated hospital discharges	-	-	-	-	(11,167)	11,167	(11,167)	11,167
Hospital Discharge Fund	Blackpool Borough Council NHS Lancashire and South Cumbria Integrated Care Board	Services to support integrated hospital discharges	-	-	-	-	-	-	(1,572)	1,572
Hospital Discharge Fund	Blackburn with Darwen Borough Council NHS Lancashire and South Cumbria Integrated Care Board	Services to support integrated hospital discharges	-	-	-	-	(1,153)	1,153	(1,153)	1,153
Learning Disabilities Pool	Westmorland and Furness Council NHS Lancashire and South Cumbria Integrated Care Board	Services for Adults with Learning Disabilities	-	-	-	-	-	-	-	-
Hospital Discharge Fund	Westmorland and Furness Council NHS Lancashire and South Cumbria Integrated Care Board	Services to support integrated hospital discharges	-	-	-	-	(2,198)	2,198	(2,198)	2,198
Better Care Fund	Cumberland Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Cumberland Council	-	53	-	583	-	-	-	603
Better Care Fund	Westmorland and Furness Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Westmorland and Furness Council	-	-	-	11,312	-	-	-	9,333

18 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Emma Woolett - Chair - NHS Confederation (Trustee and subsidiary board Chair)	34	-	-	-
Sheena Cumiskey - Non-Executive Member - NHS Confederation (work on newly appointed Chief Executive Group)	34	-	-	-
Professor Jane O'Brien - Non-Executive Member - Lancaster University (Emeritus Professor)	87	-	-	-
Dr Julie Colclou - Partner Member for Primary Care - General Practice Cartmel Surgery (GMS contract holder, Husband is also a partner in the business)	1,058	-	-	-
Dr Julie Colclou - Partner Member for Primary Care - Grange and Lakes Primary Care Network (Clinical Director)	1,707	-	-	-
Stephen Downs - Acting Chief Finance Officer (01/05/25 - 30/09/25) - Greater Manchester Mental Health NHS Foundation Trust (Wife is Deputy Director of Finance)	209	-	-	-
Mark Bakewell - Chief Finance Officer (from 1/10/25) - NHS England (Wife is employed by NHS England in national role re: Learning Disability and Autism)	-	(47)	-	(506)
Andy Knox - Acting Chief Medical Officer - Ash Trees Surgery (Partner)	5,440	-	-	-
Andy Knox - Acting Chief Medical Officer - The Well CIC (Director and Chair of the Board – unpaid positions)	109	-	-	-
Stephen Igoe - Non-Executive Member - Wirral University Teaching Hospital Foundation Trust (Audit Chair, SID and Deputy Chair)	300	-	-	-
Stephen Igoe - Non-Executive Member - Wirral Community Health & Care NHS FT (Finance Committee Chair)	12	-	-	-
Stephen Spill - Non-Executive Member (01/05/25 - 31/03/26) - Swansea Bay University Health Board (Non-Executive Director/Vice Chair)	61	-	-	-
Craig Harris - Chief Commissioning Officer - UCLAN (Honorary Professor)	-	(3)	-	-
Aaron Cummins - Partner Member for NHS Trust/Foundation Trust Acute (01/04/25 - 31/10/25) - University Hospitals Morecambe Bay NHS Foundation Trust (Chief Executive Officer)	512,119	(109)	1,761	(2,341)
Silas Nicholls - Partner Member for NHS Trust/Foundation Trust Acute (from 01/11/25) - Lancashire Teaching Hospital NHS Foundation Trust (Chief Executive Officer)	680,749	(46)	2,986	(1,677)
Chris Oliver - Partner Member for NHS Trust/Foundation Trust Mental Health - Lancashire and South Cumbria NHS Foundation Trust (Chief Executive Officer)	549,677	(109)	9,476	(1,247)
Chris Oliver - Partner Member for NHS Trust/Foundation Trust Mental Health - NHS Confederation Health and Care LGBTQ+ Network Guiding Group (Member of the Group)	34	-	-	-
Tracey Hopkins - Partner Member Voulntary, Community, Faith and Social Enterprise Sector - Citizen's Advice Blackpool (Chief Executive Officer)	142	-	-	-
Tracey Hopkins - Partner Member Voluntary, Community, Faith and Social Enterprise Sector - Blackpool Teaching Hospital Trust	605,603	(109)	10,142	(776)
Denise Park - Partner Member Local Authorities - Blackburn with Darwen Borough Council (Chief Executive Officer)	11,519	-	1,774	(6,676)

The above table identifies the interests and related transactions of individuals who have been ICB Board Members during 2025-26, where a financial transaction has been identified between the ICB and the organisation identified as an interest.

Please note that the above figures represent the total value of transactions between the ICB and the organisations identified as an interest. The values do not represent transactions with the individuals named.

The figures reported in respect of NHS England do not reflect the ICB's funding allocations received.

18 Related party transactions continued

The Department of Health and Social Care is regarded as a related party.

During the period the ICB had a significant number of material transactions with entities for which the Department is regarded as the parent Department.

Those bodies not already included in the previous table with transactions greater than £1 million are:

NHS North East and North Cumbria ICB
NHS Midlands and Lancashire CSU
East Lancashire Hospitals NHS Trust
The Leeds Teaching Hospitals NHS Trust
North West Ambulance Service NHS Trust
Mersey and West Lancashire Teaching Hospitals NHS Trust
Airedale NHS Foundation Trust
Alder Hey Children's NHS Foundation Trust
Bolton NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Cheshire & Wirral Partnership NHS Foundation Trust
North Cumbria Integrated Care NHS Foundation Trust
Liverpool Heart & Chest Hospital NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
Manchester University NHS Foundation Trust
Mersey Care NHS Foundation Trust
Pennine Care NHS Foundation Trust
Northern Care Alliance NHS Foundation Trust
The Christie NHS Foundation Trust
The Clatterbridge Cancer Centre NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
The Walton Centre NHS Foundation Trust
Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust
NHS Property Services
Community Health Partnerships

In addition, the ICB has had a number of transactions with other government departments and other central and local government bodies. Government bodies with transactions greater than £1 million that are not already included in the previous table are:

Lancashire County Council
Blackpool Borough Council
Cumberland Council
Westmorland and Furness Council

19 Events after the end of the reporting period

A consultation has been launched on 20 April 2026 on a proposed ICB restructure, the impact of which will further reduce staffing costs in order to meet required savings targets as part of NHS reforms to deliver the 10 Year Health Plan.

The Model ICB Blueprint launched in May 2025 sets a clearer future role for ICBs which requires a more focused operating model and a national running cost target of £19.60 per head of population from April 2026. The legal status of ICBs is currently unchanged.

20 Losses and special payments

Losses

The total number of NHS integrated care board losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2025-26 Number	**Total Value of Cases 2025-26 £'000**	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000
Administrative write-offs	1	0	15	25
Fruitless payments	4	9	2	0
Cash losses	0	0	2	55
Total	**5**	**9**	**19**	**80**

Special payments

	Total Number of Cases 2025-26 Number	**Total Value of Cases 2025-26 £'000**	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000
Ex Gratia Payments	0	0	2	5
Total	**0**	**0**	**2**	**5**

21 Mental Health expenditure

	2025-26 £'000	**2024-25 £'000**
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	504,707	451,680
Eligible mental health expenditure	504,735	451,713
Mental health expenditure above/(below) minimum investment required	28	33
Mental health expenditure as a proprortion of total expenditure	8.9%	8.4%

The ICB has met the Mental Health Investment Standard target.