NHS
Lancashire and South Cumbria
Integrated Care Board

Subject to approval

# Minutes of the NHS Lancashire and South Cumbria Integrated Care Board Annual General Meeting and Presentation of Annual Report and Accounts 1 April 2025 - 31 March 2026

## Thursday, 17 September 2026 at 4.30 pm - 6.00 pm in Lune Meeting Room, ICB Offices, Level 3 Christchurch Precinct, County Hall, Preston PR1 8XB

| | Name | Job Title |
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| **Members** | Emma Woollett | ICB Chair ***(Chair)*** |
| | Debbie Corcoran | Non-Executive Member |
| | Steve Spill | Non-Executive Member |
| | Aaron Cummins | Chief Executive |
| | Mark Bakewell | Chief Finance Officer |
| | Craig Harris | Chief Commissioning Officer |
| | Jane Scattergood | Interim Chief Nurse |
| | Andy Knox | Co-Medical Director |
| | Alex Heritage | Chief Strategy and Planning Officer |
| | Neil Jack | Partner Member – Local Authorities |
| | Tracy Hopkins | Partner Member – Voluntary, Community, Faith and Social Enterprise (VCFSE) Sector |
| | Dr Julie Colclough | Partner Member – Primary Care |
| **In attendance** | Neil Greaves | Director of Communications and Engagement |
| | Debbie Herring | Interim Chief People Officer |
| | Debra Atkinson | Company Secretary/Director of Corporate Business |
| | Sarah Mattocks | Head of Governance |
| | Sandra Lishman (minutes) | Committee and Governance Officer |
| | Other members of staff and members of the public attended | |

| Item | Note |
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| **1.** | **<u>Chair's Welcome and Opening Remarks</u>**<br><br>The Chair, E Woollett, welcomed all and advised that the meeting was a reflection of the last year, 2025/26.<br><br>The Chair introduced the panel and advised those present of the order of business. |
| **2.** | **<u>Apologies for Absence</u>**<br><br>Apologies for absence had been received from Evelyn Asante-Mensah, Steve Igoe, |

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| | Gareth Thomas, Jane O'Brien, Tracey Bleakley, Cath Whalley, Andy Curran and Silas Nicholls. |
| **3.** | **<u>Declarations of Interest</u>**<br><br>It was noted that if any declarations arose during the meeting, they should be highlighted for inclusion in the minutes.<br><br>**RESOLVED: That there were no declarations of interest made.** |
| **4.** | **<u>Minutes of Previous Meeting</u>**<br><br>The minutes of the previous Annual General Meeting had been approved at the subsequent ICB Board meeting on 27 November 2025 and would also be shared on the ICB website with the approved annual report and accounts for 2025/26 following this meeting. |
| **5.** | **<u>Achievements and Challenges 2025/26 and Forward View</u>**<br><br>A Cummins, ICB Chief Executive, spoke to a presentation providing an overview of the work undertaken by the Integrated Care Board (ICB) and its partners during 2025/26, together with future priorities and plans.<br><br>Members heard that the ICB commissioned health services for approximately 1.8 million residents across Lancashire and South Cumbria and remained focused on improving population health, reducing health inequalities, ensuring access to high-quality services and supporting wider social and economic wellbeing.<br><br>A Cummins highlighted a number of achievements during the year, including Referral to Treatment performance exceeding the national average, significant improvements in cancer awareness and screening programmes, achievement of a bronze award for the northwest anti-racist framework, increased GP appointment activity, continued development of neighbourhood-based models of care and the success of the Working Well pilot programme, which had supported more than 3,000 people to return to work.<br><br>Attendees noted the update provided regarding the annual assessment of the ICB's performance in which NHS England had identified strengths in urgent and emergency care, planned care, strengthened governance and improved maturity in approaches to population health management. The ICB had achieved its statutory financial duties, and the system had improved its financial position over the preceding 12 months. Areas for further improvement included cancer performance, diagnostic services, financial sustainability and driving greater impact from population health approaches.<br><br>The meeting heard that the ICB was undergoing significant organisational change in response to national policy developments and a required 40% reduction in running costs. Approximately 90% of the restructuring programme had been completed and a new operating model was being developed to support the organisation's future role as a strategic commissioner.<br><br>Looking ahead, A Cummins outlined plans to strengthen the use of population health data, develop longer-term commissioning approaches, work more closely with communities and voluntary sector organisations, and align future arrangements with emerging local government structures. Future priorities would focus on prevention, reducing health inequalities, neighbourhood care and improving core services, including a specific focus on mental health, learning disability and autism services.<br><br>In concluding, A Cummins reaffirmed the organisation's commitment to openness, public |

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| | involvement and accountability as part of its future way of working.<br><br>**RESOLVED: That the presentation be noted.** |
| **6.** | **<u>Presentation of the Lancashire and South Cumbria Integrated Care Board Annual accounts</u>**<br><br>M Bakewell, Chief Finance Officer, presented the ICB's financial position for 2025/26 and advised that the Annual Accounts and associated financial information were available on the ICB website. He thanked colleagues across the organisation for their contribution to delivering the year-end financial position.<br><br>The meeting heard that the ICB was required to operate within its financial allocations for healthcare services, running costs and capital expenditure. Members noted that all financial requirements had been achieved during the year and that the ICB had delivered a technical surplus of just under £9.7 million.<br><br>Members also noted that the ICB had achieved the national Better Payment Practice standards, ensuring that suppliers were paid within the required timescales.<br><br>M Bakewell explained that the majority of the ICB's expenditure was invested in healthcare services, including contracts with NHS providers, primary care services, prescribing, continuing healthcare, mental health and learning disability packages of care, and additional acute sector capacity. He stated his intention to provide greater information at future Board meetings held in public regarding how resources were allocated and spent across the health and care system.<br><br>**RESOLVED: That the presentation be noted.** |
| **7.** | **<u>Public Questions</u>**<br><br>The following questions were raised at the meeting:<br><br>**Q1**: ***From member of the public***<br>**How was the ICB monitoring and improving quality of care through its long-term population health strategy? Concern was raised in relation to the poor quality of hospital catering facilities. What will the ICB do to improve the health of the population? Would it be possible to have an education programme that helps teach people what they should be eating for health?**<br><br>**Response:** A Cummins acknowledged the well-established relationship between nutrition, lifestyle and long-term health outcomes. He noted that the cost-of-living crisis had made it more difficult for some people to access healthy food and advised that the ICB was working with local authority partners and other organisations to improve access to support and promote healthier lifestyles. Hospital catering arrangements were explained to be the responsibility of individual NHS trusts, and any concerns were encouraged to be raised through the relevant trust complaints processes. It was also noted that a number of trusts were reviewing food provision through initiatives such as red, amber and green food options.<br><br>A Knox outlined work taking place across Lancashire and South Cumbria with partners, including supermarkets, food banks and community organisations, to support healthier eating. Discussion was also underway with NHS trusts regarding their role as anchor institutions, including opportunities to support local food production and healthier food provision. Responsibility for food provision rested with individual trusts, while the ICB continued to work collaboratively with providers to support improvements in this area. Whilst recognising the |

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financial pressures facing providers, A Knox confirmed that nutrition remained an important element of the wider population health strategy.

The Chair advised that neighbourhood-based approaches would play a key role in improving health and wellbeing through prevention and education. Work was underway with local communities, volunteers and commissioned services to deliver health promotion messages in ways that were more accessible and effective for local people. Prevention and education were recognised as important components of the wider population health approach.

**Q2:** ***From influence panel member***
**As a volunteer to support the end of life and palliative care workstream, momentum behind this workstream, particularly the proposed digital solution, appeared to be slowing. Does the ICB remain committed to improving palliative and end of life care and would continued public involvement in this work be worthwhile?**

**Response:** The Chair provided assurance that the ICB remained committed to improving end of life and palliative care services across Lancashire and South Cumbria and that significant discussion had taken place regarding how best to achieve this.

A Knox thanked the member of the public for his contribution and passion for the subject and reiterated the ICB's commitment to delivering the best possible palliative and end of life care. He advised that he would chair the Palliative Care Board in future and had recently met with Medical Directors, senior palliative care leads and Chief Nursing Officers to progress this work across both primary and secondary care settings.

Addressing concerns regarding the digital solution, A Knox explained that implementation was complex due to the different clinical systems used across primary care and NHS trusts, which did not currently interface effectively with one another. Whilst acknowledging that a single solution would not be achievable in the short term, he confirmed that alternative arrangements were being pursued to improve communication and information sharing between services.

A Knox further advised that clear objectives had been established to improve palliative care provision, including better understanding and responding to people's preferences for care, strengthening advance care planning, increasing investment in services and enhancing partnership working with hospices. He emphasised that neighbourhood-based approaches, including closer working with social care providers and care homes, would be central to delivering these improvements.

A Knox expressed that the ICB remained fully committed to the programme and welcomed continued public involvement in shaping its development.

**Q3:** ***From member of the public***
**How will the ICB ensure that smaller voluntary, community, faith and social enterprise organisations, including local faith groups and community organisations that are not commissioned by the NHS, are involved in neighbourhood health initiatives? Is there a way for the ICB to support these organisations, for example through health education resources, and how will their voices be heard alongside larger organisations? It was highlighted that community support was not always dependent on funding, and also the importance of education, including reducing stigma and drawing on the experience of local organisations to support people within their communities.**

**Response:** The Chair advised that the Board was actively discussing how neighbourhood health approaches could strengthen engagement with local communities and voluntary sector partners.

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A Heritage explained that the question related to an earlier slide presented to the meeting, which demonstrated that a significant proportion of system spending was directed towards larger organisations and providers. He advised that there was a growing recognition that this approach needed to evolve, with greater emphasis on working alongside local communities and the voluntary, community, faith and social enterprise (VCFSE) sector to improve health outcomes.

He noted that many smaller community and faith-based organisations were already making a significant contribution to health and wellbeing. As an example, a large proportion of parent and toddler groups across Lancashire and South Cumbria were delivered through churches and other faith organisations, providing vital support networks that contributed to healthier communities. Whilst these organisations were often not formally commissioned, their impact was considerable.

Referring to a recent meeting regarding the Faith Covenant, A Heritage described work taking place with a range of faith organisations and statutory partners, including health services, local authorities, police and education partners, to better understand the contribution faith groups make within local communities. He advised that the ICB wished to sign the Faith Covenant as a demonstration of its commitment to strengthening relationships with faith groups and ensuring that smaller, community-based organisations were better recognised and involved in shaping neighbourhood health services.

A Heritage emphasised that the ICB was committed to working with organisations of all sizes and expected this to be an important area of focus over the coming year. He added that effective partnership working was not solely dependent on funding and that smaller organisations could make a significant contribution through education, community engagement, tackling stigma and supporting local people to improve their health and wellbeing.

***Q4: From Public Governor, Lancashire and South Cumbria NHS Foundation Trust***
**When reporting improvements in access to GP appointments, does this refer specifically to appointments with a GP, or does it also include appointments with other healthcare professionals within general practice?**

**Response:** A Cummins advised that it was important to recognise that not all services provided in primary care needed to be delivered by a GP. General practice had evolved significantly and increasingly involved a wider multidisciplinary team delivering care based on patients' individual needs. He explained that the ambition for neighbourhood health was to develop teams aligned to local geographies, enabling services to be tailored to the needs of different populations rather than adopting a single approach across Lancashire and South Cumbria.

A Knox confirmed that both the number of appointments with a GP and appointments delivered by allied health professionals had increased. Whilst acknowledging that there remained variation in accessibility and patient experience across Lancashire and South Cumbria, he advised that work was underway with practices to improve consistency.

He further explained that access to a range of healthcare professionals was an important part of modern primary care, as many patients could benefit from support provided by professionals with specialist expertise, such as nurses, physiotherapists, mental health practitioners and medicines specialists. Ensuring that patients were seen by the professional best suited to their needs helped to deliver the right care at the right time, whilst also ensuring that patients requiring a GP appointment were able to access one. This approach was supporting improved access to care and enabling practices to make best use of the skills available within multidisciplinary teams.

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**Q5: From *member of the public***
**The presentation referred to population health and health inequalities, but how is public health expertise and evidence informing this work? I am also concerned about the availability of medical staff within local diagnostic services and would welcome reassurance on this. In addition, when referrals are made to specialist services, how is patient choice supported when many specialist centres are located outside Lancashire and South Cumbria?**

**Response:** A Cummins acknowledged the importance of public health in informing the ICB's approach to population health and reducing inequalities. He advised that the ICB had a well-established partnership with public health and local authority colleagues and was working across Lancashire and South Cumbria to identify and deliver evidence-based interventions that would have the greatest impact on improving population health outcomes.

In relation to access to specialist services, A Cummins advised that patients could be referred to specialist centres across the northwest through both GP and consultant referral pathways where clinically appropriate. He noted that a number of patients from Lancashire and South Cumbria already accessed these services. Whilst recognising that Lancashire and South Cumbria did not host the same range of specialist centres as some larger cities, he confirmed that the ICB was exploring its future tertiary and specialist services strategy to consider how access to specialist care could be strengthened and developed. He added that access to specialist services would remain an important consideration as this work progressed.

**Q6: *From member of the public***
**The presentation referenced assessing population health needs. Does this mean that the ICB does not currently have a clear understanding of those needs? In addition, given the significant pressures expected during winter and reports that no additional national winter funding may be available, can the ICB provide financial support to providers, including local hospitals, to help manage increased demand and improve patient care?**

**Response:** A Cummins explained that the ICB was seeking to further strengthen how population health information was used to ensure that investment led to measurable improvements in outcomes. Following the transition from eight Clinical Commissioning Groups to a single Integrated Care Board, commissioning arrangements had largely operated through annual budget-setting and contracting processes. While this approach had supported service delivery, demand for healthcare services continued to grow faster than available funding. As a result, the ICB was working to develop a more robust evidence base to support greater investment in prevention and early intervention, while recognising that any shift in funding and commissioning arrangements would need to be managed carefully to avoid destabilising existing provider services.

In relation to winter planning and financial support for providers, it was explained that both NHS trusts and the ICB had a responsibility to use public resources effectively. A Curran advised that the challenges facing providers were not solely a matter of additional funding and that service delivery and operational arrangements also played an important role. He noted that additional funding alone would not necessarily resolve the issues faced by providers and that some challenges related to how services and operations were organised and delivered within individual organisations. It was further noted that providers received funding allocations and were responsible for determining how those resources were used to ensure safe care could be delivered during periods of increased demand, with operational management remaining a matter for individual provider organisations.

A Cummins continued that the ICB's role was to take a broader system-wide view and consider what additional services and interventions could be implemented outside hospital settings to improve access to care and reduce avoidable attendances. A draft winter plan, presented at

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| | the ICB Board meeting held earlier that day, set out the actions being taken across Lancashire and South Cumbria to support safe and resilient services during winter 2026/27. This included identifying system-wide measures to improve access to treatment and reduce pressure on acute services.<br><br>**Q7:** ***From member of the public***<br>**There has been a loss of funding to the YMCA on the Fylde Coast, which is having a detrimental impact on adults and children. Given the discussions regarding the importance of voluntary, community, faith and social enterprise (VCFSE) organisations, could the ICB take any action to address this? In addition, better nutrition was being supported in some hospitals, with Blackpool hospital making fruit and vegetables available for purchase at low cost for one week. A hospital in Manchester was making this available as standard - could similar approaches be encouraged locally?**<br><br>**Response:** The Chair reaffirmed that the ICB was absolutely committed to working with smaller voluntary, community, faith and social enterprise (VCFSE) organisations and recognised the important contribution they made to supporting local communities. In relation to concerns regarding the loss of funding for services and any resulting impact, the Chair advised that members of the public could email the ICB with further details of specific examples.<br><br>In relation to initiatives promoting affordable healthy food within hospitals, the Chair welcomed the example provided and agreed that such schemes had clear benefits. However, she explained that the ICB did not have jurisdiction over operational initiatives within individual hospital organisations. Whilst the ICB could work with and influence providers, decisions regarding the introduction of such schemes rested with the hospitals themselves. Members of the public were therefore encouraged to share their suggestions directly with the relevant hospital organisations for consideration.<br><br>**Q8:** ***From Gemma, Fylde Coast Network Patient Group***<br>**GP practices are at the centre of healthcare, and Patient Participation Groups play an important role in helping practices understand patient experiences and identify ways to improve access and services. However, practices have limited budgets, much of this work relies on volunteers, and some community initiatives are facing funding pressures. Given the value of Patient Participation Groups and community organisations in supporting patients and improving health outcomes, can the ICB provide more support?**<br><br>**Response**: A Knox thanked those involved in Patient Participation Groups for their work and recognised the valuable contribution they made in supporting patients and local GP practices. He advised that Patient Participation Groups were vital in helping practices understand patient experiences and identify opportunities to improve access to services. However, support for Patient Participation Groups was not within the direct remit of the ICB and sat primarily with individual GP practices.<br><br>He explained that work was currently underway within the Fylde and Wyre locality to establish a federation of practices, which would be better placed to provide support and coordination across practices and Patient Participation Groups. It was noted that this work was focused on expanding the capacity and infrastructure available to support such groups.<br><br>In response to comments regarding continuity of care, A Knox acknowledged its importance and advised that work was being undertaken to improve continuity of care wherever possible. He thanked the member of the public for their continued commitment to supporting patients and local communities.<br><br>**Q9: From** ***Paul Newman, member of the public***<br>**Given the financial constraints on the ICB, what assurance can you provide that this** |

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**does not influence decisions regarding the applications for continuing healthcare?**

**Response**: A Cummins advised that, whilst the ICB had to be mindful of the financial resources available and the need to manage public funds responsibly, decisions regarding continuing healthcare were made through established assessment processes and within the relevant national framework.

J Scattergood explained that there was a mandated framework which the ICB applied diligently and consistently, with multi-agency involvement where relevant. All Age Continuing Healthcare assessments were required to be quality assured and compliant with the national framework, and this was what drove decision-making regarding eligibility for continuing healthcare.

In response to a supplementary question regarding the relationship between clinical need and financial constraints, J Scattergood confirmed that where there was an assessed primary health need, the ICB remained mandated to provide the required care and that financial considerations did not override those requirements.

**Q10:** ***From Simon Hore, Leader of Ribble Valley Borough Council***
**Ribble Valley accounts for approximately a quarter of Lancashire's geographical area but has the smallest population, meaning that rural isolation and access to transport and hospital services remain significant challenges for local residents. With the beds at Longridge Community Hospital currently closed, patients are now required to travel to Chorley Hospital for care. It is encouraging to hear that the ICB intends to move to a four-unitary model, but how will this work in practice for communities such as Longridge? Specifically, what are the plans for the future of the beds at Longridge Community Hospital, and when is a decision expected?**

**Response:** C Harris explained that the beds at Longridge Community Hospital had been closed due to significant fire safety concerns. It was the ICB's responsibility to ensure that patients who would otherwise have been admitted to Longridge be temporarily relocated to a suitable alternative provider, which was currently Cuerden Ward at Chorley Hospital, and this remained a temporary service change.

Work was underway to review what action would be required to reopen the beds at Longridge, including assessing the building works required to address the fire safety issues and understanding the associated capital costs and funding requirements. Alternative options for the site were also being explored with the local community, including the possibility of a reduced number of beds and the development of a community health centre offering alternative services.

No decision had yet been made regarding the future of the service. C Harris advised that options appraisal and engagement activity would take place during 2026, with a decision expected in early 2027.

**Q11:** ***From Amanda, Burnley practice***
**I am pleased to see the clinical focus that the ICB is giving to the voluntary, community, faith and social enterprise (VCFSE) sector. In the absence of a mayoral authority, how will Lancashire and South Cumbria ensure that it can benefit from and drive health innovation alongside larger city regions?**

**Response:** A Heritage welcomed the question and advised that the aim was not to compete with other areas but to learn from them and build on the strengths that already existed across Lancashire and South Cumbria. He highlighted the many positive initiatives taking place locally and reaffirmed the ICB's commitment to research and innovation.

He noted that Lancashire and South Cumbria was home to world-class universities and

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| | explained that there was an aspiration for young people to study, train and develop their careers within the area before choosing to remain and work locally. Growing and retaining local talent would help drive innovation and improve health outcomes across Lancashire and South Cumbria.<br><br>Looking ahead, A Heritage advised that further examples of innovation, research and improvement work taking place across the system would be shared in the future to demonstrate the progress being made and the impact being achieved.<br><br>**Q12:** ***Jenny Hurley, Protect Chorley and South Ribble Hospital Campaign Group***<br>**With the ICB taking steps to become a strategic commissioner, if the ICB is no longer responsible for the performance management of providers, who will hold that responsibility?**<br><br>**Response:**<br>A Cummins explained that the ICB would remain responsible for ensuring that providers delivered safe and effective care through the contracts it held with them. He advised that accountability for the quality and performance management of provider organisations would increasingly be undertaken by NHS England's regional teams.<br><br>The separation of these responsibilities was intended to improve both strategic commissioning and provider oversight. During the transition period, the ICB would continue to work closely with NHS England to ensure that appropriate arrangements remained in place and that no gaps emerged in the oversight of quality and performance.<br><br>**Q13:** ***From member of the public***<br>**With regard to the new population footprints, how will public involvement be embedded within this model? How will the ICB demonstrate what action has been taken as a result of engagement with local people and communities? What investment is the ICB making in public involvement, are there plans to strengthen this resource, and how is the Board supporting and overseeing this work?**<br><br>**Response:** The Chair advised that the ICB was at the start of this journey and emphasised that it was fundamental to listen to, involve and engage with local people in order to understand the needs of the population at a detailed level and commission the right services. Services would not be improved without that understanding and she suggested that the Board would continue to consider public involvement as it developed its future commissioning approach.<br><br>N Greaves explained that the ICB already undertook engagement activity as part of specific decision-making processes, including consultations and service change proposals, supported by appropriate governance arrangements. He advised that genuine engagement with communities would take place at neighbourhood level and that work was underway to gather insight from local communities and use this alongside clinical expertise to inform service development. He noted that there were already examples of this approach working well and that, as the ICB continued its development as a strategic commissioner, it was working to ensure that meaningful community engagement became embedded consistently across the population footprints. He emphasised the importance of ensuring engagement within communities and that local insight informed future service design. |
| **8.** | **<u>Closing Remarks</u>**<br><br>The Chair conveyed her thanks for the information shared, the contributions made, the engagement with ICB colleagues and the questions raised throughout the session. She welcomed the energy and enthusiasm demonstrated by participants and highlighted the importance of maintaining that momentum over the coming year. The ICB would seek to |

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| | develop clear priorities and commitments against which progress could be measured and held to account.<br><br>The meeting closed. |

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