

BAF-001

BAF-001: Strategic Commissioning

Commissioning Committee | Chief Commissioning Officer |

SO1	To improve population health and reduce inequalities through effective strategic commissioning.	•
SO2	Commission high quality, safe and accessible services that deliver better and more equitable outcomes and patient experience.	•
SO3	To develop and sustain the workforce, leadership and organisational capability required to operate as an effective strategic commissioner.	
SO4	Improved financial sustainability through directing available resources to deliver the greatest possible value.	•
SO5	To deliver agreed national and local outcomes through a balanced focus on performance, improvement and long-term system resilience.	

Risk Description and Impact on Strategic Objectives

Cause (Likelihood)	If the ICB does not deliver its strategic commissioning plan and intentions, with clear priorities, robust data-driven decision-making, and effective oversight of value, quality and equity.
Event	Then we will be unable to improve population health outcomes, reduce health inequalities, and improve equitable access to high-quality healthcare and achieve financial sustainability.
Effect (Consequence)	Resulting in: - Continued unwarranted variation in service provision - Continued inequalities in access and outcomes - Slower progress in reducing Health inequalities - Lack of autonomy to invest in service transformation and therefore improve outcomes for our population - Ineffective system and partnership working - Reputational damage - Unaffordable healthcare services - Continued focus on finance as the overriding factor

Risk Scoring and Appetite

Quarter/ Score 25/26	Q1	Q2	Q3	Q4	Target Score/ Date		Risk Appetite Statement	Linked ORR Risk level	
Likelihood	4	4			2	31 Mar 27	Cautious (4-10)	Low	-
Consequence	4	4			4			Med	-
Risk Score	16	16			8			High	-

Risk Update

The ICB's clinical strategy was received and endorsed by the board at its meeting on 9 July; the clinical strategy will be included within the revision of the ICB's 5YSCP as part of the 2027/28 planning guidance requirements to ensure it directly informs future commissioning decisions. The Commissioning Intentions for 2026/27 have now mobilised with quarterly reporting on progress provided through the newly established Commissioning Committee. Assurance has been provided against progress of the commissioning intentions for 2026/27 following mobilisation; a framework to support monitoring of their delivery and impact across the CI programme will continue to develop and include oversight of delivery partners, responsible officers and current progress. Further work is underway to rationalise the commissioning intentions into a smaller number of priority areas aligned to patient outcomes, quality, financial sustainability and strategic priorities, supported through revised prioritisation criteria including financial sustainability, value for money and resource implications.

A refresh the ICB's strategy, target operating model and transition plan as described in "*Our Strategic Next Steps: Strategy Refresh, Target Operating Model and Transition Plan*" is progressing, with a programme of workshops and engagement sessions planned throughout July and August, to inform the refresh and ensure it reflects system-wide priorities. The refreshed strategy will be launched in November alongside the new ICB Target Operating Model providing a clear strategic and organisational framework to support the next phase of delivery.

Key Controls:

The Board-approved 5 Year Strategic Commissioning Plan, Medium Term Plan, 2026/27 Commissioning Intentions (CI), Clinical Strategy and Operating Model provide the strategic framework for commissioning decisions, ensuring that priorities are aligned to population health, health inequalities, quality, access and financial sustainability.

The Chief Commissioning Officer is accountable for delivery of the commissioning programme, with formal oversight through Commissioning Committee and reporting to the board.

Delivery of 2026/27 CIs is underway with quarterly reporting to the Commissioning Committee against implementation to show progress against delivery milestones.

Integrated Strategic Needs Assessment, Population Health Management tools and LSC System Intelligence Service Products are used to inform prioritisation, identify unwarranted variation, target interventions and support evidence-based commissioning decisions.

Ratified Service Change Policy and Service Change Advisory Group provide a structured governance process for service change, including advice on required engagement, consultation, evidence, decision-making and assurance requirements.

Quarterly contract management reports and the Integrated Performance Report provide oversight of delivery, performance, quality, activity, value and escalation for underperforming commissioned services.

Strategic Commissioning Prioritisation Framework applies criteria including strategic alignment, financial sustainability, value for money, quality, outcomes, health inequalities and resource implications to support consistent and transparent commissioning decisions.

Commissioning delivery plans agreed.

QIA and EHIRAs are completed for all material commissioning decisions and service changes, with findings recorded in decision-making papers to ensure quality, safety, access and equity impacts are considered before approval.

Public engagement, outreach and Working with People and Communities insight reports provide patient, public and community intelligence to inform commissioning priorities and test whether planned changes reflect population need and experience.

Gaps in Controls or Assurances

What are the gaps to be addressed to achieve the target risk score to improve adequacy of assurance?

Spend on current commissioned services is exceeding agreed budget allocation limiting the ICB's ability to redirect resources towards higher-value priorities, transformation and prevention.

The new target operating model, model ICB Blueprint and associated cost reduction requirements are not yet fully implemented.

Capacity and capability within the ICB's data and business intelligence function remains insufficient to fully support strategic commissioning which limits the ICB's ability to use high-quality analytics to identify unwarranted variation, target interventions, assess impact, monitor delivery and provide timely assurance on whether commissioning decisions are improving outcomes and reducing inequalities.

The development of a Joint Commissioning Framework with Local Authority Partners is not yet agreed or embedded which limits the ICB's ability to align priorities, resources, decision-making and delivery across partners, particularly where outcomes depend on integrated pathways, shared responsibilities and wider determinants of health.

Assurance Mapping

Defence Line	Sources of Assurance	Q1	Q2	Q3	Q4
1st Line (management/internal controls)	5YSCP and Commissioning Delivery Plan	X	X		
	Waste Reduction Plan and programme updates 2026/27	X	X		
	Commissioning Prioritisation Framework	X	X		
	Service Change Advisory Group	X	X		
	Transformation and Finance Improvement Group	X	X		
2nd Line (corporate oversight)	Reports to ICB Board Reports to ICB Board	X	X		
	Reports to Finance and Contracting Committee	X	X		
	Reports to Commissioning Committee	X	X		
	Working with People and Communities Insight Reports	X	X		
3rd Line (independent/internal audit)					
4 th Line (external audit/regulator)	Regional Delivery & Regulatory Oversight Group (DROM)		X		

Further Actions: Additional assurance or actions to reduce likelihood/ consequence

No.	Action Needed	Lead Director	Due Date	Quarterly Update
1.	Implementation of new commissioning operating model	CEO/ Execs	Q4 26/27	Update: Refreshed Strategy, Target Operating Model and Transition Plan are in development. A critical path with delivery milestones has been established through July–November 2026.
2.	Develop a Joint Commissioning Framework with Local Authority Partners	CCO	Q4 26/27	Discussions have continued with LCC and LSCFT to support and inform the development of a joint commissioning framework.

3.	Align commissioning intentions with the 3-year clinical strategy with defined outcomes and measures to achieve.	CCO	Sep 26	UPDATE: The clinical strategy was endorsed by the board in July, and will be included within the revision of the ICB's 5YSCP as part of the 2027/28 planning guidance requirements
4.	NEW: Review of contract register, contract renewals and commissioning intentions to inform forward planning	CCO/ Head of Procurement	TBA	UPDATE: A full review of the ICB's contracts register is underway to ensure contract end dates and future procurement timetables are aligned to commissioning intentions.

BAF-002

BAF-002: Data, Intelligence and Performance Commissioning Committee | Chief Strategy and Planning Officer |

SO1	To improve population health and reduce inequalities through effective strategic commissioning.	•
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SO4	Improved financial sustainability through directing available resources to deliver the greatest possible value.	
SO5	To deliver agreed national and local outcomes through a balanced focus on performance, improvement and long-term system resilience.	

Risk Description and Impact on Strategic Objectives	
Cause (Likelihood)	If the ICB does not have access to timely, accurate and integrated data, with sufficient analytical capacity and intelligence capability
Event	Then we will be unable to generate and use robust intelligence to inform strategic commissioning, planning and performance oversight to improve our population's health
Effect (Consequence)	Resulting in: - Impaired delivery of strategic commissioning plans and priorities - Ineffective prioritisation of resources and investment-led decisions - Limited insight into quality, safety and system performance - Reduced ability to identify variation, target interventions and track progress against inequalities objectives effectively - Reduced ability to address population health needs and inequalities - Ineffective market management

Risk Scoring and Appetite

Quarter/ Score	Q1 Current	Q2	Q3	Q4	Target Score/ Date		Risk Appetite Statement	Linked ORR Risk level	
Likelihood	4	4	4	3	3	TBC	Cautious (4-10)	Low	-
Consequence	4	4	4	4	3			Med	-
Risk Score	16	16	16	12	9			High	-

Risk Update:

The Business Intelligence (BI) team has transferred from the CSU into the ICB, and a baselining exercise is underway to assess current workload, capacity and capability. Provider contract management reports have been developed for all main acute and independent sector providers, setting out activity and cost against plan. In parallel, an Integrated Performance Report Development Group has been established to identify the work required to transform reporting so that it reflects population footprints and provides clearer evidence of progress against the ICB's strategic objectives. A review of the use and effectiveness of existing dashboards and BI products has also commenced.

Key Controls:

Integrated performance reporting framework brings together performance, activity, quality, safety, inequalities and population health intelligence to support strategic commissioning and oversight.

Population health management tools and linked datasets to identify variation, inequalities, unwarranted variation and opportunities for targeted intervention.

Executive and committee-led oversight of data, intelligence and performance, with lead responsibility for digital, data and technology.

Regular provider and system performance review meetings, using newly developed contract performance packs at provider level. Risk focused review meetings with providers off plan. Review of datasets and dashboards to review delivery and associated risks and actions to monitor improvement.

Standardised dashboards and scorecards with consistent definitions, version control, trend analysis, benchmarking and clear narrative interpretation.

Business Intelligence team brought in-house.

Gaps in Controls or Assurances

What are the gaps to be addressed to achieve the target risk score to improve adequacy of assurance?

Data governance framework needs reviewing and embedding across the system with variation in ownership, standards, escalation routes and accountability.

Inconsistent data quality processes across providers and partners, leading to variation in completeness, accuracy, timeliness and reconciliation of key datasets.

Fragmented data systems and limited interoperability, restricting the ICB's ability to access joined-up activity, quality, finance, workforce, inequalities and population health intelligence.

Integrated performance reporting framework requires further expansion to include finance and workforce information, be aligned to health populations and provide trajectories for improvement and success measures.

Delays in access to validated datasets, limiting the timeliness of reporting, performance oversight and strategic decision-making.

Data-sharing arrangements and information governance protocols not consistently mature, which may restrict timely access to partner data and linked intelligence products.

Analytical capacity remains constrained, with increase in demand for insight, business intelligence, analytics and intelligence resource whilst in-housing review is undertaken.

Analytical capability is variable across the system, including differences in skills, methods, tools and ability to undertake forecasting, population health analytics, inequalities analysis and evaluation.

Prioritisation of analytical work programmes is not yet fully systematised, creating a risk that limited capacity is not consistently aligned to the highest-risk strategic commissioning and performance priorities.

Limited assurance that intelligence is consistently translated into action, including commissioning decisions, improvement plans, investment choices and performance recovery interventions.

Dashboards and reporting products not fully standardised, with variation in definitions, version control, benchmarking, narrative interpretation and use of trend analysis

Further work required to align business intelligence, analytics and intelligence resource to strategic commissioning, planning and performance priorities.

Assurance Mapping

Defence Line	Sources of Assurance	Q1	Q2	Q3	Q4
1st Line (management/internal controls)	Analytical Team Meetings	X	X		
	Provider Management Working Group	X	X		
	Provider Management Oversight Group	X	X		
	Commissioning and Contracting Assurance Meeting	X	X		
	Transformation and Finance Improvement Group	X	X		
2nd Line (corporate oversight)	Integrated Performance Reports to Board and assuring committees	X	X		
3rd Line (independent/internal audit)					
4 th Line (external audit/regulator)					

Further Actions: Additional assurance or actions to reduce likelihood/ consequence				
No.	Action Needed	Lead Director	Due Date	Quarterly Update
1	Embed system-wide data governance arrangements and consistent data quality assurance processes.	Chief Strategy and Planning Officer	Q4	TBC
2	Improve interoperability, data-sharing and access to timely validated datasets.	Chief Strategy and Planning Officer	Q4	CSU/NHSE Data and Tooling Service Review underway
3	Review and strengthen analytical capacity and capability against strategic commissioning priorities.	Chief Strategy and Planning Officer	Q3	CSU BI resource TUPE transfer 1 st July 2026, further structure review planned during Q3
4	Standardise dashboards, reporting definitions and intelligence products across the system.	Chief Strategy and Planning Officer	Q4	CSU Intelligence products and report utilisation – Draft August 2026
5	Ensure intelligence is routinely translated into commissioning, improvement and performance actions.	Chief Strategy and Planning Officer	Q3	Provider Contract Monitoring reports have been designed and are informing contract reviews.
6	Expand the Integrated Performance Report	Chief Strategy and Planning Officer	Q4	Development group established and transition plan developed, with a phased introduction of improvements.

BAF-003

BAF-003: Transition to Model ICB Blueprint

Transition and Change Committee | Chief Executive Officer | Interim Chief People Officer

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SO4	Improved financial sustainability through directing available resources to deliver the greatest possible value.	•
SO5	To deliver agreed national and local outcomes through a balanced focus on performance, improvement and long-term system resilience.	•

Risk Description and Impact on Strategic Objectives

Cause (Likelihood)	If the ICB does not have the organisational design, leadership stability, and workforce capacity and capability to support the transition to the Model ICB Blueprint, whilst delivering the nationally required reduction in the cost of commissioning.
Event	Then we may be unable to implement the new operating model safely, sustain critical capacity in key functions and operate effectively as a strategic commissioner.
Effect (Consequence)	Resulting in: - Failure to discharge statutory responsibilities - Inability to deliver improved health outcomes for the people of Lancashire and South Cumbria - Uncertainty to long term delivery of strategies and plans - Lack of capacity and capability through inability to retain necessary knowledge and skills - Reduced staff morale due to organisational change - Lack of cohesive clinical and care professional leadership - Impact on equality, diversity and inclusion in the workforce

Risk Scoring and Appetite

Quarter/ Score	Q4 25/26	Q1	Q2	Q3	Target Score/ Date		Risk Appetite Statement	Linked ORR Risk level	
Likelihood	4	4	4		3	30/10/2026	Cautious (4-10)	Low	-
Consequence	4	4	4		4			Med	-
Risk Score	16	16	16		12	31 Mar 27		High	-

Risk Update

The outcome of the staff consultation was presented to the board who approved the move to implementation stage. The final proposed structures remained close to the original consultation and broadly in line with initial financial assumptions. Additional time-limited arrangements to support transition were agreed including additional People capacity, Estates function costs, CSU TUPE-related business intelligence costs and an additional recurrent Clinical Executive post.

A People Impact Assessment (PIA) was undertaken which indicated that whilst overall workforce representation remained broadly stable, some disproportionate impacts were identified within

mapped outcomes for disabled colleagues, BME colleagues and, to a lesser extent, LGBTQ+ colleagues. This will be actively monitored with continued Executive oversight through the implementation stage.

Controls and actions to mitigate the risk continue to be managed through programme governance, Executive oversight, business continuity planning, staff engagement, People Services support, OD support, inclusive selection arrangements, redeployment processes and the Transition and Change Committee. A structured programme of support will be implemented during transition and stabilisation to help the organisation move into the new operating model and manage workforce, cultural and capability risks.

Progress towards the establishment of the Office of Pan ICB Commissioning continues. Hosting arrangements, management and infrastructure costs, additional commissioning capacity and resilience, specialist commissioning expertise, clinical leadership and finance workforce models are being considered as part of the target operating model and the TUPE transfer process being completed.

Key Controls:

The Transition and Change Committee and Executive Committee provide formal governance and oversight of responsibilities for internal transition to the model ICB, external workforce transitions including disestablishment of CSU, and establishment of the Office for Pan-ICB Commissioning (OPIC) including delivery, risks, decisions and escalation to the Board.

An OPIC Development Board has been established and is operational to support programme governance, workstream risk reporting and action tracking.

The Board report on the outcome of consultation and final proposed organisational structures provides a formal decision point for approval of the consultation outcome, final structures, associated Target Operating Model, implementation timetable and process for filling posts, redeployment and redundancy.

Programme governance, executive oversight and implementation planning are in place to manage business continuity, workforce transition, staff morale, financial exposure, delivery of statutory functions and mobilisation of the new operating model.

Business impact assessments and business continuity planning are being used to identify critical functions, capacity risks and mitigations to maintain statutory and delegated responsibilities during transition.

The Organisational Change Policy provides a consistent and legally compliant framework for consultation, pooling, slotting-in, ring-fenced selection, redeployment, equality considerations and staff support.

The consultation process has included formal consultation, directorate briefings, all-staff sessions, staff feedback routes, senior leader engagement, weekly Staff Partnership Forum discussions and ongoing trade union involvement.

The consultation outcome report and final structures demonstrate how feedback has shaped the final proposals, including changes to population commissioning, place leadership, population health, People and EDI capacity, Quality, SEND/LDA, digital/data, corporate governance and implementation processes.

Functional and professional pooling, slotting-in, ring-fenced selection and redeployment processes are designed to reduce the number of colleagues unnecessarily placed formally at risk and to maximise suitable alternative employment opportunities.

Line manager review, consistency checks, senior moderation and Filling of Posts Panel oversight, including People Services and EDI representation, provide controls over the fairness and consistency of slotting-in and related outcomes.

Inclusive Assessment and Selection During Change training, validation of slotting training, trained panels, objective scoring, advance sharing of interview questions, flexible interview options, reasonable adjustments and EDI oversight are in place to support fair and inclusive selection.

Redeployment support will include aspirational interviews, review of skills and aspirations, priority consideration for suitable alternative roles, pay protection where applicable, trial periods and reciprocal vacancy-sharing arrangements with partner ICBs across the North West.

The People Impact Assessment provides assurance on equality impacts and will continue to inform ring-fenced selection, redeployment support, reasonable adjustments, EDI oversight and further outcome monitoring.

Financial controls include tracking recurrent and time-limited structure costs, voluntary redundancy costs and savings, wider cost reduction programmes, CSU-related assumptions, OPIC and “Do Once” opportunities, and continued engagement with NHS England.

Two voluntary redundancy schemes have generated projected recurrent savings of £16.106m, with total scheme costs of £18.581m, supporting the required reduction in expenditure alongside wider cost reduction work.

The management, leadership and OD support programme for the next 12 to 18 months will support transition and stabilisation, including leadership alignment, team effectiveness, staff engagement, matrix working, strategic commissioning capability and organisational resilience.

A time-limited Strategic Estates arrangement is proposed while NHS England regional discussions continue, and the permanent strategic estates model is clarified.

Gaps in Controls or Assurances

What are the gaps to be addressed to achieve the target risk score to improve adequacy of assurance?

National and regional policy direction continues to evolve, including the final shape of regional functions, ICB responsibilities and the wider system architecture.

The permanent Strategic Estates model remains unresolved, including whether estates capabilities should be retained internally, delivered regionally or commissioned through another route.

The final implementation outcomes for slotting-in, ring-fenced selection, ring-fenced pools, appeals, redeployment and potential compulsory redundancy remain subject to validation and formal process.

The People Impact Assessment identifies disproportionate impacts for disabled and BME colleagues, and potential impact for LGBTQ+ colleagues, requiring active monitoring and mitigation through remaining selection and redeployment stages.

There remains a risk of loss of corporate memory, local relationships, professional expertise and leadership capacity during transition, particularly where colleagues leave through VR, redeployment or redundancy.

Residual capacity risk remains across some statutory and high-risk functions, including AACC, SEND, safeguarding, quality, commissioning, digital/data, population health and finance, where the operating model depends on matrix working and new ways of working.

There is a risk that matrix working, new role accountabilities and interfaces between directorates are not embedded quickly enough to maintain delivery during transition.

The short-term combined cost position is above the recurrent position due to time-limited arrangements, requiring ongoing financial control, transition planning and clear exit or review arrangements.

Further work is required to develop and embed the refreshed Strategy, Target Operating Model and Transition Plan so that structures, governance, workforce capability, digital infrastructure and operating practices are fully aligned.

The organisation will need to continue to monitor staff morale, wellbeing, retention, sickness absence, workload and engagement during the period of notice, selection, redeployment and mobilisation.

OPIC workforce risks include TUPE transfers, staff consultation requirements, staffing liabilities, vacancies and alignment of NHS England and ICB workforce processes.

Proposed arrangements for Strategic Clinical Networks remain in discussion

Assurance Mapping

Defence Line	Sources of Assurance	Q	Q	Q	Q
1st Line (management controls)	Weekly Executive Committee oversight of consultation, final structures, filling of posts, implementation timetable and financial	X	X		
	Transition Planning Programme Group oversight of business continuity, implementation workstreams and transition risks.	X	X		
	People Services implementation oversight of pooling, slotting-in, ring-fenced selection, redeployment, appeals and ESR rebuild.	X	X		
	Filling of Posts Panel with Executive, People Services, EDI and staff-side involvement.		X		
	People Impact Assessment monitoring and outcome review through implementation.	X	X		
	OD, leadership and management support programme for transition and stabilisation.	X	X		
	Business continuity planning and updated business impact assessments.	X	X		
	Financial monitoring of recurrent and time-limited structure costs, VR savings and wider cost reduction programmes.	X	X		
	Strategic Estates transitional arrangement and ongoing regional discussions.		X		
2nd Line (corporate oversight)	Reports to Transition and Change Committee including update reports on ICB Transition Planning - Service and Staffing Transition (CSU/OPIC/do once services)	X	X		
	Reports to ICB Board, including the 30 July 2026 consultation outcome and final proposed organisational structures paper.		X		
	Reports to Finance and Contracting Committee on financial implications, running cost position and cost reduction plans.	X	X		
	Reports to Commissioning Committee on governance arrangements to support transition (Specialised Commissioning and Staff Partnership Forum engagement and trade union consultation.		X		
		X	X		
	Equality, diversity and inclusion oversight of process, panels and outcomes.	X	X		
	People Impact Assessment reporting and further equality outcome reporting to Transition and Change Committee and Board.	X	X		
	Consultation outcome report and appendices, including the operating model, final structures, costings, timetable, estates proposal and People Impact Assessment.		X		
3rd Line (independent/ internal audit)	Internal audit review to be considered for organisational change governance, implementation controls or workforce transition once implementation progresses.				
	Independent review or targeted assurance of equality impacts and selection outcomes to be considered if adverse impacts emerge.				
4th Line (external audit/regulator)	NHS England engagement and oversight, including regional discussions on Strategic Estates, OPIC, commissioning support assumptions and running cost expectations.	X	X		
	External audit value for money review.				
	NHS England business case or assurance sought where applicable.				

Further Actions (Additional assurance or actions to reduce likelihood/consequence)				
No.	Action Needed	Lead Director	Due Date	Quarterly Update
1	Implement the final proposed organisational structures and associated Target Operating Model following Board approval, including publication of the consultation outcome document and final structures.	CEO / Interim CPO	From 30 July 2026	Following Board approval on the 30 July 2026 the organisation moved into formal implementation phase.
2	Complete pooling, slotting-in, validation and appeals, ensuring consistency checks, senior moderation and Filling of Posts Panel oversight.	Interim CPO	Weekly	Executive-led pooling and slotting panels will take place weekly commencing 18 August and will continue as required throughout the process
3	Issue at-risk notices where required and commence ring-fenced selection, aspirational interviews and redeployment support.	Interim CPO	From 24 August 2026	No at-risk notices will be issued before 1 September at the earliest; these will be where there has been no obvious pool identified and no at-risk notice letter will be issued before individual conversations have taken place. Ring-fenced interviews, aspirational interviews, appeals and redeployment activity will run through August to November 2026.
4	Continue equality monitoring and mitigation through the People Impact Assessment, with specific focus on disabled, BME and LGBTQ+ colleagues and further review following ring-fenced selection outcomes.	Interim CPO / Director of Inclusion	September–November 2026	PIA findings identify disproportionate impacts for disabled and BME colleagues and potential impact for LGBTQ+ colleagues. Monitoring, EDI oversight, reasonable adjustments and further outcome review will continue through implementation.
5	Deliver the management, leadership and OD support programme to support transition and stabilisation, including team effectiveness, leadership alignment, staff engagement, matrix working and strategic commissioning capability.	Interim CPO	12–18 months from August 2026	A structured programme of support will be implemented during transition and stabilisation to help the organisation move into the new operating model and manage workforce, cultural and capability risks.
6	a) Develop and implement the refreshed Strategy, Target Operating Model and Transition Plan, ensuring alignment with the Model ICB Blueprint, national priorities, consultation	Chief Strategy and Planning Officer / CEO	November 2026	The Transition Plan continues to be co-developed through collective leadership across the Executive and Senior Leadership Team; “People and Culture” has been established a distinct and explicit “pillar” within the model. This places greater

	feedback and the final structures.			emphasis on workforce, OD and culture as critical enablers of successful transformation.
	b) OPIC/Specialised Commissioning Transition Plan implementation	CCO	October 2026	Significant progress has been made following the board's deep dive review in July, particularly in relation to the governance blueprint, supporting frameworks and committee terms of reference. Work is progressing to plan with oversight through the SRO and the ICB's CEO as co-Chair of the System Development Group.
7	Monitor recurrent and time-limited financial implications, including final structure cost, interim arrangements, VR savings, wider cost reduction programmes and progress towards the required running cost position.	Chief Finance Officer	Monthly through 2026/27	Two rounds of VR have been completed. The organisation has reduced by 235 posts voluntarily at this point. A further targeted VR will be offered but only where there are more people than posts in a ring-fenced pool and/or where individuals have little or no prospects of a suitable alternative position.
8	Resolve the permanent Strategic Estates model with NHS England regional colleagues and return to Board if the permanent model changes materially or requires additional approval.	Chief Finance Officer / CEO	12–18 months, or earlier if required	A time-limited Strategic Estates arrangement is proposed while regional discussions continue. Further decisions may be required as national and regional expectations become clearer.
9	Rebuild ESR, issue new contracts following appointment to post and maintain redeployment support until implementation is complete.	Interim CPO	August–November 2026	ESR rebuild and contract issue will run alongside redeployment, job evaluation, mobilisation and implementation activity through August to November 2026.

BAF004

BAF-004: Sustainable Finances

Finance and Contracting Committee | Chief Finance Officer |

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SO5	To deliver agreed national and local outcomes through a balanced focus on performance, improvement and long-term system resilience.	

Risk Description and Impact on Strategic Objectives	
Cause (Likelihood)	Due to the continued significant financial challenges facing the ICB
Event	There is a risk that the ICB will be unable to deliver its agreed financial plan for 2026/27 and establish a recurrent, sustainable financial position over the medium term.
Effect (Consequence)	Resulting in: - Failure to achieve statutory duties - Prolonged intervention/increased risk of further regulatory actions and reputational damage. - Inability to commission effectively will prevent sustainable transformation and increased health inequalities - Reduced local discretionary decision-making impacting on delivery of local priorities and plans. - Inability to achieve value for money - Investment opportunities will be lost which will impact on delivery of our organisational strategies and plans

Risk Scoring and Appetite

Delivery of Financial Plan for 2026/27

Quarter/ Score	Q4 25/26	Q1	Q2	Q3	Target Score/ Date		Risk Appetite Statement	Linked ORR Risk level/ No.	
Likelihood	2	4	4		2	March 2029	Cautious (4-10)	Low	-
Consequence	5	5	5		5			Med	-
Risk Score	10	20	20		10			High	-

Establishing a recurrent, sustainable financial position over the medium term

Bi-Annual Score	H2 2027	H1 2028	H2 2028	H1 2029	Target Score/ Date		Risk Appetite Statement	Linked ORR Risk level/ No.	
Likelihood	4	3	3	2	2	March 2029	Cautious (4-10)	Low	-
Consequence	5	5	5	5	5			Med	-
Risk Score	20	15	15	10	10			High	-

Risk Update

The risk was reviewed and the description broadened to move beyond a single-year financial plan delivery risk and capture the underlying financial position over the medium term. Further work was undertaken during Q2 to refine the risk position, including development of mitigations such as the financial strategy, prevention initiatives and demand management approaches alongside in-year recovery plan activity.

AACC: At M3 delivery against the AACC plan was showing break-even however, service demand and operational capacity constraints due to Voluntary Redundancy (VR) and staff sickness absence continued to be closely monitored, to identify any potential impact on the ICB's in-year financial performance. Financial risks associated with increasing overdue reviews across Continuing Health Care, Fast Track and Funded Nursing Care pathways continue to be managed. Furthermore, the delay in procurement of a Framework for Care Homes continued to impact unit cost.

The year-to-date financial position held between M3 and M4, but significant risk remains to delivery of the planned position by the end of the year. Key priorities are to de-risk the required elements of the mitigations e.g. the £215m plan and continue to deliver and implement the remaining elements medium/high-risk WRP schemes. It is likely that the ICB will need to secure additional mitigations to offset some recognised shortfalls in year WRP and will need to manage any operational pressures and identify alternative mitigations.

Key pressures within the year-to-date position include some aspects of mental health and learning disabilities expenditure, community services (weight management and prescribing), alongside adverse pressure against reserves given updates that have been required to the original plan assumptions. Further work continues to assess all areas of ICB expenditure including NHS contract performance, and delivery of original activity assumptions. The mitigations regarding cost-of-commissioning/organisational structure adjustment remain under validation given relative progress of implementing organisational change and other related issues such as commissioning support unit transfers.

Key Controls:

ICB's three-year financial plan, annual budget and operational plan approved.

Annual budget allocation agreed and accepted with lead officers; budget holder meetings held to monitor accountability, delivery and recovery actions against plan.

Financial Improvement Programme 2026/27 established with identified schemes, trajectories and delivery milestones and regular monitoring of delivery.

System Delivery Meetings continue to operate led by NHS England to oversee delivery of the financial plan and recovery trajectory.

Waste Reduction Programme (WRP) for 2026/27 fully identified with implementation plans commencing in April 2026.

Regular updates to Finance and Contracting Committee and weekly oversight through the Transformation and Financial Improvement Group (TFIG)

ICB Standing Financial Instructions/Scheme of Reservation and Delegation remain in place to support financial governance, decision-making and control.

Oversight through Finance and Contracting Committee and Board including the review of financial performance, delivery risks and mitigations.

Commissioning Resource Group (CRG) in place to support prioritisation of investment decisions.

Regular reporting of risk-adjusted position, forecast outturn and run-rate to Finance and Contracting Committee to support early identification and escalation of emerging financial pressures.

Senior improvement support secured to support deliver WRP 26/27 and strengthen financial recovery arrangements.

Monthly run rate reviews and expenditure deep dives through TFIG to monitor cost drivers, identify adverse variance and support corrective actions.

Monthly integrated contract meetings support oversight of commissioned activity, contractual performance and financial pressures within commissioned services.

AACC:

Monthly AACC Dashboard reporting to Finance and Contracting Committee to monitor cost against plan, and seek assurance on mitigations for any adverse activity and spend

Waste Reduction Programme Schemes 2026/27 identified monitored through a weekly programme meeting and weekly Delivery Unit meeting

Regular activity and expenditure deep dives through TFIG to monitor cost drivers, identify adverse variance and support corrective actions.

AACC Improvement Board fortnightly to scrutinise delivery and risk mitigation.

Monthly Finance Meetings to monitor delivery against plan and early identification/escalation of variance.

Gaps in Controls or Assurances

What are the gaps to be addressed to achieve the target risk score to improve adequacy of assurance?

If delivery of planned position is met by non-recurrent means this will impact on underlying position within future financial reporting periods.

Strategic commissioning operating model not fully established

Monthly integrated contract meetings still require development

Gaps in business intelligence support reduce early identification of adverse variance

Cost of commissioned services/contract activity higher than planned/budgeted levels

Delivery of the AACC Improvement Plan continues to be monitored

Risks remain within WRP plans; non-recurrent mitigation risks underlying financial sustainability

Cost of Commissioning shortfall to be addressed

Outstanding contract issues to be resolved.

AACC:

The ICB continues to see sustained demand levels for AACC above national benchmarks.

Workforce capacity constraints due to VR and staff sickness absence affecting assessments and review timeliness.

Assurance Mapping

Defence Line	Sources of Assurance	Q1	Q2	Q3	Q4
1st Line (management/internal controls)	Waste Reduction Programme Schemes	X	X		
	Discretionary Spend Panel	X	X		
	Transformation and Financial Improvement Group (TFIG) Reporting	X	X		
	Budget holder meetings	X	X		
2nd Line (corporate oversight)	Finance and Contracting Committee Reporting	X	X		
	ICB Board reporting	X	X		
	Executive Committee reporting	X	X		
3rd Line (independent/internal audit)	2026/27 MIAA/Internal Audit reviews: Key Financial Processing Controls (Q2/Q3)	-			
	Waste Reduction Programme (Q3)	-	-		

4th Line (external audit/regulator)	NHE England System Delivery Meetings (SDM)	X	X		
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AACC Assurance Mapping					
1st Line	Improvement Plan Reporting	X	X		
2nd Line	Funding Approval Panels held daily for funding approval	X	X		
3rd Line	All Age Continuing Care Internal Audit (Q4)	-	-		
4th Line	NHS England North-West AACC Recovery Oversight Meetings	X	X		

Further Actions (Additional assurance or actions to reduce likelihood/ consequence)				
No.	Action Needed	Lead Director	Due Date	Quarterly Update
1.	Full identification and delivery of WRP programme 2026/27	Exec Team	Ongoing	From September the format of TGIF will move to a more focused approach with deep dives to enable a greater focus on specific programmes.
2.	Financial Governance 2026/27	CFO	Q1 26/27	Two recommendations due in May still to be followed up. Actions to address audit findings in relation to efficacy of financial governance controls have been agreed and will be monitored through audit reporting follow up.
3.	Structured deep dive review of expenditure across all ICB areas	CFO	End of Q2 June 26	Expenditure analysis has been undertaken across demand management, coding and counting reviews. Initial findings have indicated that further work is required, and this is anticipated to be completed by the end of September 2026.
AACC Actions				
4.a	MIAA commissioned for 6-month period to undertake reviews and subsequent MDTs	Rakhee Jethwa	Dec 26	MIAA workstream scope to be extended to cover shortfall of activity from NHSP scheme (limitations due to recruitment issues).
4.b	NEW: External provider assistance consideration to support capacity constraints and delivery of statutory duties for H2 26/27	Rakee Jethwa	End of Sep 26	Options appraisal and report in development.
5.	Procurement Framework for Nursing Homes	Rakhee Jethwa	End Q2 Q3/Q4	Three associated workstreams: 1. Joint Framework with LAs on ICB footprint for Residential and Nursing Care. Initial meeting 14.07.26. Turnaround timeframes scheduled for completion by end of Q2 but delayed due to holiday season therefore likely to extend into Q3/Q4.

				2. NW Regional Framework Development – currently being explored. First workshop held on 17.07.26. Scope currently under development. 3. ICB led procurement may be explored to cover any gaps in the above. This is currently paused.
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BAF-005

BAF-005: Achieving transformation through effective partnerships and collaborative working Commissioning Committee | Chief Strategy and Planning Officer

SO1	To improve population health and reduce inequalities through effective strategic commissioning.	●
SO2	Commission high quality, safe and accessible services that deliver better and more equitable outcomes and patient experience.	●
SO3	To develop and sustain the workforce, leadership and organisational capability required to operate as an effective strategic commissioner.	
SO4	Improved financial sustainability through directing available resources to deliver the greatest possible value.	●
SO5	To deliver agreed national and local outcomes through a balanced focus on performance, improvement and long-term system resilience.	●

Risk Description and Impact on Strategic Objectives	
Cause (Likelihood)	If the ICB does not develop and maintain effective partnership and collaborative arrangements and implement an effective governance structure for partnership working
Event	Then collaborative working and shared decision making may not be enabled, and we will fail to achieve the transformation required to deliver improved health outcomes for our local population
Effect (Consequence)	Resulting in: - Continued inequalities in access and outcomes - Unaffordable cost of health care - unwarranted variation in service provision - worsened quality of service experienced. - Duplication and unnecessary bureaucracy - Reputational damage and poor relationships

Risk Scoring and Appetite								
Quarter/ Score	Q4 25/26	Q1	Q2	Q3	Target Score/ Date		Risk Appetite Statement	Linked ORR Risk level
Likelihood	3	3			2	31 Mar 27	Cautious (4-10)	Low -
Consequence	4	4			4			Med -
Risk Score	12	12			8			High -

Risk Update
Engagement sessions with local members of parliament in Lancashire and South Cumbria continued, with a focus on commissioning plan updates, delivery priorities for the coming 12 months and updates on communication and resident engagement.
The ICB hosted a System Leadership Day (3 July) with representation from senior health and care leaders across LSC including NHS, local government, VCFSE and university partners. The aim of the session was to discuss how the system can work together effectively for the benefit of our residents, communities and workforce. Key themes from the sessions have been shared and a commitment

made to enhancing existing partnership forums/governance, relationship building, sharing good practice more systematically.

Dr Claire Fuller, NHS England's Primary Care Medical Director visited Lancashire and South Cumbria as part of an open and developmental conversation to help us progress neighbourhood health plans. The visit included local authority partners, members of the VCFSE, trusts, primary care and colleagues from our Place teams and provided a positive platform for neighbourhood health and how it can transform care closer to home.

A facilitated development session was held with the ICB Board to further understand and consider the role of the ICB and its partners in shaping the approach to Neighbourhood Health; the discussion included consideration of the implications of local government change, the wider operating environment, and how Place and partners can work together to support delivery.

A refresh of the ICB's strategy, target operating model and transition plan as described in "*Our Strategic Next Steps: Strategy Refresh, Target Operating Model and Transition Plan*" is progressing, with a programme of workshops and engagement sessions planned throughout July and August. The ICB's strategy refresh and transition to the new ICB operating model presents opportunities to ensure emerging national and regional priorities are reflected and there is alignment of strategic priorities across partners and stakeholders.

Key Controls:

Board and leadership development programmes strengthen the capability and behaviours required for effective system leadership and collaborative decision-making.

Defined executive portfolios, including the Chief Strategy and Planning Officer role, provide clear accountability for strategy, partnership working and system planning.

Place-based partnership arrangements bring together the ICB, local authorities, primary care and VCFSE partners to agree local priorities, coordinate delivery and escalate shared risks

Integrated Care Strategy provides a shared framework for improving population health, reducing inequalities and coordinating system transformation.

Cross-sector membership of the Board and committees supports partner challenge, shared perspectives and informed decision-making.

Provider Collaborative Board participation supports alignment of provider plans, management of dependencies and coordinated delivery.

Regular Chair and system-leader meetings maintain strategic relationships, resolve emerging issues and support collective leadership.

The Service Change Policy establishes a consistent governance process for assessing, approving and assuring significant service change.

The Service Change Advisory Group provides multidisciplinary scrutiny of proposals, risks, impacts and statutory requirements.

Planning Oversight Board

System Planning Group

Health and Wellbeing Boards align NHS and local authority priorities for population health, inequalities and neighbourhood delivery.

Governance Forward Plan

VCFSE Alliance/Partnership Agreement and Joint Work Plan

Strengthened sectorial membership on ICB Board

Gaps in Controls or Assurances

What are the gaps to be addressed to achieve the target risk score to improve adequacy of assurance?

The implementation of an agreed cross-system governance structure to strengthen decision-making and agree system joint vision, aims and priorities.

Timescales for finalisation of key plans (Clinical Strategy, Health and Wellbeing Board-led Neighbourhood Plans and Medium-Term Plan).

Impact of national policy change including progress with model ICB Blueprint to achieve running and programme cost reductions.

Impact of ongoing organisational change processes on workforce capacity/capability.

ICB's position in NOF4 and requirements to meet 2026/27 financial plan.

Assurance Mapping					
Defence Line	Sources of Assurance	Q1	Q2	Q3	Q4
1st Line (management/internal controls)	Single Improvement Plan	X	X		
	Place Based Partnership Arrangements	X	X		
	Governance and Leadership Action Plan	X	X		
2nd Line (corporate oversight)	ICB Board Reports	X	X		
	Service Change Advisory Group Reports		X		
	Provider Collaborative Board	X	X		
	System Planning Group (weekly)	X	X		
	Planning Oversight Board supports coordination of strategy development, planning and engagement activity.	X	X		
	Working with People and Communities Insight Report	X	X		
3rd Line (independent/internal audit)	Participation from cross-sector partners	X	X		
4th Line (external audit/regulator)					

Further Actions (Additional assurance or actions to reduce likelihood/ consequence)				
No.	Action Needed	Lead Director	Due Date	Quarterly Update
1.	To increase visibility, learning and insights from programme of board visits across Place and partners.	Chair/CEO	On-going	UPDATE: Regular partnership meetings with local MPs have continued, with discussions covering the ICB's five-year strategic plan, neighbourhood health centres and progress in moving towards our target operating model.
2.	To lead and convene system partnership and stakeholder collaboration arrangements through agreed governance arrangements.	Chair/CEO/ DoCG	On-going	Governance arrangements established through the Planning Oversight Board (POB), which coordinates strategy development, planning and engagement activity. The ICBs Executive Committee is appraised of operational delivery, progress and risks/mitigations via the POB

3.	New: To ensure there is clear alignment and connection between strategic planning, partnership working and transition governance.	Chief of Strategy and Planning	UPDATE: In July the ExCo endorsed the proposals set out in “Our Strategic Next Steps: Strategy Refresh, Target Operating Model and Transition Plan”. The strategy refresh will provide an opportunity to respond to evolving national and regional policy direction and sharpen focus on the collective priorities of Lancashire and South Cumbria. A series of engagement sessions are scheduled through July-August to support broader engagement with our communities, partners, and staff to ensure our strategic priorities are understood, aligned and owned across the system
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BAF-006

BAF-006: Quality, regulation and compliance

Quality and Outcomes Committee | Chief Nurse | Medical Director

SO1	To improve population health and reduce inequalities through effective strategic commissioning.	●
SO2	Commission high quality, safe and accessible services that deliver better and more equitable outcomes and patient experience.	●
SO3	To develop and sustain the workforce, leadership and organisational capability required to operate as an effective strategic commissioner.	
SO4	Improved financial sustainability through directing available resources to deliver the greatest possible value.	
SO5	To deliver agreed national and local outcomes through a balanced focus on performance, improvement and long-term system resilience.	

Risk Description and Impact on Strategic Objectives

Cause (Likelihood)	If the ICB does not have a robust framework to effectively monitor and identify quality issues and have effective mechanisms in place for early identification and escalation (e.g. contract monitoring, or clinical governance frameworks)
Event	Then we may not effectively recognise and respond to fundamental quality and regulatory standards in local care provision, and our duty of continued quality improvement
Effect (Consequence)	Resulting in: - Negative Impact on patient safety and health outcomes for local people and communities. - Poor patient experience - Continued unwarranted variation in service provision - Continued inequalities in access and outcomes - Health inequalities - Reputational damage

Risk Scoring and Appetite

Quarter/ Score	Q4 25/26	Q1	Q2	Q3	Target Score/ Date	Risk Appetite Statement	Linked ORR/Risk Level
Likelihood	3	3	3		3-2	Cautious (4-10)	Low -
Consequence	4	4	4		4		Med -
Risk Score	12	12	12		12-8		High Y

Risk Update

The national quality landscape has evolved significantly during the reporting period with the publication of the NHS Quality Strategy in July 2026, the establishment of a strengthened National Quality Board, emerging expectations arising from the Dash Review, and increasing clarity regarding the future roles of NHS England regions and Integrated Care Boards within the strategic commissioning model.

Further to the Dash Review, which highlighted that the NHS quality and patient safety landscape had become fragmented, overly focused on assurance, and insufficiently focused on outcomes, the recommendations are now being embedded through the NHS Quality Strategy, with an increased emphasis on quality as the organising principle of NHS care, clearer accountability, streamlined

oversight, stronger leadership, and the use of data to improve safety, effectiveness, experience, and population outcomes. In response, the ICB is working with region, partners and cross-directorates to ensure a connected and inclusive review of its current ICB Quality oversight framework. A new Integrated Impact Assessment (IIA) template has been implemented which provides a single, streamlined process to consider the impacts of proposal, service change, policies and programmes across quality, equality, health inequalities, inclusion health and human rights. Guidance materials and staff training has been provided and further development of digital tools to support and enhance the use of the assessment continue to be progressed.

Key Controls:

The ICB's Clinical Strategy (2026-2031) provides clinical direction and rationale for commissioning and service priorities and decisions. Ensuring that resources are focused on improving outcomes, quality, safety and population health

The ICB's Quality Governance Framework provides escalation and assurance across totality of ICB business including provider performance to Board.

The Quality and Outcomes Committee provides assurance and escalation reports to the ICB Board.

The Clinical Effectiveness Group identifies clinical risks, variation and improvement needs.

QIAs and EHIRAs assess quality, safety and inequalities impacts of service changes.

PSIRF supports incident oversight, learning and improvement.

Quality Contract Reviews monitor provider quality and performance.

System and Regional Quality Groups identify, escalate and manage quality risks.

ICS Shared Learning Group promotes learning and reduces repeat harm.

SEND Partnership Board oversees SEND quality, access and improvement across the system.

Gaps in Controls or Assurances

What are the gaps to be addressed to achieve the target risk score to improve adequacy of assurance?

Primary care quality oversight remains challenged by capacity constraints affecting both reactive and proactive assurance.

SEND demand and pathway fragmentation continue to drive long waits and require stronger joint commissioning and oversight.

Quality intelligence triangulation needs further maturity across performance, safety, complaints, CQC, inequalities and soft intelligence.

Provider improvement is inconsistent, with some organisations requiring clearer improvement plans, metrics and delivery trajectories.

Waste Reduction Programmes require stronger ongoing assurance that quality, safety and inequalities impacts continue to be monitored after initial approval.

Operational pressures in elective care, diagnostics, cancer services, primary care and community services continue to present quality and patient experience risks.

ICB operating model changes require testing to ensure quality governance, accountability, escalation and assurance arrangements remain effective as the ICB transitions to a strategic commissioner role.

Assurance Mapping

Defence Line	Sources of Assurance	Q1	Q2	Q3	Q4
1st Line (management controls)	Primary Care Quality Group	X	X		
	SEND and CYP Reports to Quality and Outcomes Committee	X	X		
	Clinical Effectiveness Group		X		
	Primary Care Contracting Sub-Committee	X	X		

	ICB 3 Year Safeguarding Strategy/Safeguarding Dashboard/Annual Reports	X	X		
	National Quality Board Self-Assessment	X			
	Provider Quality Accounts (2024/25)				
	Provider Safety Incident Response Framework (PSIRF) Policy and Plan Updates	X	X		
	Provider Quality Accounts (2025/26)		X		
2nd Line (corporate oversight)	Quality and Outcomes Committee – assurance reports	X	X		
	Committee escalation reports to ICB Board	X	X		
3rd Line (independent/internal audit)	Internal audit reviews				
	Quality Impact Assessments (moderate assurance) Internal SEND Audit (moderate assurance)				
	System Quality Group	X	X		
	Regional Quality Group	X	X		
	NHS England assurance on quality systems				
4th Line (external audit/regulator)	Provider Regional Oversight Meetings (PROM)		X		
	CQC and OFSTED reports CQC reports published for trusts and primary care providers		X		

Further Actions (Additional assurance or actions to reduce likelihood/ consequence)				
No.	Action Needed	Lead Director	Due Date	Quarterly Update
1.	Development of mechanisms to provide assurance that risk to quality and patient safety through the delivery of WRP's is considered and any mitigations are clear.	CNO/MD	Completed.	UPDATE: A new Integrated Impact Assessment (IIA) template and supporting guidance has been developed and provides a single, streamlined process to consider the impacts of proposal, service change, policies and programmes across quality, equality, health inequalities, inclusion health and human rights
2.	SEND demand and pathway management	CNO	Ongoing	Draft service specification is reaching maturity; the DfE/DHSC SEND reforms bring a requirement for joint commissioning with local authorities and that is currently in the planning phase.
3.	Ongoing demand creating pressure on services with a quality impact identified through tier 1 meetings, complaints, soft intelligence.	CNO	Ongoing	Feedback to commissioners to liaise with providers for patient communication and mitigating risks. Use of triangulated information to confirm impact and harm levels. Urgent and Emergency Care winter assurance site visits have taken place and noted any harms as well as risk of harms arising from pressure on that part of the system. Visits included patient feedback.

4.	Maturation of quality and data intelligence triangulation.	CNO	Ongoing	Maturation constrained by workforce capacity and to a lesser degree information systems. However, there is some evidence of triangulation examples in primary care and trusts prior to quality assurance visits.
5.	Quality Governance Framework Review	CNO	End of Q3	The framework will be reviewed against the ICB's new operating model and strategy refresh, the national quality strategy and regional blueprint.
6.	NEW: Full implementation of PROM governance arrangements with region and provider reflective of the ICB's quality oversight framework.	CNO	Ongoing	Full refresh and review of the ICB's quality oversight framework following the publication of the national quality strategy.

BAF -007

BAF007- Responsive and Resilient Health Care Services Quality and Outcomes Committee | Exec Lead Medical Director and Chief Nurse|

SO1	To improve population health and reduce inequalities through effective strategic commissioning.	•
SO2	Commission high quality, safe and accessible services that deliver better and more equitable outcomes and patient experience.	•
SO3	To develop and sustain the workforce, leadership and organisational capability required to operate as an effective strategic commissioner.	
SO4	Improved financial sustainability through directing available resources to deliver the greatest possible value.	•
SO5	To deliver agreed national and local outcomes through a balanced focus on performance, improvement and long-term system resilience.	•

Risk Description and Impact on Strategic Objectives	
Cause (Likelihood)	If the ICB does not commission clinically appropriate responsive and resilient health care services, aligned to the ICB's clinical strategy
Event	We will not improve access, clinical outcomes and patient safety, and stabilise fragile services
Effect (Consequence)	- Inability to reduce health inequalities - Emerging harm and risks to patient safety as a result of long waits in A&E departments, further impacted by delays in ambulance handovers. - Recovery and operational performance targets not being achieved - Provision of sub-optimal service leading to poor patient experience and outcomes - Reputational damage and higher levels of intervention from NHS England - Financial impact on unfunded activity against contracts

Risk Scoring and Appetite

Quarter/ Score	Q4 25/26	Q1	Q2	Q3	Target Score/ Date		Risk Appetite Statement	Linked ORR Risk level	
Likelihood	4	4	4		3	30 Jun 26 31 Mar 27	Cautious (4-10)	Low	-
Consequence	4	4	4		4			Med	-
Risk Score	16	16	16		12			High	-

Risk Update

A pre-consultation business for the Vascular Reconfiguration Programme, in line with the Major Clinical Service Change process, was endorsed by the Commissioning Committee. The ICB's Communication and Engagement Strategy and associated delivery plan was also endorsed which will support delivery of the ICB's 5-Year Commissioning plan. A Local Enhanced Service (LES) 2026/27 programme delivery update for April and May provided assurance of participation agreements for LSC practices and reductions on non-elective admissions associated with the Long-Term Conditions LES. This supported the aim of shifting care closer to home and reduce reliance on acute services. Further work to ensure patient and public engagement is reflected within future updates was supported, alongside acknowledgement of the challenges
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regarding availability of performance data and the work that was underway to strengthen the ICB's approach to data quality and assurance, including clearer distinctions between data sourcing, validation and analytical capacity issues.

Work to review and refresh the Urgent and Emergency Care Strategy 2026/27 was reported with an update on winter planning arrangements presented to the Commissioning Committee. The annual winter plan submission will be coordinated across ICB teams and providers to ensure provider-plan alignment. A winter exercise is scheduled for 18 September, to support system stress-testing prior to formal board approval and submission.

Key Controls:

The Board-approved Five-Year Strategic Commissioning Plan, Medium Term Plan, 2026/27 Commissioning Intentions, and Operating Model set the framework for commissioning decisions, aligning priorities and resources to population need, health inequalities, quality, access, service resilience and financial sustainability.

The ICB Clinical Strategy 2026–2031 provides the clinical rationale for commissioning and service priorities, directing resources towards interventions that improve outcomes, quality, safety and population health.

Delivery of the 2026/27 Commissioning Intentions is monitored quarterly by the Commissioning Committee against agreed milestones and outcomes, enabling slippage or underperformance to be identified, escalated and addressed.

Public, patient and stakeholder insight is used to shape commissioning decisions and service change proposals, helping services reflect lived experience, improve accessibility and avoid widening inequalities.

Primary Care Federations work collectively as a Confederation to coordinate provision at scale, share capacity and strengthen primary care resilience, reducing variation and the risk of service disruption.

The Integrated Strategic Needs Assessment provides population health and inequalities intelligence to inform prioritisation and targeted interventions, reducing the risk that commissioning decisions fail to address evidenced local need.

The Local Enhanced Services Commissioning Plan commissions targeted primary care services against identified local need, improving access and reducing unwarranted variation in provision and outcomes.

Neighbourhood Health arrangements support proactive, integrated care closer to home, improving access and reducing avoidable demand on urgent and acute services.

Clinical Commissioning Policies apply consistent, evidence-based criteria to treatment and access decisions, supporting clinical appropriateness, equity and effective use of resources.

The UEC Five-Year Strategy 2024–2029 sets the system approach to preventing avoidable demand, improving flow and strengthening urgent and emergency care capacity and resilience.

Local UEC Delivery Boards monitor delivery of provider improvement and capacity plans against agreed performance measures, escalating variance through system oversight arrangements to support timely intervention and reduce risks arising from demand, flow pressures and ambulance handover delays.

The Strategic Ambulance Improvement Group monitors ambulance handover performance and coordinates improvement action, reducing delays and associated risks to patient safety, flow and ambulance availability.

The Strategic System Oversight Board for UEC and Flow reviews whole-system performance and improvement action, escalates material variation and supports coordinated intervention and shared learning across partners.

The ICB's Quality Assurance and Quality Governance Frameworks support routine surveillance and proactive identification escalation, and management of emerging quality and patient safety concerns

Winter plans are reviewed through the Executive Committee, Commissioning Committee and ICB Board, providing oversight of capacity, resilience, quality, finance and delivery risks and enabling escalation where plans are insufficient.

Quality and patient safety impacts arising from delivery of WRP measures are assessed, with required mitigations identified and overseen by the Quality and Outcomes Committee to reduce the risk of unintended harm.

The Integrated Performance Report brings together performance, quality and health equity measures, enabling committees to identify deterioration, variation and emerging risks and to seek corrective action.

Service Change Policy and Service Change Advisory Group established with QIA/EHIRA undertaken to mitigate risks that service reconfiguration or commissioning decisions inadvertently worsen quality, safety, access or inequalities.

The Primary Care Quality Sub-Committee undertakes routine surveillance using the quality governance frameworks, escalating emerging concerns and overseeing action to reduce risks to quality, safety and continuity of primary care services.

Gaps in Controls or Assurances

What are the gaps to be addressed to achieve the target risk score to improve adequacy of assurance?

Service change plans do not consistently define consultation requirements, ownership, timescales or success measures, limiting assurance on lawful and equitable delivery.

Demand for urgent, emergency and mental health services remains high

UEC performance remains below agreed standards, indicating that capacity, flow and improvement controls are not yet consistently effective.

Elective recovery performance remains below plan increasing the risk of long waits, poorer experience and patient harm.

Limited availability of primary care activity data and limitations in analytical and reporting capacity

Assurance Mapping

Defence Line		Q1	Q2	Q3	Q4
1st Line (management/internal controls)	Director of system coordination and flow	X	X		
	System Coordination Centre (SCC) – oversight of operational responses	X	X		
	Contract meetings	X	X		
	UEC Delivery Boards aligned to acute trust footprints	X	X		
	LES Oversight Group	X	X		
	Primary Care Sub-Contracting Group	X	X		
	Primary Care Quality Sub-Committee	X	X		
2nd Line (corporate oversight)	Quality and Outcomes Committee, Finance and Contracting Committee Reporting, Commissioning Committee	X	X		
	ICB Board Reporting	X	X		
	Strategic System Oversight Board for UEC and Flow	X			
3rd Line (independent/internal audit)	System level engagement on clinical strategy development (complete)	X			
	MIAA QIA review 25/26 (moderate assurance)				
	Shared learning and discussions through Strategic System Improvement Group – UEC and Flow	X			

4th Line (external audit/regulator)	Provider Regional Oversight Meetings (PROM)		X		
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Further Actions

(Additional assurance or actions to reduce likelihood/ consequence)

No.	Action Needed	Lead Director	Due Date	Quarterly Update
1.	Develop a 3-year Clinical Strategy, with defined outcomes and measures co-produced by system stakeholders and clinical professionals.	MD/CNO	Completed	The ICB's clinical strategy was endorsed by the board in July 2026 and will be incorporated into the next refresh of the Five-Year Strategic Commissioning Plan.
2.	NEW: Urgent and Emergency Care 5-Year Strategy Refresh	Wendy Lewis	30 Sep 26	UPDATE: The review of the UEC strategy is due to conclude in September; this is to reflect the publication of the 10 Year Health Plan and structural changes across NHS England and ICBs.
3.	NEW: Development of Winter Plans and Board Assurance Statements	Wendy Lewis	Oct 26	UPDATE: A North West Winter Planning Exercise is scheduled for 18 September with the board sign-off of the Assurance Statement scheduled for October 2026
4.	Development of mechanisms to provide assurance that risk to quality and patient safety through the delivery of WRP's is considered and any mitigations are clear (Links to BAF-006 actions)	CNO/MD	Completed	UPDATE: A new Integrated Impact Assessment (IIA) template and supporting guidance has been developed and provides a single, streamlined process to consider the impacts of proposal, service change, policies and programmes across quality, equality, health inequalities, inclusion health and human rights.