

Subject to approval at the next meeting

**Minutes of a Meeting of the Integrated Care Board Held in Public on
Thursday, 9 July 2026 at 1.00pm
in the Lune Meeting Room, ICB Offices,
Level 3 Christ Church Precinct, County Hall, Preston, PR1 8XB**

Part 1

	Name	Job Title
Members	Emma Woollett	Chair
	Steve Spill	Non-Executive Member
	Jane O'Brien	Non-Executive Member
	Debbie Corcoran	Non-Executive Member
	Steve Igoe	Non-Executive Member
	Aaron Cummins	Chief Executive
	Mark Bakewell	Chief Finance Officer
	Jane Cass (deputy for Craig Harris)	Director of Partnerships and Collaboration
	Jane Scattergood	Interim Chief Nurse
	Andy Knox	Acting Co-Medical Director
	Alex Heritage	Chief Strategy and Planning Officer
	Neil Jack	Partner Member – Local Authorities
	Silas Nicholls	Partner Member – Trust/Foundation Trust – Acute and Community Services
	Tracy Hopkins	Partner Member – Voluntary, Community, Faith and Social Enterprise (VCFSE) Sector
In attendance	Debbie Herring	Interim Chief People Officer
	Debra Atkinson	Company Secretary/Director of Corporate Business
	Neil Greaves	Director of Communications and Engagement
	Dr Karen Perkins (up to minute reference 78)	Principal Clinical Scientist, University Hospitals of Morecambe Bay HNHS Foundation Trust
	Dr Santhosh Davis	Clinical and Care Professional Lead – East Lancashire Place-Based Partnership
	Sandra Lishman	Committee and Governance Officer

Ref	Item
73/26	<u>Welcome and Introductions</u> The Chair opened the meeting and welcomed all those present. She thanked the members of the public who were observing the Board meeting, either in person or through the live stream.

	The Chair extended a particular welcome to N Jack, Partner Member for Local Authorities, who was attending his first ICB Board meeting and also A Heritage, ICB Chief Strategy and Planning Officer, who was attending his first Board meeting held in public. A further welcome was extended to Dr Santhosh Davies, Clinical and Care Professional Lead for the East Lancashire Place-Based Partnership, who was attending the meeting as an observer as part of his professional development.
74/26	<u>Apologies for Absence/Quoracy of Meeting</u> Apologies for absence had been received from Andy Curran, ICB Acting Co-Medical Director, Dr Julie Colclough, Partner Member – Primary Care, Cath Whalley, Partner member – Local Authorities, Chris Oliver, Partner Member – Trust/Foundation Trust – Mental Health, and Prof Craig Harris, ICB Chief Commissioning Officer. Jane Cass was in attendance as deputy for Prof Harris. RESOLVED: The ICB Board noted the apologies and confirmed that the meeting was quorate.
75/26	<u>Declarations of Interest</u> Board Register of Interests - Noted. RESOLVED: That no declarations were noted which related to the business items on the agenda. The Chair would be advised of any conflicts that arise during the meeting as appropriate.
76/26	a) <u>Minutes of the Board Meeting Held on 14 May 2026, Matters Arising and Action Log</u> Members were asked to note that as part of item 66/26, Northwest Specialised Joint Committee Escalation and Assurance Report, reference to <i>the Office of Public Inquiry Commissioning</i> should read <i>the Office for Pan-ICB Commissioning</i>. b) <u>Action Log</u> There were no current outstanding actions for Board members on the action log. RESOLVED: That the minutes of the meeting held on 14 May 2026 be approved as a correct record, subject to the above amendment.
77/26	<u>Community Experience: Improving access to blood testing for patients with learning disabilities or severe needle phobia</u> A Knox introduced the item and welcomed Dr Karen Perkins. A Knox advised that the innovation demonstrated many of the values and ambitions that the ICB Board consistently championed, including a focus on patient outcomes, collaborative working, innovation and the importance of identifying, codifying and spreading best practice across the system. Dr Perkins explained that the innovation had originated from challenges experienced by clinical scientists, GPs and learning disability nurses seeking to obtain blood samples from patients for whom conventional venepuncture was extremely difficult or impossible. She explained that, historically, the best available alternatives had been limited to procedures such as finger-prick testing and dried blood spot cards, which did not always meet clinical needs. Through collaborative work, she had identified the potential of transdermal capillary blood collection devices, which were applied painlessly to the upper arm and gently collected blood

	samples. Feedback from patients using the devices had been overwhelmingly positive. Dr Perkins highlighted that many patients with learning disabilities and other complex needs faced significant barriers to accessing routine blood tests, contributing to poorer health outcomes. She noted that there remained an estimated 20-year gap in life expectancy for some patient groups and emphasised that approximately 60% of clinical decisions relied on blood test results. She stated that while support and adaptation within laboratory services had been required, the benefits for patients had been substantial. She further noted that innovation should not be limited to testing providers and that laboratories also had an important role in identifying and adopting new technologies. A short video was shown featuring, a young person who required monthly blood tests and had experienced significant difficulties with conventional blood collection methods. The video demonstrated the use of the transdermal capillary blood collection device, which was attached to the upper arm and enabled a painless blood sample to be collected. Dr Perkins advised that the approach had been particularly effective for patients with learning disabilities. The Chair reflected on the presentation and asked how the system could encourage wider innovation and ensure that successful approaches such as this were spread consistently across Lancashire and South Cumbria. She observed that the patient remained firmly at the centre of the innovation and noted that the benefits extended not only to patients but also to carers and staff. She highlighted the strategic importance of understanding how the wider system could support adoption and spread. A Knox commended the compassionate leadership demonstrated by laboratory teams and recognised the close involvement of patients and their families in the development of the innovation. A Knox also noted that the variation in application was deliberate and warranted, recognising that the devices were relatively expensive and therefore needed to be targeted appropriately towards patients who experienced significant barriers to conventional blood testing. He explained that the innovation was intended specifically for patients who struggled to have blood samples taken, particularly people with learning disabilities and autism. He confirmed that discussions had already commenced with laboratories across Lancashire and South Cumbria regarding opportunities to support wider implementation in line with the clinical strategy and associated objectives. Dr Perkins added that the programme represented a flagship opportunity for the ICB, given the diversity of the local population and geography. She advised that discussions had taken place with NHS England digital, diagnostics and transformation programme leads, who had expressed strong support for the initiative, alongside backing from regional innovation networks. She expressed hope that the work could be developed further over the forthcoming year as a nationally recognised flagship programme. S Nicholls advised that, from a provider perspective, organisations would work closely with colleagues to support the adoption and spread of the innovation across the system. T Hopkins welcomed the presentation and agreed that expanding the use of the innovation was consistent with the overall direction of travel. Referring to the short video played, she noted the compelling human impact of the initiative but sought assurance regarding how the wider clinical benefits were being measured. She asked how the programme could demonstrate broader impact on health inequalities affecting local communities. In response, Dr Perkins advised that an initial pilot involving 20 patients had already delivered clinically significant outcomes. The pilot had identified two patients with previously undiagnosed hypothyroidism, one patient requiring further diabetic investigations and two patients experiencing hypoglycaemia. She noted that these were individuals who had
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	previously been unable, or only rarely able, to provide blood samples. Dr Perkins further advised that emerging data continued to demonstrate that the ability to access blood samples from these patients was uncovering pathology data that would have previously been unknown. A Knox added that significant work had already been undertaken within primary care to improve annual physical health checks for patients with learning disabilities. He stated that there was already evidence demonstrating that the innovation could improve the effectiveness of such health checks. A Cummins stated that he was keen for the ICB to explore its commissioning role in scaling the approach and suggested that the initiative could act as a test case for the system's broader approach to innovation, population health, inequalities and improvement. He expressed a desire to see similar outcomes achieved across all communities and requested that further work be undertaken to consider how the approach could be taken forward. Action : A Knox (Action log) A Cummins also asked Dr Perkins how straightforward it had been to progress the innovation from identifying the device through to implementation. Dr Perkins explained that the programme had progressed through relevant national pathways and discussions. She noted that extensive laboratory validation work had been required to ensure that capillary blood samples produced reliable and clinically comparable results. This work had taken approximately a year to complete and was supported by emerging research evidence, including work undertaken by an MSc student in Essex. J O'Brien described the presentation as an excellent example of the power of research and innovation and reflected that a key question for the ICB was how to foster research and innovation more broadly across Lancashire and South Cumbria, including addressing practical issues such as ethics governance and approval processes. A Cummings suggested that there should be opportunities for greater collaboration across organisations to reduce duplication and support the spread of proven approaches. Dr Perkins advised that a specialist interest group had now been established and was already considering issues relating to ethics approvals. The Board reflected on the wider role of research and innovation in improving outcomes and reducing health inequalities across Lancashire and South Cumbria, and discussed how the ICB could support innovation and system-wide learning more effectively. The Chair thanked Dr Perkins and colleagues for the presentation and welcomed further work to explore mechanisms for spreading successful innovations consistently across the system while minimising barriers to implementation. RESOLVED: That the ICB Board noted the presentation and discussion.
78/26	<u>Chair's Report</u> The Chair reported the recent appointment of two new members to the Board, comprising a Deputy Chair and a Non-Executive Member (NEM). The Chair stated that both appointments would complement and strengthen the existing Board and reflected that the strength of the field of applicants was a testament to both the progress made by the organisation and the opportunities that the Integrated Care Board (ICB) now had for improving. The Chair also referred to a question received from a member of the public regarding the Board's views on proposals within the Health Bill to remove the statutory requirement for local authority representation on ICBs. In response, she stated that the organisation would comply with any statutory requirements introduced. However, she emphasised that statutory requirements represented the minimum expectation and highlighted that the Board had

	recently appointed two local authority members. The Chair noted that the Board fully recognised the importance of its relationship with local authorities if it was to achieve the changes and improvements it sought across the system. Whilst it remained unclear what the final statutory requirements would be, as the detail had not yet been published, she stressed that any legislative changes would not diminish the Board's commitment to partnership working. She assured members that strong local authority representation would continue to be maintained both at the Board table and through wider system meetings and forums. In drawing attention to the agenda, the Chair commented that it provided an appropriate balance between operational and strategic matters, as well as financial performance and quality outcomes, which were areas of significant Board interest. She highlighted the integrated performance report, noting the positive contribution of the new Strategic Director in strengthening the narrative and context provided within the report, whilst acknowledging that performance remained below the desired position in some areas. Members noted that these matters would continue to be scrutinised through the ICB Quality and Outcomes Committee. The Chair further highlighted the paper relating to the Clinical Strategy, describing it as an excellent report which set out how clinical leadership and expertise would drive and inform future commissioning decisions. She emphasised the importance of the strategy in ensuring that clinical input remained central to decision-making processes. Finally, she drew attention to the Case for Change for integrated urgent care, describing the work as critically important and noting that it had the potential to make a significant difference to the outcomes that could be achieved across Lancashire and South Cumbria. RESOLVED: That the ICB Board note the report.
79/26	<u>Report of the Chief Executive</u> A Cummins thanked colleagues from across the system for their continued work to improve services, outcomes for patients and organisational performance, including progress in relation to financial stability. He acknowledged that this work was being delivered against a backdrop of significant organisational change across the ICB, NHS providers and local authorities. A Cummins recognised the uncertainty being experienced by leadership colleagues during this period and expressed his pride in the way teams continued to maintain focus and deliver high-quality work, noting that this was reflected within the year-end report. He advised that the ICB was awaiting formal notification from NHS England regarding formal undertakings and confirmed that a more detailed update on progress against these would be provided at the next Board meeting. The Board was advised that work on the ICB's organisational restructure remained ongoing and was expected to conclude during the following month. A session had been scheduled for 30 July, at which he would present an operating model designed to support delivery of the organisation's strategic objectives. A Cummins reported that proposals had been shared with partner organisations and that feedback received had informed and helped shape the final proposals. A Cummins further advised that work to establish the ICB to host a pan-ICB specialist commissioning infrastructure was now approaching its midpoint. He noted that a session relating to this work had taken place earlier in the day and said he looked forward to bringing colleagues together from across the system to work collaboratively on the next phase of development. Reflecting on a number of reports which had recently received national attention, A Cummins referred specifically to the Amos report relating to maternity services and the Fuller report

	concerning mortuary safety. He noted that the matters raised within these reports were being fully considered by providers within the Lancashire and South Cumbria system and emphasised that the ICB, as commissioner, had an important role in supporting providers to address the findings and implement any necessary improvements. A Cummins also referred to the significant media coverage surrounding the tragic death of a young child, including the subsequent conviction of those responsible and the issues raised regarding the circumstances of the case and the actions taken by organisations involved. He advised that the system would continue to play its part in ensuring that any lessons arising from the case were fully considered and acted upon. The Board received an update on a national visit which had taken place the previous week involving Dr Claire Fuller, who leads national primary care development work. A Cummins advised that approximately 70 colleagues from across the system had participated, representing a broad range of sectors and organisations. He described it as a privilege to hear directly from places and neighbourhoods about the experiences of local communities and reflected that the visit had left him feeling optimistic about the strength and resilience within communities, whilst also highlighting the importance of achieving greater consistency in outcomes and service delivery across all neighbourhoods. A Cummins further reported that he had met with leaders from across the system on the preceding Friday to discuss collective ambitions and priorities. He described the session as highly productive and explained that discussions had focused on identifying two or three shared objectives which could only be achieved through collective action across organisations and sectors. He advised that this work would help inform future Board discussions and strategic planning. RESOLVED: That the ICB Board note the report.
80/26	<u>Quality and Outcomes Committee Escalation and Assurance Report – 10 June 2026</u> S Spill presented the report on behalf of the committee Chair, who was unable to attend today's meeting. He highlighted the following alert from the report: Alert: Primary Care Quality Group Through reporting of the Primary Care Quality Group, it emerged that discussions following Care Quality Commission (CQC) visits to primary care contractors, had raised questions regarding why certain issues were being identified through the CQC process rather than through the ICB's own oversight arrangements. Whilst the inspections had not resulted in any adverse findings, the discussion highlighted the need to consider the effectiveness and reach of existing assurance mechanisms. The committee noted that capacity within the oversight group and team continued to present a challenge and constrained the level of oversight activity that could be undertaken. As a result, delivering the full range of oversight activity that would ideally be undertaken across primary care services had remained challenging. In response, J Scattergood outlined the mitigation arrangements that were in place, explaining that intelligence and thematic information were being drawn together from a range of data sources. This included intelligence gathered through the wider primary care architecture, including local medical committees, the primary care confederation and other established networks. She noted that whilst proactive visits remained valuable, the information obtained could quickly become outdated. As a result, there was a need to strengthen arrangements for the continuous and consistent collection of intelligence through data and other reporting mechanisms.

	She further advised that the ICB continued to receive Freedom to Speak Up (FTSU) alerts, which provided an important source of intelligence and assurance. These alerts, together with concerns raised by citizens and other intelligence streams, contributed to the overall picture of quality and risk across primary care services. The Chair recognised the valuable intelligence provided through FTSU processes and the contribution these made to the organisation's oversight and assurance arrangements. RESOLVED: That the ICB Board: • Note the Alert, Advise and Assure and approve any recommendations as listed • Note any summary of items or issues referred to other committees of the Board over the reporting period • Note the ratified minutes of the committee meetings.
81/26	<u>Lancashire and South Cumbria ICB Antimicrobial Resistance (AMR) and Infection Prevention and Control (IPC) improvement priority areas</u> A Knox introduced the report and advised that its purpose was to strengthen oversight and assurance arrangements in relation to antimicrobial resistance (AMR) and infection prevention and control (IPC), enabling the ICB to improve its stewardship of antimicrobial use across the system. He thanked all those involved in developing the collaborative programme of work, recognising the expertise, commitment and partnership working that had contributed to the proposals. A Knox explained that the work stemmed from growing international concern regarding antimicrobial resistance, including calls to action from the World Health Organisation and NHS England, recognising AMR as a significant public health threat. He highlighted the need for clear responsibilities and the need for the ICB to provide effective operational oversight. Strong Board-level leadership was required, and he confirmed that he had executive responsibility. The Board heard that a dedicated AMR and IPC Board would be established and fully operational by December 2026. Appropriate reporting arrangements would be implemented through existing governance structures, including the Quality and Outcomes Committee, with annual reporting to the Board. A Knox outlined the proposed priority areas: improving infection prevention and control arrangements within primary care; reducing the prescribing of broad-spectrum antibiotics across the system and improving the appropriateness of antibiotic prescribing for children aged 0–9 years. He referred to learning from the Scottish Government, where restrictions on the use of a particular broad-spectrum antibiotic within hospital settings had been associated with a significant reduction in antibiotic-resistant infections. He acknowledged that Lancashire and South Cumbria was not currently performing as well as some other systems against key national indicators. However, recent improvements had been seen and he expressed confidence that further progress could be achieved through a coordinated system-wide approach. A Knox advised that the programme contained clear priorities and achievable actions. D Corcoran welcomed the paper and highlighted the importance of the issue and its impact on patients. She noted that the report was clear in setting out that current performance was not where the system wanted it to be for local communities. Whilst recognising the strong focus on commissioning and provider actions, she questioned whether sufficient attention was being given to the demand side of the issue. She also reflected on situations where parents

	brought an unwell child for treatment expecting antibiotics and clinicians were required to have difficult conversations regarding why antibiotics were not appropriate. D Corcoran suggested that greater public awareness could benefit both patients and parents and queried how public education and engagement would be incorporated into the programme. In response, A Knox confirmed that many common childhood illnesses, including approximately 80% of ear infections, were caused by viruses and therefore did not require antibiotic treatment. However, telling parents that pain management rather than antibiotics was the appropriate course of action could be challenging. He advised that earlier work undertaken in Morecambe Bay had demonstrated a significant reduction in inappropriate antibiotic demand following the use of educational materials and videos and suggested that this learning should be revisited and applied more consistently across Lancashire and South Cumbria. A Knox also referred to the value of trusted clinicians providing clear advice and noted opportunities to share information proactively ahead of appointments. A Knox confirmed that the programme teams worked closely with engagement colleagues and sought to involve patients and communities through established engagement mechanisms. S Nicholls commented that antimicrobial resistance represented a significant challenge facing healthcare, noting that if commonly used antibiotics became ineffective, many routine surgical procedures would become substantially more difficult to undertake safely. He confirmed that provider organisations fully supported the sharing of information and learning in relation to this agenda. However, he observed that the report did not address the widespread use of broad-spectrum antibiotics within agriculture, particularly within large-scale animal farming. He questioned whether there was a role for public health colleagues in addressing this issue, given its wider impact on antimicrobial resistance. A Knox agreed that the use of antibiotics in agriculture was an important issue and acknowledged that there was a role for organisations to use their influence and lobbying powers to highlight the public health implications of excessive antibiotic use. He also referred to research regarding penicillin allergies, noting that evidence suggested many individuals who believed themselves to be allergic to penicillin may not be. He explained that improving understanding in this area could support greater use of narrow-spectrum antibiotics and reduce reliance on broader-spectrum alternatives. The Chair welcomed the discussion and noted that antimicrobial resistance was an important issue requiring strong system leadership. RESOLVED: That the Board: • Note the contents of the report. • Support the three priority areas for AMR improvement • Approve the proposed actions, monitoring and governance arrangements • Receive a further report at its meeting in July 2027 and annual reports thereafter.
82/26	<u>Integrated Performance Report</u> A Heritage introduced the report by setting out the strategic context and advising that, as the ICB continued to progress through organisational transition, there would need to be an enhanced focus on population health outcomes and the development of a comprehensive outcomes framework. He explained that achieving this would require a more sophisticated digital and data environment capable of linking person-level data, supporting risk stratification

	and providing deeper insight into health inequalities. Whilst this represented the direction of travel, he acknowledged that significant work remained necessary to establish the foundations required to move towards a more forward-looking and predictive approach to system intelligence. A Heritage advised that a further benefit of this approach would be the ability to better understand variation across the system, including both warranted and unwarranted variation. He noted that current reporting was often based on system-level metrics, which could mask poorer outcomes or service gaps within particular communities. He emphasised the importance of recognising that every data point represented an individual service user and stated that a more person-centred approach to data and intelligence would support more effective decision-making and improved outcomes. In relation to performance, A Heritage stressed the importance of maintaining a strong focus on performance management as a strategic commissioner. The Board heard that the regulatory environment continued to evolve and that the ICB was working closely with regional colleagues, particularly those leading provider oversight arrangements. Although provider oversight responsibilities were changing, he advised that all existing performance metrics had been retained within the report to ensure Board members continued to receive appropriate assurance regarding safety and performance. A Heritage also thanked the Quality and Outcomes Committee for its consideration of the report at its June meeting and confirmed that no matters had been escalated to the Board. A Heritage highlighted several key points. He noted ongoing improvements in elective care performance, reflecting the shared ambition to ensure patients received treatment as quickly as possible. Progress had also been made in community services, particularly within children and young people's services, although further improvement remained necessary. He advised that emergency care providers continued to perform well despite sustained demand pressures, demonstrating strong partnership working across organisations. Since publication of the report, Blackpool Teaching Hospitals NHS Foundation Trust had received correspondence from NHS England regarding deterioration against elements of its agreed plan. The Trust had been asked to respond directly and the ICB was working closely with the organisation on recovery planning and performance improvement, with progress to be monitored through existing reporting arrangements. T Hopkins welcomed the ambition to develop a more outcomes-focused approach to performance and population health management and the importance of strengthening the use of data and intelligence to better understand the long-term impact of interventions on population health outcomes and to inform future decision-making. By way of example, she highlighted recent improvements in life expectancy in Blackpool. Whilst the improvement was modest, she noted that it was particularly significant as it reflected substantial effort across a range of indicators, including smoking cessation and other measures aimed at influencing long-term population behaviours. A Heritage acknowledged that outcomes were often longer-term measures and could be more difficult to demonstrate than immediate performance indicators. He noted that many NHS organisations had historically focused on operational performance rather than outcomes and agreed that there was a need to build a fuller picture of the relationship between interventions and outcomes. As a strategic commissioner, he felt the ICB should be increasingly curious about what was driving improvements and what could be learned from areas of success. He suggested that a greater focus on place and person-level analysis, supported by enhanced analytical and technological capability, would provide richer intelligence and improve understanding of what was making the greatest difference. N Jack emphasised the importance of understanding variation in outcomes across Lancashire
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	and South Cumbria, and that system-wide averages could mask significant differences between local populations and that richer place-based intelligence would be essential to identifying and addressing health inequalities. Using vaccination uptake as an example, he noted that a 1% change in one locality could have a very different significance when compared to another area. The Chair agreed that the Board needed to understand outcomes in relation to both constitutional standards and health inequalities. She emphasised the importance of richer place-based intelligence and cautioned against becoming overly focused on high-level data at the expense of understanding who was receiving services and where. The Chair stated that the Board required assurance that inequalities were being actively addressed and that appropriate action was being taken where issues were identified. She observed that a significant amount of time was currently spent explaining historical performance and suggested that the organisation should increasingly move towards using data predictively. The Board needed clear assurance that concerns were being recognised and appropriately managed. J O'Brien commented that the system did not yet have a sufficiently rich understanding of the impact of specific interventions. Referring to smoking cessation programmes as an example, she noted the importance of understanding which interventions were making the greatest difference and how learning could be applied more widely. A Cummins reflected on previous Board discussions regarding the importance of the commissioning cycle and the need to demonstrate outcomes. He welcomed the development of a new outcomes model under A Heritage's leadership, which would support this ambition. Whilst recognising that the current integrated performance report remained largely focused on operational performance, he suggested there should be greater emphasis at Board level on primary care, community services and population outcomes. A Cummins also commended providers for the performance improvements being achieved across the system. He noted that the Board had invested substantial finance into growth and transformation initiatives and therefore needed assurance that the system was securing the best possible value from that investment. He believed this should form part of future Board discussions. A Cummins also highlighted the changing regulatory and oversight environment and raised concerns regarding cancer performance. He advised that he had asked the executive team, working with A Heritage, to provide a dedicated report on cancer performance for future Board consideration, setting out current performance, areas of concern and proposed actions. Action: C Harris (Action log) In addition, he requested quarterly reporting on contractual and performance delivery to provide assurance that funded improvements were delivering the outcomes and activity levels expected. Action: A Heritage (Action log) RESOLVED: That the ICB Board note the achievement and on-going actions against key performance indicators and the work underway to improve quality and safety and reduce health inequalities across Lancashire and South Cumbria.
83/26	<u>Finance and Contracting Committee Escalation and Assurance Report – 20 May and 24 June 2026</u> S Igoe presented two escalation and assurance reports to the Board. The first, from the 20 May committee meeting, reflected on the system's year-end financial position and the delivery of the 2025/26 financial plan, whilst the report from 24 June focused on financial performance during the first two months of 2026/27. In relation to the year-end position, S Igoe advised that the report reflected the system's exit

	velocity and whether it had delivered the commitments made during 2025/26. He confirmed that the system had achieved its control total, however, this had been supported by the receipt of £47 million of additional funding from the region. Overall, S Igoe reflected that the year-end position had been positive, with the system having delivered against the commitments it had made. Looking ahead to 2026/27, S Igoe reported that the operational planning process had identified a significant savings requirement across the system, creating considerable delivery challenges. Whilst the system had achieved full identification of its cost improvement programme and running cost reduction plans, he advised that the value of schemes would reduce once risk assessment and deliverability reviews had been completed. As a result, substantial work remained to ensure that planned savings were realised and that the financial plan could be delivered. The Finance and Contracting Committee had also considered the position regarding All Age Continuing Care (AACC). S Igoe advised that a common theme emerging across recent reports was concern regarding increasing demand, process backlogs and associated cost pressures. The committee had therefore requested further information from the responsible teams regarding how these issues would be addressed and managed going forward. The Board heard that the committee had also reviewed cost reduction programmes and the delivery of the previous year's exit velocity commitments. Month 2 financial reporting indicated that performance remained broadly in line with plan, although it remained very early in the financial year. S Igoe emphasised that significant work remained in delivering cost improvement programmes and managing AACC expenditure pressures. S Igoe further advised that discussions had taken place regarding commissioning arrangements and the relationship between the Finance and Contracting Committee and the Commissioning Committee. The intention was to provide greater clarity regarding the outputs expected from both committees and how financial resources could best support delivery of commissioning objectives. He looked forward to working closely with the Commissioning Committee to further develop and strengthen these arrangements. Referring to discussions at the previous Board meeting regarding the Green Plan, S Igoe advised that the Finance and Contracting Committee had considered how progress could be monitored through its governance arrangements. Further work would be undertaken to improve visibility and assurance for the Board in due course. Finally, S Igoe highlighted the committee's discussion regarding strategic risks, noting developments in relation to the AACC risk. He emphasised that maintaining financial control remained essential, observing that organisations without sufficient financial control or capacity to direct resources were significantly limited in their ability to determine and deliver their strategic priorities. RESOLVED: That the ICB Board: • Note the Alert, Advise and Assure within the committee report and approve any recommendations as listed • Note the summary of items or issues referred to other committees of the Board over the reporting period • Note the ratified minutes of the committee meetings.
83/26	<u>Finance Performance Report – Month 2</u> M Bakewell presented the financial performance report as at May 2026 and advised that there remained a challenging year ahead for the system. He reported that there continued to be a

	significant underlying financial challenge and that a range of mitigations were being developed and implemented to manage the position. M Bakewell explained that the absence of some contracting information continued to present challenges in fully understanding the financial position. Month 3 reporting was being finalised and additional work was underway to reconcile and review April contracting data. Whilst he acknowledged the frustrations associated with these delays, he confirmed that colleagues were working closely together to resolve the issues and improve the timeliness of information. Referring to reported variances, M Bakewell noted that some reflected the benefit of prior-year adjustments and accounting assessments made at year-end. He drew particular attention to the system's recurrent financial improvement and waste reduction programme savings, reporting that progress during the first quarter had been encouraging and was ahead of plan. However, he stressed that further opportunities would need to be identified and progressed collectively if the financial plan was to be delivered in full. M Bakewell advised that a number of operational pressures were beginning to emerge, some of which reflected trends that had been experienced in previous years. These had been highlighted to budget holders and further mitigating actions were being explored to offset financial pressures. The Board was advised that the financial position remained dynamic, with a number of factors changing on a monthly basis. M Bakewell highlighted plans for a system-wide risk summit to be held in the near future, which would bring together a triangulated view of provider delivery, considering finance, contracts and operational performance. He advised that a meeting involving Chief Finance Officers, Directors of Finance and Chief Operating Officers was scheduled for 24 July, followed by a further meeting of the wider finance community, with the intention of developing a shared understanding of the system position and supporting collective delivery of financial improvement objectives. He noted that this collaborative approach had been welcomed across the system. During discussion, clarification was sought regarding the "other services" category within the financial report, noting that it represented a significant figure and was not immediately clear. In response, M Bakewell explained that financial ledger structures required certain expenditure types to be recorded within specific cost centres. As a result, a number of programme costs, reserves, contingencies and other centrally managed allocations were grouped together within the "other services" category. He advised that the available reporting categories were limited and therefore some expenditure was necessarily reported as a broader aggregate figure. M Bakewell further explained that some variances reflected reporting requirements, including the treatment of specialised commissioning expenditure and associated offsets. He cautioned against interpreting the variance within this category as an indication that services were behind plan, noting that it represented a combination of different financial movements and accounting adjustments. A Cummins reflected on the importance of ensuring that financial improvement plans focused not only on cost reduction but also on demand management, contract management and the effective use of growth and investment funding to support service transformation and performance improvement. He noted that, as the system moved into future years, growth funding should increasingly be used to support investment, prevention and service shift rather than solely managing operational pressures. A Cummins requested that future quarterly reviews include a focused assessment of the risks associated with these investment programmes and the mitigations in place to ensure that intended benefits and service outcomes continued to be delivered. He observed that financial and operational pressures across both providers and commissioners were increasing and stressed the importance of identifying risks early to avoid significant pressures emerging later in the financial year, particularly during quarters three and four. Action: M Bakewell (Action log)
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	RESOLVED: That the ICB Board note the reporting position as at M2 (May 2026) in respect of the year to date position.
84/26	<u>Lancashire and South Cumbria Clinical Strategy</u> A Knox presented the Clinical Strategy and sought the Board's approval and endorsement of the document as a key component of the ICB's development as a strategic commissioning organisation. The strategy had been developed to inform future iterations of the ICB's strategic plan. A Knox expressed his thanks to A Curran, who had led the work, together with J Scattergood, and acknowledged the significant contributions of T Whalley and J Williams in helping to shape the final document. A Knox emphasised that this was a clinical strategy rather than a medical strategy and described it as a framework for how the ICB would apply clinical leadership and clinical insight within a modern commissioning organisation. He stressed that the strategy was specifically for the ICB in its role as a strategic commissioner and was not intended to be a clinical strategy for the wider Lancashire and South Cumbria health and care system. The strategy set out how clinical leadership could help reduce health inequalities and defined what effective clinical leadership should look like within a commissioning organisation. As the ICB was undergoing significant organisational change, A Knox explained that the strategy supported this transition by ensuring that population health needs were understood and used to inform priorities. He noted that health needs would be described through a clinical lens, clinical inputs would be embedded within decision-making processes, and clinical resources would be directed towards areas where they could have the greatest impact on outcomes. The strategy would therefore provide the clinical framework through which future priorities and decisions could be considered. He recognised that the ICB did not directly manage providers and explained that the role of a strategic commissioner was not to control operational delivery but to understand needs, align investment, support collective action and focus the system on delivering agreed outcomes. He stated that the strategy would strengthen the ICB's ability to fulfil that role. The Board noted that the strategy had been considered by both the Commissioning Committee and the Quality and Outcomes Committee, with feedback from both committees reflected in the final document. S Spill referred to the consultation undertaken during the development of the strategy and sought assurance that the document was aligned with the wider system and partner organisations. In response, A Knox confirmed the strategy had been developed collaboratively with partners. Whilst acknowledging that individual trusts and primary care organisations had their own clinical strategies, he reiterated that the purpose of the ICB's strategy was to ensure commissioning priorities aligned with wider system priorities and supported collective action around agreed areas of focus. T Hopkins welcomed the strategy and recognised that it set out a clear direction of travel. She sought clarification regarding the relationship between the strategy and neighbourhood working, noting that neighbourhoods would be an important delivery vehicle for many of the ambitions set out in the document. She asked how progress would be measured at neighbourhood level. A Heritage acknowledged that further work was required to bring together the ICB's various strategic ambitions and confirmed that this would be undertaken over the summer and autumn through the Board's development programme. He observed that a number of themes discussed during a recent executive leadership event were reflected within the strategy,

	including the importance of place, neighbourhoods, research and continuous improvement. N Greaves advised that work was already underway to communicate the developing commissioning strategy and operating model, enabling stakeholders to better understand the role of the ICB as a strategic commissioner. He confirmed that the Clinical Strategy had been informed by insight gathered directly from local people and communities. This had enabled the strategy to focus on the issues which residents identified as most important and where they most wanted to see improvement. D Corcoran welcomed the document, noting that feedback from committees had strengthened the final version, particularly around research and innovation. She observed that several connected programmes of work were being developed, including those relating to workforce, digital enablement and neighbourhood development. D Corcoran questioned how these various strategies and frameworks would be brought together and how the Board could gain assurance that decisions across these areas were aligned. J O'Brien strongly supported the workforce section of the strategy, but noted that the ICB was not directly responsible for the workforce employed by partner organisations. She suggested that future implementation plans should clearly reflect the ICB's role as a strategic commissioner and set out how influence and partnership working would be used to achieve the desired outcomes. S Nicholls advised that the Provider Collaborative had been involved throughout development of the strategy and fully supported its aims. He welcomed the inclusion of feedback provided during consultation and described the strategy as an important framework for decision-making and investment choices. Whilst acknowledging that the ICB did not directly manage providers, he highlighted its important role in influencing system-wide priorities. Reflecting on discussions at a recent leadership event, S Nicholls noted that demographic projections indicated significant future increases in demand relating to cardiovascular disease, cancer and mental health services. He stressed the importance of understanding the key interventions that could help mitigate these pressures, including improvements in data, diagnostics, care delivered in the most appropriate settings and reducing clinical interventions that did not add value for patients. He suggested that consideration should now be given to the future delivery plan required to support implementation of the strategy. S Nicholls also highlighted evidence demonstrating the wider determinants of health, including social mobility, employment and economic prosperity, and stressed the importance of future-proofing the system by focusing on these wider influences on health outcomes. In response, A Knox reflected on the significant mindset shift required as the ICB moved from a traditional commissioning organisation to a strategic commissioner. Drawing on learning from other health systems, he noted the importance of maintaining a clear vision whilst allowing local partners and neighbourhoods flexibility in how outcomes were delivered. He explained that the role of the ICB was to be clear about priorities and desired outcomes whilst holding the system to account for delivery through measurement and oversight. A Knox referred to successful examples of innovation and improvement already taking place across Lancashire and South Cumbria, including frailty services in East Lancashire and the Morecambe Bay respiratory network. He noted that although excellent work existed across the system, it had not always been consistently codified, shared and implemented more widely. The strategy provided a mechanism to identify such successes and support their adoption across Lancashire and South Cumbria, enabling the system to focus collectively on agreed priorities, tackle inequalities and improve outcomes through continuous learning.
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	He acknowledged the importance of the supporting enablers highlighted by Board members, including workforce, culture, digital technology, data and analytical capability. He commented that the workforce continued to experience significant pressures and hoped that the strategy would provide a clear sense of purpose and direction, helping to foster compassionate leadership across organisations. Further work on digital technology, data and performance dashboards would be brought to the Board over coming months to support improved monitoring and assurance. He concluded by emphasising that neighbourhood working was central to the strategy and would be key to improving outcomes for local communities. A Cummins welcomed the discussion and reflected that the strategy represented an important statement of intent for the organisation. He described it as a powerful document, designed to signal to the organisation, partners and the wider market where the ICB's priorities lay and the approach it intended to take to improvement. The Chair noted the strong support expressed by the Board and welcomed the priorities identified within the strategy. She reflected that further work would be required to articulate clearly the commissioning cycle and how the various enabling strategies and frameworks aligned with it. She acknowledged the communication and engagement work already underway and recognised that this would be important in supporting implementation and understanding of the strategy. The Chair concluded by reiterating the Board's thanks to A Curran for the significant amount of work undertaken in developing the strategy. RESOLVED: That the ICB Board • Note the content of the proposed Lancashire and South Cumbria ICB Clinical Strategy • Approve the Clinical Strategy for inclusion within future updates of the 5-Year Strategic Commissioning Plan and for publication.
85/26	<u>Case for Change: Integrated Urgent Care Re-Design</u> J Cass presented the case for change for the redesign of Integrated Urgent Care (IUC) services across Lancashire and South Cumbria. By way of context, she explained that Integrated Urgent Care referred to the collective provision of same-day, unplanned urgent care services delivered outside of accident and emergency departments. J Cass advised that the case for change had been developed in response to a system that was currently fragmented and inequitable, with significant variation in access, quality, digital capability, workforce models and cost across localities. Demand for urgent care services continued to grow at a rate exceeding that of available capacity, placing increasing pressure on emergency departments. She stated that the current model was not sustainable and that a system-wide redesign would be required to ensure services were capable of meeting population needs over the next ten years. The Board heard that many of the existing services had been designed before the COVID-19 pandemic and no longer reflected current patient behaviours, demand patterns or expectations. In addition, many arrangements had transferred into the ICB from former Clinical Commissioning Groups and had not subsequently been reviewed as part of a wider strategic redesign. J Cass noted that simply re-procuring the current contracts without redesign would risk perpetuating outdated models of care and would not address the underlying challenges facing the service. J Cass outlined the strategic drivers underpinning the proposal, including alignment with the

	NHS 10-Year health plan, the ICB's 5-year strategic commissioning plan and wider urgent and emergency care priorities. She explained that current performance challenges were well understood, with emergency department attendances significantly above the national average and continuing to increase. Demand for primary care appointments was also rising. The redesign would seek to support a more consistent twenty-four-hour urgent care offer, clearer and more consistent service naming and the development of a network of integrated urgent care hubs. The financial implications were identified as a critical component of the review. J Cass noted that current spending on urgent care varied considerably between localities, reflecting historic contractual arrangements and differing service specifications, making meaningful comparisons difficult. She advised that modernising the urgent care offer would provide an opportunity to review economies of scale and secure greater financial sustainability. The principal risks associated with the programme were outlined and included the complexity of the procurement process, workforce and cultural changes required to support any future model, challenges associated with digital interoperability and the risk of misalignment with wider urgent and emergency care transformation programmes. However, J Cass stated that the potential benefits included more equitable access to urgent care services, reduced emergency department attendances and associated hospital pressures, improved workforce resilience, better patient outcomes and experience, and increased financial efficiency. The Board noted the proposed timelines set out within the paper and heard that further work would be undertaken to determine whether formal public consultation would be required; J Cass emphasised that no assumptions had yet been made in relation to consultation requirements. Depending upon the outcome of that assessment, an implementation date could potentially be achieved by June 2028 or, should formal consultation be required, by September 2029. In conclusion, J Cass stated that maintaining the status quo was not sustainable and that the system could not simply recommission current services in their existing form. She advised that redesigning urgent care services would support efforts to relieve pressure on both hospital and primary care services while creating a model better equipped to meet future demand. The programme would be delivered in two phases, with the first stage focusing on procurement of integrated urgent care services in West Lancashire, followed by a second phase covering the remainder of Lancashire and South Cumbria. Progress on the West Lancashire procurement would be reported through future governance arrangements. The Chair emphasised that the purpose of the case for change was to determine whether there was a compelling case to redesign services and not to predetermine either the outcome or the specific model that would be implemented. She welcomed the paper and commented that it clearly articulated the challenges associated with existing service provision. A Cummins described the document as well-written, evidence-based and compelling. Whilst agreeing that the case for change was strong, he questioned what additional work was being undertaken across the system to reduce demand for urgent care services and avoid some of the activity currently presenting within urgent care pathways, suggesting that this should be considered alongside the redesign programme. He also expressed concern regarding the length of the proposed timescales, noting that implementation in 2028 appeared a considerable distance away and asking whether opportunities existed to progress elements of the work more quickly. A Heritage reflected that feedback from patients and communities frequently highlighted poor connectivity between different parts of the health and care system. He emphasised the need to consider how technology could support faster progress and improve integration, suggesting
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	that shared care records represented an important opportunity for both patients and healthcare professionals. The Chair noted that neighbouring ICBs had implemented shared care records and suggested that learning should be drawn from these examples. She reiterated the importance of identifying actions that could reduce demand on urgent care services in the short term and questioned whether improvements in systems and interoperability with existing providers might address some of the issues identified within the case for change. Whilst supportive of the programme, she suggested that consideration should be given to breaking the work into more achievable and immediate stages. T Hopkins agreed that there were actions which could be undertaken immediately. She noted that patients frequently reported confusion regarding the range of urgent care services available and uncertainty about where they should go when they required care. This often resulted in avoidable attendance at emergency departments. T Hopkins suggested that improving public understanding and simplifying the language used to describe services could help manage demand more effectively. D Herring raised concerns regarding workforce implications and cautioned that the success of any future model would depend upon the availability of an appropriately skilled workforce. She noted that previous service transformation programmes had often encountered challenges because workforce planning had not kept pace with service redesign. D Herring stressed the need for a clear understanding of the future workforce requirements, how staff would be recruited and developed, and the timescales required to create a workforce capable of supporting new models of care. In response, J Cass agreed that workforce planning would be a critical consideration throughout the programme. She acknowledged Board members' concerns regarding both the scale of the work and the proposed timelines and indicated that future presentations would seek to present the programme in a way that better demonstrated shorter-term milestones and opportunities for earlier improvement. She emphasised that work to address immediate pressures, including demand management, prevention, navigation and improvements in public messaging, should continue alongside the wider redesign programme. J Cass also acknowledged a discrepancy within the meeting paper relating to walk-in centre provision on the Fylde Coast and advised that this would be reviewed as part of the ongoing work. The Chair welcomed the discussion and confirmed support for the case for change. She observed that there were a number of areas in which the system was not currently as effective as it needed to be and these needed to be addressed at pace. She suggested that the programme should incorporate a phased approach, bringing together immediate actions focused on demand management, communications and service navigation, medium-term improvements in interoperability and system integration, and longer-term work focused on future service models and workforce development. This approach would ensure that benefits could begin to be realised whilst the wider redesign programme progressed. RESOLVED: That the ICB Board: • Approve the case for change • Require a phased approach to ensure benefits could be realized whilst the wider scheme progressed • Note that work is progressing on the next stage of the service change process- options appraisal.
86/26	<u>Commissioning Committee Escalation and Assurance Report – 20 May and 17 June 2026</u>

	D Corcoran presented the two Advise, Alert and Assure (AAA) reports from the Commissioning Committee and highlighted the following key issues, drawing links to a number of agenda items considered elsewhere during the meeting. She advised that there were no alerts arising from either meeting. Referring to the meeting held on 20 May, D Corcoran noted that the committee had considered both the Clinical Strategy and the Integrated Urgent Care (IUC) Case for Change, and Board members could see from the reports how committee feedback had informed the subsequent papers presented to the Board. As part of assurance, she advised that the committee had received an update regarding children's ADHD services and had noted growing demand and activity levels, which were also reflected within the financial and Integrated Performance Reports considered elsewhere on the agenda. Given the ongoing pressures and challenges associated with demand growth, the committee had requested a further update on pathway redesign work and had agreed to receive a further review in six months' time to assess the impact of the changes being implemented. D Corcoran also highlighted assurance received in relation to primary care oversight arrangements. The committee had received assurance regarding the approach being taken and had sight of the Primary Care Assurance Framework to support its ongoing oversight responsibilities. Providing an update from the 17 June meeting, D Corcoran advised that the committee had considered pre-consultation business cases relating to the Furness General Hospital Intensive Care Unit and the Vascular Reconfiguration Programme. The committee had provided feedback on both proposals and noted the ongoing engagement and discussions taking place with Health Overview and Scrutiny Committees. The committee had also received its regular bi-monthly people and workforce update and had reviewed work being undertaken with local communities, including a strengthened focus on commissioning, engagement and involvement. D Corcoran reported that the committee had endorsed the Communications and Engagement Strategy, recognising its importance in underpinning the ICB's commissioning approach and strategic commissioning ambitions. Whilst offering its support, the committee had provided some minor feedback for officers to consider, particularly around ensuring that communications were clear and accessible to the public. Members had felt it was important that residents understood what the ICB's role as a strategic commissioner meant in practice and how commissioning decisions would affect local services and communities. RESOLVED: That the ICB Board: • Note the Alert, Advise and Assure within the committee report and approve any recommendations as listed • Note the summary of items or issues referred to other committees of the Board over the reporting period • Note the ratified minutes of the committee meetings held on 22 April and 20 May 2026.
87/26	<u>Audit Committee Escalation and Assurance Report – 15 June 2026</u> S Spill presented the Audit Committee's Advise, Alert and Assure (AAA) report and advised the following key highlights. He confirmed that there were no alerts requiring escalation to the Board and noted that the Board had already received a report from the Audit Committee through the Private Board meeting.

	Assure: ICB annual report and audited accounts for the period 1 April 2025 – 31 March 2026 The committee agreed to recommend to the Board that it approved the final report and accounts, including the associated financial statements and the External Auditor's Report. Assure: Internal audit annual report and head of internal audit opinion 2025/26 Internal audit had provided moderate assurance across the majority of areas reviewed. The exception was All Age Continuing Care (AACC), where limited assurance had been provided, reflecting concerns regarding controls and the need for further improvement. He advised that work was underway to address the issues identified and strengthen assurance arrangements in this area. RESOLVED: That the ICB Board: • Note the Alert, Advise and Assure within the committee report and approve any recommendations as listed • Note the ratified minutes of the committee meeting held on 18 March 2026.
88/26	<u>Northwest Specialised Joint Committee Escalation and Assurance Report – 29 April 2026</u> J Cass presented the North West Specialised Commissioning Joint Committee Advise, Alert and Assure (AAA) report and highlighted the following matters considered at the meeting held on 29 April 2026. Alert: Adult Critical Care Transfer Service (ACCTS) There remained an ongoing issue and associated risk relating to the provision of ACCTS. The absence of confirmed capital funding continued to prevent procurement of a fully compliant North West service. A joint letter had been issued to the national team seeking resolution of the funding position and approval to proceed with procurement, and this continued to be actively pursued by the North West team. Alert: Ongoing operational and quality pressures Several ongoing operational pressures continued to be monitored through the committee. These included challenges relating to cardiac waiting times, cancer services, renal dialysis capacity and breast screening delays. A recovery trajectory and associated mitigations were being developed in relation to breast screening performance, with the aim of ensuring that the current level of risk became acceptable over time. In response to pressures within cardiac services, mutual aid arrangements had been secured across the North West to provide additional short-term capacity for cardiac surgery. However, discussions within the committee had recognised that reliance upon mutual aid was not a sustainable long-term solution and that a more robust and enduring approach would be required. Alert: St Andrew's Healthcare The closure of St Andrew's Healthcare continued to create pressures across specialised mental health services. There were currently no specialised patients from Lancashire and South Cumbria placed within that provider. Advise: Office for Pan-ICB Commissioning (OPIC) Progress continued to be reported and monitored through the North West Specialised Commissioning Joint Committee as part of ongoing commissioning arrangements. During discussion, S Spill drew attention to the Adult Critical Care Transfer Services, noting that the requirement was for three North West ICBs to jointly commission and procure the

	service, which had not yet been achieved due to the capital funding shortfall. As a result, each ICB had put interim arrangements in place which were operating satisfactorily. S Spill emphasised that the service continued to be delivered and queried whether the future hosting arrangements would make any difference to resolving the issue. In response, J Cass advised that the fundamental challenge remained the lack of capital funding. She confirmed that the issue would continue under future arrangements and that discussions with the national team regarding funding remained ongoing. RESOLVED: That the ICB Board note the Alert, Advise and Assure committee report and approve any recommendations as listed.
89/26	<u>Fit and Proper Persons Test Annual Submission</u> D Atkinson presented the report and advised that it provided assurance that the ICB had completed the Fit and Proper Persons Test (FPPT) assessment process for all Board members. The submission covered the period 1 July 2025 to 30 June 2026 and supported the Chair in making the required annual declaration, together with the internal assurances outlined within the report. D Atkinson confirmed that the annual declaration had been submitted on 30 June 2026, in line with national requirements and prescribed timescales. The Board was advised that no concerns had been identified through the assessment process and that a copy of the completed submission was attached to the report for assurance purposes. RESOLVED: That the ICB Board note the completion and submission of the NHS England Fit and Proper Persons Test annual submission and declaration in line with NHS England requirements.
90/26	<u>Use of the Seal</u> D Atkinson presented the report on the use of the ICB Seal. She advised that, in accordance with the ICB Constitution, the use of the Seal must be reported to the Board on a biannual basis. The previous report had been presented to the Board in January 2026 and the current paper provided the next scheduled update. D Atkinson reported that the Seal had been used on one occasion during the reporting period. The Seal had been affixed on 31 March 2026 in accordance with the relevant constitutional and governance requirements, as detailed within the report. RESOLVED: That the ICB Board note the use of the ICB Seal.
91/26	<u>Report concerning matters considered in Private Board meetings</u> D Atkinson presented the report of business conducted by the ICB Private Board and advised that the Private Board had met on three occasions since the previous report, on 14 May 2026, 4 June 2026 and 15 June 2026. The Private Board held on 14 May had considered a range of matters, including progress updates in relation to enforcement undertakings, organisational change and staff consultation activity, developments relating to Special Educational Needs and Disabilities (SEND) reform and updates in relation to a number of service change proposals. At the meeting held on 4 June, the Board approved the launch of the procurement process for the community equipment services in Lancashire, and received an update regarding the

	ICB's risk management framework and associated governance arrangements. D Atkinson advised that the meeting held on 15 June 2026 had focused primarily on governance matters, including consideration and approval of the ICB's Annual Report and Accounts, subject to NHS England review and approval. Since that meeting, the ICB had received confirmation from NHS England that the submission was compliant with national requirements. As a result, the Annual Report and Accounts would be published on the ICB website in advance of the Annual General Meeting being held on 17 September 2026. RESOLVED: That the ICB Board note the contents of the report.
92/26	<u>Any Other Business</u> RESOLVED: That there were no items of any other business.
93/26	<u>Items for the Risk Register</u> RESOLVED: That there were no items to be included on the ICB Risk Register.
94/26	<u>Closing Remarks</u> The Chair thanked all those present, and those observing the meeting, for their contributions and formally closed the meeting.
95/26	<u>Date, Time and Venue of Next Meeting</u> The next meeting to be held in public would be held on Thursday, 17 September 2026, 1 pm - 4 pm, in the Lune meeting room, ICB Offices, Level 3 Christ Church Precinct, County Hall, Preston, PR1 8XB. The meeting closed.

Exclusion of the public:

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