NHS
Lancashire and South Cumbria
Integrated Care Board

LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD

Annual report

2022/23

1 JULY 2022 - 31 MARCH 2023

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Welcome to the NHS Lancashire and South Cumbria Integrated Care Board Annual Report 2022/23

Welcome to the NHS Lancashire and South Cumbria Integrated Care Board (ICB) Annual Report, covering the period 1 July 2022 to 31 March 2023.

We came into existence on 1 July 2022. ICBs replaced clinical commissioning groups (CCGs) in the NHS in England from that date and are statutory bodies responsible for planning and funding most NHS services locally. In our case this is in all of Lancashire and in South Cumbria.

In 2022, a national extension of the timetable for the establishment of ICBs meant that CCGs continued with their statutory arrangements until 30 June 2022. Hence CCG Reports exist for the first quarter of the financial year 2022/23 and this Annual Report pertains to the remainder of that financial year.

At the time of writing, we have just published Turning Challenges into Opportunities[1], our State of the System report giving an overview of the health and care system in 2023. Turning Challenges into Opportunities focuses on the future, the challenges we face and our plans to succeed in meeting these.

In this Annual Report we share with you the important work we have undertaken in the first part of our existence, as the NHS approaches the 75th anniversary of its establishment.

The hard work began in earnest in 2022/23. We now have a clear strategy to tackle some of our key issues focusing on prevention and the integration of health and social care in place. We are working towards the NHS Long Term Plan 2023/24 will see the developments and delivery of local plans and budgets which will set us on the right path to achieve what we need to.

We will rise to challenges and overcome adversity. This is our opportunity to make a real difference to the provision of NHS services in Lancashire and South Cumbria and to the health and lives of the people who live here.

Kevin Lavery

Chief Executive Officer

David Flory

Chair

[1] https://www.healthierlsc.co.uk/application/files/7616/7950/3448/07a_-_State_of_the_System_Report.pdf

Contents

About this Annual Report

This annual report has been written with patients and the public in mind. Working within the requirements of the Department of Health's annual report and accounts guidance we have attempted to make this document:

People-focused

Informative

Easy to read and understand

Visually appealing

Glossary

Some common terms used when describing the NHS in Lancashire and South Cumbria.

Anchor institution: This refers to large, public-sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchor institutions, who are rooted in their local communities, can positively contribute to their local area in many ways such as: widening access to quality work for local people; buying more from local businesses; reducing our environmental impact; using buildings and spaces to support communities; working more closely with local partners.

Clinical commissioning groups: Clinically led statutory NHS bodies which, under the Health and Care Act 2022 closed down on 30 June 2022 and their functions transferred to Integrated Care Boards.

Fragile services: Services which are at risk of being unsustainable because of lack of staff or other resources.

Health and Care Act 2022: A new law regarding health and social care provision which originated in the House of Commons in July 2021 and completed the Parliamentary process in April 2022. Amongst other things, the legislation aims to tackle health inequalities and create safer, more joined-up services that puts the health and care system on a more sustainable footing.

Health inequalities: The unfair and unacceptable differences in people's health that arise because of where we are born, grow, live, work and age.

Integrated Care Board (ICB): Under the Health and Care Act 2022, this is the NHS organisation that was established on 1 July 2022 - NHS Lancashire and South Cumbria Integrated Care Board[2]. CCGs closed down and their functions transferred to the new organisation, which is responsible for NHS spend and the day-to-day running of the NHS in Lancashire and South Cumbria.

Integrated Care Partnership (ICP): The broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.

Integrated Care System (ICS): Refers to the health and care system across Lancashire and South Cumbria. There are 42 ICSs across the country. Within each ICS there is an Integrated Care Partnership and an Integrated Care Board.

[2] https://www.lancashireandsouthcumbria.icb.nhs.uk/

Model of care: This broadly defines the way health and care services are organised and delivered.

Neighbourhoods: Based on local populations of between 30,000 and 50,000. Neighbourhoods, in some instances, may align with Primary Care Networks and Integrated Care Communities.

Networked services: This describes the way a clinical service works in a joined-up way across multiple sites or organisations. Often a clinical network will have one clinical lead who oversees the whole service.

Place: An area covered by a local authority – an area where partners can come together and take action to support local communities.

Place-based director of health and care integration: There are four directors of health and care integration responsible for improving health and wellbeing of residents within each of four place-based partnerships. They sit both on the ICB board and the board of the local authorities to create positive working links and shared priorities between both organisations. These roles have been put in place through collaboration with local authority partners. You can find out more about who they are on the ICB website.[3]

Place-based partnerships: Planners and providers working together across health, local authority and the wider community, to take collective responsibility for improving the health and wellbeing of residents within a place. For information on our place-based partnerships visit the web page.. [4]

Population health management: A way of improving the health of people in local communities by looking at which groups in the local population are most likely to become unwell and working out how to prevent and treat ill-health. This uses data and an understanding of local populations to identify those who are at risk to proactively plan and deliver care.

Primary care: Primary care is the first point of contact for healthcare for most people. It is mainly provided by GPs (general practitioners) but community pharmacists, opticians, dentists and other community services are also primary healthcare providers.

Primary Care Networks (PCNs): GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices. PCNs build on existing primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care for people close to home. Find out more on PCNs on the NHS England website.[5]

Provider Collaborative: Service providers will be collaborating at the various different levels of system, place and neighbourhood according to need. National guidance, Working together at scale: Guidance on Provider Collaboratives[6] has been published and a Provider Collaborative Board (PCB) has been established to enable partnership working of the acute, mental health and community providers across Lancashire and South Cumbria. Find out

[3] https://www.lancashireandsouthcumbria.icb.nhs.uk/news-and-media/latest-news/four-new-directors-health-and-care-integration-appointed-lancashire-and-south-cumbria
[4] https://www.healthierlsc.co.uk/integratedcare/developing-place-based-partnerships-lancashire-and-south-cumbria
[5] https://www.england.nhs.uk/primary-care/primary-care-networks/
[6] https://www.england.nhs.uk/publication/integrated-care-systems-guidance/

about the Provider Collaborative in Lancashire and South Cumbria. [7]The organisations that are involved as part of the collaborative are:

- Lancashire Teaching Hospitals NHS Foundation Trust
- Blackpool Teaching Hospital NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Lancashire and South Cumbria NHS Foundation Trust

Secondary care: Care that you receive in hospital, either as an inpatient or an outpatient. This may be planned or emergency care. It is more specialist than primary care.

Social determinants of health: The non-medical factors that influence health outcomes

Social value: This is about how we secure wider social, economic and environmental benefits for our population in addition to providing health and care. As anchor institutions we want to make the greatest positive impact possible on the lives of our communities to improve health and wellbeing, and reduce health inequalities.

Specialised commissioning: Planning and buying specialised services which support people with a range of rare and complex conditions, for example, rare cancers, genetic disorders or complex medical or surgical conditions.

Triple Aim: The triple aim is a legal duty on NHS bodies which requires them to consider the effects of their decisions on:

- the health and wellbeing of the people of England (including inequalities in that health and wellbeing)
- the quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services)
- the sustainable and efficient use of resources by both themselves and other relevant bodies.

In pursuit of these aims, the Lancashire and South Cumbria ICB is part of a wider integrated care partnership (ICP), which is a partnership of all organisations that deal with improving care, health and wellbeing for the people of Lancashire and South Cumbria.

This partnership includes all the healthcare organisations and local authorities in the region.

Wider determinants of health: The diverse range of social, economic and environmental factors which influence people's mental and physical health. These include employment, housing, crime, education, air quality, access to green spaces and access to health and care services, among other things.

[7] https://lscprovidercollaborative.nhs.uk/

PERFORMANCE REPORT

Performance Overview

The full Annual Report and Accounts gives detail about the ICB, its purpose, the key risks it faces in striving to achieve its objectives and how it has performed in the period between 1 July 2022 and 31 March 2023.

The purpose of this performance overview is to provide the user a short summary with sufficient information to understand the ICB.

Chief Officers Statement

The Lancashire and South Cumbria Integrated Care Board (ICB) was established on 1 July 2022 under the Government's Health and Care Act 2022. It is one of 42 ICBs in the country and replaced the eight clinical commissioning groups (or CCGs) that previously existed across the region. The ICB has since taken on responsibility for planning and buying NHS services for the 1.8million people living in Lancashire and South Cumbria.

Despite the challenges, these are exciting times for the NHS. I would like to thank everyone who has worked so diligently in the establishment of the ICB. It has been no small task and I do not underestimate the level of reserves that some people have called upon to get us where we are today. The people of Lancashire and South Cumbria, colleagues, partners, patients and the public are good humoured, with compassion and a 'can-do' attitude. This makes the area a great place to work and one which I have no doubt will respond to all the challenges faced in a constructive, collaborative and ultimately successful manner.

The ICB has made a step change in the openness of the NHS in its part formative year. It has gone to great lengths to encourage the public to understand and contribute to planning and developments.

It is important we involve people from all of the diverse communities across Lancashire and South Cumbria in our work. There are a number of key places where people can find out more and become involved in the future of the NHS. This is important because actively engaging people helps to reduce the differences in health and life expectancy and deliver services that meet the needs of our population.

At the time of writing we are also continuing to consult on the Integrated Care Strategy[8], which we plan to be approved early in the 2023/24 financial year. The strategy describes how partners will work together to improve the health, care and wellbeing of people in Lancashire and South Cumbria.

The ICB website[9] gives up-to-date information and news.

The State of our System report[10] describes ICB leadership ambitions.

The Public Involvement and Engagement Advisory Committee (PIE AC)[11] supports the ICB in ensuring the voice of local people and residents is actively embedded and valued in decision making.

[8] https://www.healthierlsc.co.uk/application/files/8316/7950/3443/08a_-Appendix_A_-_Draft_Integrated_Care_Strategy.pdf
[9] https://www.lancashireandsouthcumbria.icb.nhs.uk/
[10] https://www.healthierlsc.co.uk/application/files/9416/8235/4122/State_of_our_system_report.pdf
[11] https://www.lancashireandsouthcumbria.icb.nhs.uk/get-involved/public-involvement-and-engagement-advisory-committee

There are many other ways to become involved from 'listening events'[12] to joining our Citizens Panel[13] or Volunteering.[14]

The time since 1 July 2023 has been very much formative.

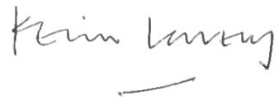
Prominent amongst our successes in the short time since, we have, amongst other things:

- Improved the way our services work together and how we work as a part of the Health and Care Partnership. [15]
- Aligned new Place[16] based partnerships [17]with existing and newly formed local authority footprints.
- Prepared to take on new responsibilities for Dentistry, Ophthalmology and Community Pharmacy.
- Helped PCNs to respond to the Fuller Stocktake report - "Next steps for integrating primary care" - published in May 2022.
- Consulted with staff on putting in place a more efficient and effective staffing structure for the future.
- Facilitated digital and other innovations for patients and the public. Amongst these there is ChatBot, to help manage waiting lists, and Virtual wards to help manage the pressure on inpatient facilities and new ways to reduce the risk of Type 2 diabetes.
- Coordinated the system response to Industrial Action and Winter pressures.

The ICB is a key part of the wider partnership of all organisations that deal with improving care, health and wellbeing for the people of Lancashire and South Cumbria.

Together, this partnership will achieve a vision of longer and healthier lives for our population across Lancashire and South Cumbria.

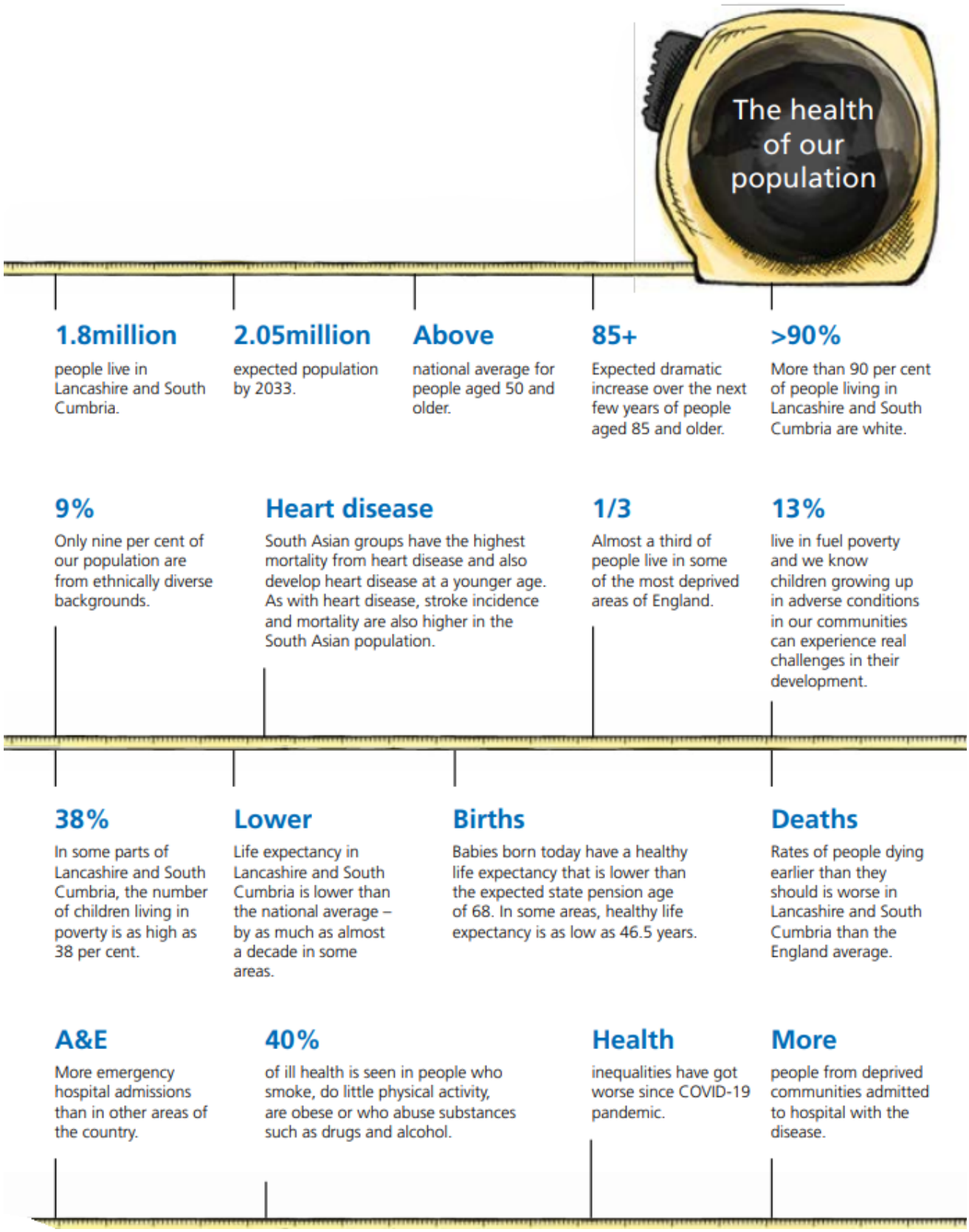
I wish everyone well for the future.



Kevin Lavery
Chief Executive Officer
29th June 2023

[12] https://www.lancashireandsouthcumbria.icb.nhs.uk/get-involved/listening-events
[13] https://www.lancashireandsouthcumbria.icb.nhs.uk/get-involved/citizen-panel
[14] https://www.lancashireandsouthcumbria.icb.nhs.uk/get-involved/volunteering
[15] https://www.healthierlsc.co.uk/integratedcare
[16] https://www.healthierlsc.co.uk/application/files/8116/5900/9793/20220727_place_boundary_announcement_.pdf
[17] https://www.healthierlsc.co.uk/application/files/8116/5900/9793/20220727_place_boundary_announcement_.pdf

Some facts and figures about Lancashire and South Cumbria



Purpose and activities of the ICB

An integrated care board (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.

Nationally, the expectation is that an ICB will:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

The initial major priority themes that have been identified in Lancashire and South Cumbria are:

- Urgent and emergency care, discharge and elective care recovery
- Deliver a challenging budget for 2022/23
- Integration of community health and social care services
- Primary care development
- Improve quality and performance of our NHS trusts
- Prevention priorities
- Integrate health equity into our plans

ICBs were legally established on 1 July 2022, replacing clinical commissioning groups (or CCGs), taking on the NHS planning functions previously held by CCGs (as well as absorbing some planning roles from NHS England).

Here in Lancashire and South Cumbria our ICB has replaced NHS Blackpool and NHS Fylde and Wyre CCGs (which were previously known as the Fylde Coast CCGs), NHS Morecambe Bay CCG, NHS West Lancashire CCG, NHS Chorley and South Ribble and NHS Greater Preston CCGs (previously known as Central Lancashire CCGs) and NHS Blackburn with Darwen CCG and NHS East Lancashire CCG.

ICBs have their own leadership teams, which include a chair and chief executive, executives and non-executive members, and also includes members from NHS trusts/foundation trusts, local authorities, general practice, and an individual with expertise and knowledge of mental illness.

As you would expect with bringing together eight organisations, there is a considerable programme of organisational development underway. This includes robust and transparent processes for working with staff to establish organisational structures appropriate for the strategic priorities of the ICB across Lancashire and South Cumbria.

The senior leadership team for the ICB has been confirmed as part of these processes and information is included in the structure charts below.

Executive team

A full structure chart can be found on the ICB website.[18]

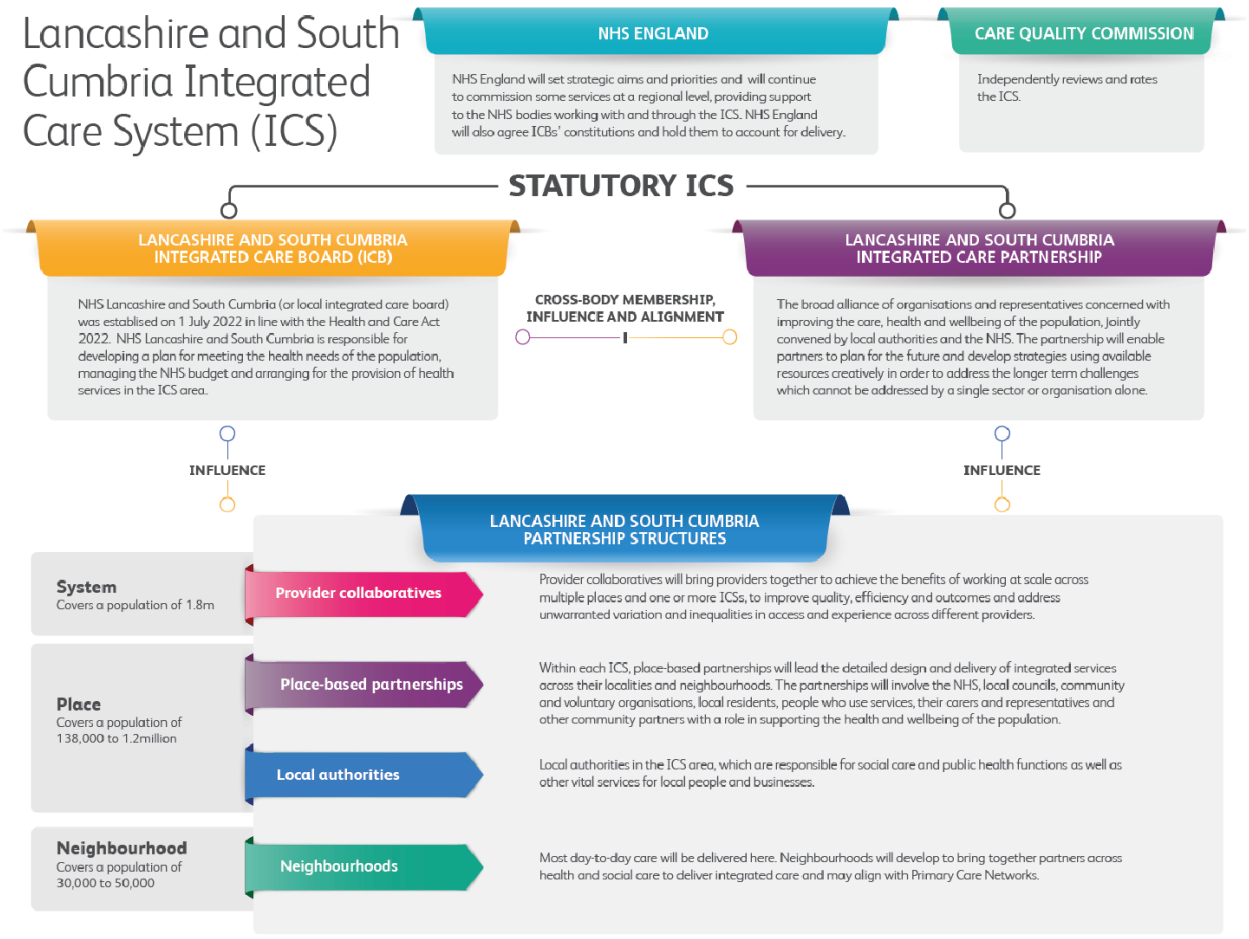
As an ICB, we need to look at ways in which we can use our resources more effectively. In November 2022, the ICB agreed a number of measures to tackle some our financial challenges. One of these measures was a mutually agreed resignation scheme (MARS) which was offered to all staff employed by the ICB prior to the end of December. Following a review of the response to the MARS, we are confident we have made positive steps on cost reductions. As this work has not concluded, full information on the structure cannot be provided but will be kept up to date on the ICB website in the coming months.

Performance appraisal and progress towards delivering objectives.

The Performance analysis section of the annual report provides an overall explanation of how the ICB discharged its functions between 1 July 2022 and 31 March 2023. The performance analysis includes a Balanced Scorecard to show Key Performance Indicators and it highlights key achievements.

The performance analysis describes what the ICB has done to improve quality, manage risk and contribute to safeguarding. We do not capture everything we do in our annual report but the performance analysis describes the strides the ICB has taken to engage with people and communities, to strive to achieve 'net zero', reduce health inequalities and engage with local stakeholders. Should people want the detail on these matters, the performance analysis is a good place to start.

Working with partners



[18] https://www.healthierlsc.co.uk/VCFSE

The ICB is a key part of the integrated care system which is a partnership of all organisations that deal with improving care, health and wellbeing for the people of Lancashire and South Cumbria. This includes all the healthcare organisations and local authorities in the region who work together as an Integrated Care Partnership.

The Integrated Care Partnership (or ICP) works together to address the health, social care and public health needs of their communities, always making sure the public's voice is at the heart of decision-making. An integrated care strategy (link to the website) has now been agreed following extensive engagement and involvement with partners, staff and the public throughout 2022/23.

Partners include local authorities, NHS organisations, businesses, education, Healthwatch and voluntary, community, faith and social enterprise (VCFSE) organisations[19]

As part of the Health and Social Care Act 2022, NHS Lancashire and South Cumbria Integrated Care Board (ICB)[20] and the unitary and upper tier local authorities have a statutory duty to coordinate Lancashire and South Cumbria ICP together.

The first formal Lancashire and South Cumbria ICP meeting took place on Friday 30 September 2022, and it started with an opportunity for the members to hear from our residents.

We are facing some very significant challenges. These include widening health inequalities, rising demand, pressure on quality and safety, staffing shortages, the wellbeing of our colleagues, and funding. These are well documented and have been exacerbated by the COVID-19 pandemic.

We must address these challenges with urgency. The State of our System report [21]gives more detail on the ICB's aim to turn challenge into opportunity.

We have seen that joining forces as equal partners can have huge benefits. Collaboration during the COVID-19 pandemic demonstrated what we can do together at scale to support our colleagues and patient care.

By working collaboratively, we will be much more likely to achieve our vision than if we work alone. This is because we will be able to better:

- agree joint priorities and how to best join forces to deliver them
- learn from and support each other
- share skills and best practice
- pool resources to support fragile services
- provide flexible career paths across organisational boundaries
- standardise our approach across Lancashire and South Cumbria to reduce variation and duplication
- support the local economy and the environment to add social value.

The Lancashire and South Cumbria Provider Collaborative

Our partnership brings together the five provider NHS trusts in Lancashire and South Cumbria to improve health and healthcare.

This is about working together to make sure patients, their families and communities benefit across the whole of the area.

[19] https://www.healthierlsc.co.uk/VCFSE
[20] https://www.lancashireandsouthcumbria.icb.nhs.uk/
[21] https://www.healthierlsc.co.uk/application/files/9416/8235/4122/State_of_our_system_report.pdf

The aim is to reduce health inequalities and improve services, outcomes and people's experiences of accessing healthcare. Our partnership also aims to ensure that Lancashire and South Cumbria is a great place to work.

The Provider Collaboration Board's vision, as agreed by the chairs and chief executives of the five trusts, is to ensure:

- The best health and wellbeing of our population
- High-quality services
- A happy and resilient workforce
- Financial sustainability

This is known as the 'quadruple aim'.

The Provider Collaboration Board has agreed seven priorities:

1. Develop a joint clinical vision
2. Develop a joint vision for central (non-clinical) services
3. Achieve parity of esteem between mental and physical health
4. Recover and restore elective care and other operational services
5. Improve the emergency and urgent care performance of the system
6. Develop our leadership and ensure a great place to work with a resilient workforce
7. Develop a clear financial strategy

There are many good examples of collaboration making a difference across Lancashire and South Cumbria, within both a clinical and non-clinical setting which you can read about LSC Provider Collaborative :: Collaboration in action[22]

Examples of system working

Examples of how working with our partners has benefitted the health and wellbeing of our patients are included throughout the rest of this report but some others of note are:

[22] https://lscprovidercollaborative.nhs.uk/collaboration-action

1. COVID-19

Our response to COVID-19 has outlined the huge benefits of collaborating – together we were able to make a massive difference to the lives of local people and their families.

The trusts supported each other to manage critical care capacity during time of huge pressure on NHS services, for example.

Pathology services also worked together to coordinate testing at scale. As one of 11 pilot sites for rapid saliva (LAMP) testing, by working collaboratively the service was set up in record time to enable mass testing of NHS staff.

2. Virtual outpatient appointments

At the beginning of the COVID-19 pandemic, it was necessary for our hospitals to deliver virtual clinics. The four acute trusts worked collaboratively to quickly put new digital systems in place.

The joined-up approach to using video consultations for scheduled clinic appointments received great feedback from staff and patients.

3. ChatBot - managing waiting lists

Chatbot is an automated call system, which guides patients through a series of questions designed by NHS consultants and healthcare experts. The pilot saw 2,282 waiting list patients in Morecambe Bay and Preston receive a call asking about their health condition. 75 per cent of patients responded to either the automated call, or a follow-up call from a member of staff.

The 2022/23 Chatbot programme has now been rolled out to other hospitals and medical specialties in Lancashire and South Cumbria and aims to contact 30,000 patients before the end of March 2023.

So far, out of 17,299 patients contacted this year, 13,583 have been validated at a response rate of 79 per cent with almost 1,200 patients indicating they could leave the waitlist.

Chatbot was Shortlisted as a finalist in the 2023 HSJ Awards.

4. Collaborative bank

The five trusts are developing a collaborative bank for nurses, midwives, health care assistants, allied health professionals and administrators. A collaborative bank is a Lancashire and South Cumbria-wide bank, with the trusts working together to boost our temporary workforce and improve patient care.

We want to make working at the bank attractive to increase our temporary workforce, meaning more colleagues supporting our departments and each other.

A collaborative bank will also mean fairer, more consistent bank rates, with colleagues able to work seamlessly across different trusts should they wish.

We also want to reduce our reliance on agency staff, so we have a more stable, consistent workforce who have all had the same training and understand our consistent processes to enhance patient care.

Performance analysis

This section of the annual report provides an overall explanation of how the ICB discharged its functions between 1 July 2022 and 31 March 2023. It includes information on specific areas as required in reporting guidelines. The Performance analysis gives detail for users wanting to know more than is included in the earlier Performance Overview.

The Performance analysis starts with the sections required by reporting guidelines before moving on to further information which may be of benefit to the user.

The Accountability Report section of this report includes a **Governance Report** that details the accountability and decision-making framework that the ICB operates within, including details of its Unitary Board and Committees of the Board.

Detailed and comprehensive information about NHS Lancashire and South Cumbria Integrated Care Board can be found on the ICB website[23].

[23] https://www.lancashireandsouthcumbria.icb.nhs.uk/

Performance Dashboard

The system has been subject to significant pressure throughout the year which has had an impact on performance across a range of areas. Not one part of the system operates in isolation, therefore pressures in one area are seen to directly affect another.

DOMAIN	Metric	Actual (Latest)	Target
Elective Recovery	Total patients waiting more than 104 weeks to start consultant-led treatments	6 Mar-23	0
	Total patients waiting more than 78 weeks to start consultant-led treatments	217 Mar-23	0 Mar-23
	% Patients on incomplete pathway waiting less than 18 weeks	**60.3%** Mar-23	92%
Diagnostic Waiting Times	% Patients waiting less than six weeks for diagnostic test	**80.8%** Mar-23	95% Mar-24
CYP / Maternity	Smoking at time of delivery	**11.9%** Dec-23 YTD	6%
	Population vaccination coverage - MMR for 2 doses (5yrs old)	**89.4%** Oct-Dec22	-
Cancer	2 week wait referrals	**90.9%** Mar-23	93%
	31 Day First Treatment	**88.3%** Mar-23	96%
	62 Day referral to treatment	**59.4%** Mar-23	85%
	% meeting faster diagnosis standard	**75.4%** Mar-23	75%
Urgent and Emergency Care	A&E 4 Hour Standard (76% Recovery Target)	**76.9%** Mar-23	76%
	Average ambulance response time: Category 2 [NWAS]	**00:30:57** Mar-23	00:18:00
Mental Health and Learning Disabilities	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	**540** Feb-23	0
	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	**685** Jan-23	0

	Estimated diagnosis rate for people with dementia	**68.3%** Mar-23	66.7%
	Access Rate for Improving Access to Psychological Therapy (IAPT) Services	**TBC**	
Primary Care	Number of general practice appointments per 10,000 weighted patients	4561 Mar-23	
	Seasonal influenza vaccine uptake amongst GP patients in England 2022 to 2023 - 65 Years +	**79.2%** Sep22-Feb23	85.0%
	Proportion of diabetes patients that have received all eight diabetes care processes	**43.5%** Jan-Dec22	

Note: The figures given are the latest available at the time of preparation of this Report. Data is collated by the Planning, Performance and strategy directorate.

Key Lines of Enquiry (KLOEs)

Below details five characteristics of governance arrangements to support effective collaboration. It also sets out the key lines of enquiry used by NHS England.

Governance arrangement	Description	Key lines of enquiry
Developing and sustaining strong working relationships with partners:	The manner of engagement must be consistently constructive and where appropriate proactive.	• Do providers consistently engage with partners in a meaningful, effective and constructive way? • Are providers contributing to building a culture of transparency, honesty, and constructive challenge where collective responsibility is taken for problems and conflicts are resolved quickly? • Do providers communicate system vision, values and strategic goals to their staff and other stakeholders?
Ensuring decisions are taken at the right level	Decisions should be taken at the most appropriate level (eg ICP, ICB, place-based partnership, provider collaborative, provider board).	• Do providers actively participate in all relevant and appropriate planning and decision-making forums? This may include system and place-based partnerships or provider collaboratives. • Are decisions taken at the most appropriate level given the nature of the issue and are providers working with partners, including NHS bodies, local government and primary care, and engaging staff, patients and the wider public as necessary? • Do providers engage with all relevant organisations and stakeholders on decisions that might affect them?
Setting out clear and system-	There should be clear consideration and articulation of why	• Are providers collaborating to develop the business case for any proposed system improvements, through a structured planning

minded rationale for decisions	decisions have been made, having regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all, and sustainable use of NHS resources.	process, and working with patients, workforce and external partners? • Do providers support an open and constructive dialogue regarding any risks or concerns? • Has an equalities and health inequalities impact assessment been conducted where appropriate to inform decision-making? • Have decisions been made with regard to the triple aim duty to support better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources, giving particular attention to reducing health inequalities between communities within the population? • Are providers actively building business intelligence capacity to enable a single shared view of local challenges, performance and progress against delivery?
Establishing clear lines of accountability for decisions	There must be clear lines of accountability for decisions, taking into account providers' legal responsibilities and internal governance.	• Have providers established clear reporting lines and accountabilities, with timely and effective oversight of their involvement in system and place-based partnerships, and provider collaboratives? • Do providers empower system, place-based and at scale provider decision-making by appropriately delegating responsibility? • Are there appropriate governance mechanisms within the organisation and joint working arrangements with partners, such as dispute resolution or escalation mechanisms, in place and are they well understood and effective? • Are providers' strategic plans integrated with the ICB's five-year joint plan and annual capital plan, and the plans of place-based partnerships and provider collaboratives? • Are providers actively involved in co-producing and driving programmes and plans?
Ensuring delivery of improvements and decisions	There must be adequate systems and processes to ensure providers follow through on shared decisions so that system and place level improvements are delivered for the benefit of patients and the public.	• Are providers committed to enabling the successful delivery of plans, including a willingness to share any risks or benefits that arise from collaboration? • Do providers proactively and openly share high-quality information as appropriate to support planning and/or implementation of improvements for the benefit of patients? • Do providers commit adequate resources and staff to participate in system planning and delivery, such as taking up system leadership roles, embedding or seconding staff to partner organisations, or contributing to funding a joint project management office? • Have providers put in place detailed delivery plans for their own organisations and agreed actions against which progress is regularly

		monitored, to enable them to identify and manage any risks or challenges that arise?

Some of the responses to the NHS England key lines of enquiry are included within the report as we highlight specific schemes and those not included can be found on the website. [24]

[24] https://www.healthierlsc.co.uk/download_file/7845/0

Performance narrative

Elective Recovery

The proposed refresh of the Elective Recovery Programme was presented to the Provider Collaborative Board (PCB) on the 16 February 2023 and approved.

The four acute Trusts have been working together to reduce waiting times for people requiring treatment.

Eliminating long waits and reducing waiting times

Due to the impact of the junior doctor industrial action in March 2023, Lancashire and South Cumbria was not able to fully eliminate 78 week waits by the end of March 2023 but the work done, particularly in recent months, to reduce long waiters has been immense and should be acknowledged. From a position on the 1 January 2023 of 4,498 patients within the 78 week cohort, this reduced to 160 by the 31 March 2023. 74 of the 160 patients were unable to be treated due to capacity, with the remaining 84 not treated due to being complex or patient choice.

Mirroring the national trend, the number of patients waiting over 52 weeks is also reducing; 7,670 as at 31 March 2023 compared with 10,646 on the 1 January 2023.

104-week waits were eliminated by the end of June 2022 in line with the national target.

We continue to work extremely hard to reduce waiting times and are working towards ensuring everyone is treated within 65 weeks by the end of March 2024, as per the national target. This is only possible because the trusts continue to focus great collective effort to improve access to care. For example, hospitals with shorter waiting times are offering appointments to patients whose nearest hospital has longer waits. As of April 2023, nearly 2,000 patients had chosen to travel further to have a quicker appointment.

Both theatre utilisation and day case rates within Lancashire and South Cumbria are within the top quartile within England at 81 per cent and 82.5 per cent respectively.

Diagnostics

Although the performance for diagnostics is not meeting the target, it has been improving over the year. For Lancashire and South Cumbria, the latest reported figure is the lowest since diagnostics was first reported at ICB level in July 22. The most challenged area is endoscopy, although the ICB has an extensive plan to develop capacity in endoscopy and continues to develop the Community Diagnostic Centre capacity and capability, which is beginning to have a positive effect on waits for diagnostic tests.

Diagnostic Imaging Network

Patient waiting times for some diagnostic tests have improved because imaging services are being delivered as a collaborative network across the four hospital trusts in Lancashire and South Cumbria.

During the COVID-19 pandemic in April 2020, 47% of patients were waiting over six weeks for their CT and MRI scans. This has now reduced to below 6.6%.

Part of this involves offering patients whose nearest hospital has longer waits access to a scan more quickly at a hospital with a smaller waiting list. This means some patients are travelling further to be seen more quickly.

The Diagnostic Imaging Network made up of the four hospital trusts (Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust), provides the following imaging scans: CT, MRI, X-Ray, DEXA, radionuclide and non-obstetric ultrasound.

By working together, elective imaging activity across the Network has increased. As of 31 March 2023 our network is delivering 137% MRI and 150% CT scanning activity compared to pre-COVID levels in 2019/20.

Children and Young People

The level of vaccination coverage of MMR for five years olds is above regional and national levels. There are ongoing workstreams to further increase coverage, including communications to parents and schools on the importance of vaccination for MMR

The level of smoking at the time of delivery is higher in the ICB than regionally or nationally. The key initiative is to implement support into maternity units to the four main providers to reduce tobacco dependency.

National Priorities

In relation to the voice of our children we have started to hear patient stories at the Children's Board and have ensured that our children help us to develop any new projects. We have undertaken training and will embed the Lundy model of participation within the ICB engagement strategy. This will ensure our children are involved in decision making and will be at the heart of everything we do.

The CYP team have been working to achieve the key clinical national priorities. Clinical Networks and Leads are in place for Asthma, Epilepsy, Palliative Care, and Diabetes.

Palliative Care

Palliative Care is now a statutory function of ICBs. The ICB has an active Palliative Care Clinical Network. This year we have implemented specialist Kentown Palliative Care Nurses to support children and young people with palliative care needs /life limiting conditions. We are working to recruit a Palliative Care Consultant to provide specialist clinical advice for children and young people in Lancashire and South Cumbria

In addition, we are working in partnership with Derian House Children's Hospice to implement a palliative care training programme for the children's workforce, which will upskill and improve the understanding of children's palliative care needs across all sectors.

Asthma

Lancashire and South Cumbria was successful in our bid to become a national pilot site to support the early support for children at high risk of an asthma attack. Our two specialist asthma nurses have been in post since early December and are working with our partners in Primary Care to identify our high-risk children and support the optimisation of their care and annual reviews.

Other projects we are progressing include the introduction of asthma-friendly schools, promotion of free accredited asthma training for the workforce, improvement work with our acute trusts in relation to treatment and discharge plans, ensuring children receive a personalised asthma action plan, working with our partners in the VCFSE to empower our children and families to manage their asthma, trialling an asthma app and working with our partners in housing to provide wrap around support for vulnerable families.

Diabetes

The Diabetes Network is working to address inequalities in diabetes care (National Paediatric Diabetes Audit), reduce the incidence of Type 2 diabetes and improve access to technology for our deprived and ethnic minority populations

Data highlights poorer outcomes for children with Type 1 diabetes living in areas of social deprivation, children from ethnic minority backgrounds and young adults. In 2022-23 we have participated in 3 x pilot projects to increase access to technology (which has been shown to improve health outcomes) for these groups of young people. These pilots are currently showing excellent results with increased numbers of CYP now using technology.

We have undertaken partnership work the VCFSE to improve the care for children at risk of or diagnosed with type 2 diabetes. Using a culturally sensitive, targeted intervention we are hoping to improve the health outcomes for these children.

Lancashire and South Cumbria is expanding our pilot site for services for children with excess weight (who are at high risk of developing Type 2 diabetes). This will ensure that children receive support from both clinical and health coaching teams which will help to improve their health outcomes in the future.

Epilepsy

The Epilepsy Network is working to address inequalities in epilepsy care, improve transition to adult services, improve access to mental health screening and access to specialist services. Expressions of interest have been submitted to the National team to support a senior Epilepsy Specialist Nurse who will work across LSC to drive forward these improvements. A further bid has been placed to pilot the implementation of a mental health screening tool with associated psychological care. National funding has been accessed to support the employment of an additional epilepsy specialist nurse at one Trust in LSC.

Elective care

The children and young people (CYP) team is working with ICB, Regional and Trust colleagues in relation to elective recovery work, the emphasis is on restoring activity to pre pandemic levels. Work is ongoing with community dental colleagues and the ICB to address backlogs in activity (which is a Core 20 plus 5 priority). The team attends regional meetings working with NHSE and the children's hospitals, to identify appropriate models of recovery and prioritisation tools that are specific to children and young people.

Finally, the team is working in partnership with regional colleagues to identify priorities from the Getting it Right First-Time programme and to implement system wide improvements. This year's improvement guideline related to the management of abdominal pain in children.

Further plans are in place for the year ahead in relation to introducing youth workers who will empower children and young people to manage their long-term conditions', we will also appoint mental health champions on the children's inpatient wards to ensure joint working to meet the needs of these children.

Send

Lancs and South Cumbria ICB continues to work in close partnership with Local Authorities across the system, as an example the ICB and North and South Cumbria Local Authority jointly participated in a successful Ofsted and CQC follow up inspection of our SEND services. The inspection clearly demonstrated collaborative working across the system and that we were and are clear where continued improvements need to be focussed.

As an ICB we are determined to continue to work hard to improve services for our children, young people and families with SEND, working in collaboration and promoting C0-production with Local Authorities, providers, the independent, voluntary sector, charities and CYP and families amongst others.

Children and Young People Speech and Language Therapy

Speech and Language Therapy have maintained significantly long waits for children and young people over the last couple of years due in part to the impact of COVID and the lack of workforce to deliver support with the increase in demand.

A redesign of the model for speech and language based on the Balanced system model which is seen as national best practice is underway, and testing of this model has shown significant reductions in waiting times alongside improved outcomes, as an example, Hyndburn now has no waits for speech and language therapy. Formal roll out of the new model is underway across the ICB and will commence during 23/24.

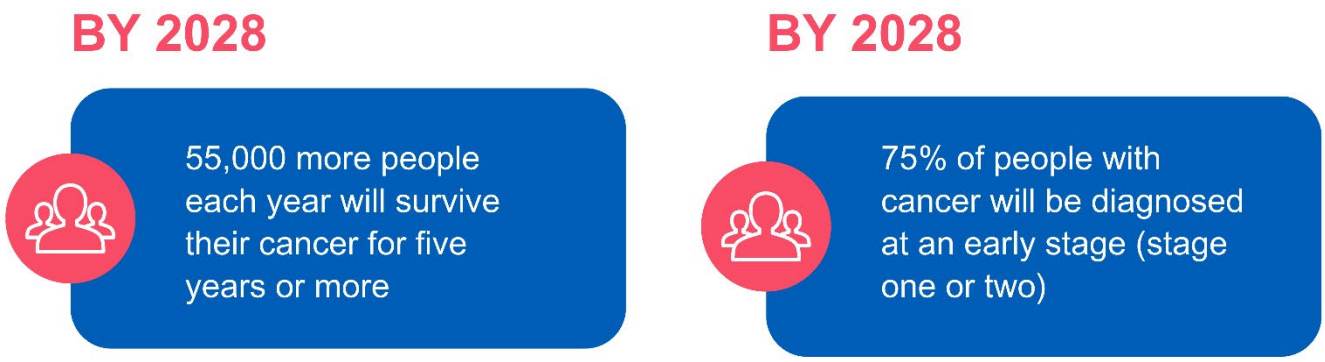
Cancer

The ICB is not meeting some of its cancer waiting times targets and action plans; led by the Lancashire and South Cumbria Cancer Alliance, are in place to support improvement. There are challenges and increases in demand in various pathways which continue to be addressed. A robust programme of pathway improvement is in place which supports best practice pathway development, reduces unnecessary steps and the alignment of administrative and clinical processes in the interests of patient care.

Lancashire and South Cumbria Cancer Alliance

Lancashire and South Cumbria Cancer Alliance [25]is a collaboration of all professionals and organisations involved in the delivery of cancer care for the people who live in our region.

The key ambitions in the Long Term Plan are:



[25] https://www.lancashireandsouthcumbria.icb.nhs.uk/our-work/canceralliance

Sponge on a string' boost for cancer services in Lancashire and South Cumbria

An innovative 'sponge on a string' diagnostic test is set to improve cancer care and ease the pressure on health services in Lancashire and South Cumbria.

The potentially life-saving device, known as Cytosponge, will help identify people most at risk of oesophageal (gullet) cancer and be available close to people's homes. Cytosponge involves the patient swallowing a capsule attached to a 'string'. The capsule dissolves after a few minutes to release a sponge that gathers oesophagus cells for analysis after it is removed.

The test will be offered to people on endoscopy waiting lists who have conditions such as Barrett's oesophagus (when the normal cells lining the gullet have been replaced by abnormal cells, increasing the risk of developing oesophageal cancer). The test is minimally invasive and generally more comfortable, needs no sedation and can be delivered in a nurse-led clinic in about 15 minutes.

By contrast, an endoscopy requires a team of specialists in hospital and can take several hours of preparation.

The pandemic has increased the demand for endoscopy, a procedure in which a camera attached to a flexible tube is inserted into the patient's body, with Lancashire and South Cumbria having the fourth highest rate of upper gastrointestinal endoscopies in England.

The Lancashire and South Cumbria Cancer Alliance has worked with partners including the Innovation Agency to secure £500,000 from the SBRI Healthcare fund to spread Cytosponge from hospital services into the community.

Urgent & Emergency Care

The new national target of 76 per cent of patients to be seen within four hours by the end of 2023-24 has been set. Accident and Emergency services were under significant pressure throughout 2022-23, with high numbers presenting for treatment. Performance levelled off across the first half of the year, but has deteriorated in the winter months, which is consistent to previous years. The number of attendances in February dropped significantly (almost 13,000 less attendances than December 2022). Performance across L&SC exceeds the national average.

Historically there were no reports of ambulance handover delays of over 60 minutes. During 2022-23 the number of delays reported was unprecedented, with December 2022 seeing the highest numbers of delays recorded. This impacts directly on the ability for ambulance crews to respond to calls and is reflected in the underperformance against the Category 2 response target. A reduction in delays has been since January 2023.

A robust programme of work is in place to support urgent and emergency care, and ahead of winter this year a number of initiatives and schemes were deployed to support the expected increase in demand on urgent care services across L&SC.

The ICB was allocated £12.95 million to support mobilisation of 27 demand and capacity schemes across L&SC in 2022-23. The schemes were robustly monitored through the Resilience and Surge Planning Group with monthly submissions to the regional and national teams.

The schemes were focussed on creating additional bed capacity both within hospital and in the community, in order for this to be achieved there was a range of schemes that supported timely discharges such as additional domiciliary care hours, patient transport, workforce and additional beds.

Funding for the demand and capacity schemes ended on 31 March 2023. However, due to the substantial and unrelenting pressures across our hospitals and some significant upcoming risks, the ICB's Resilience

and Surge Planning Group (RSPG) sought approval to extend a small number of schemes on short-term basis until 30 June 2023.

Additionally, examples of the other range of focus for the urgent and emergency care programme have been, optimising SDEC pathways, establishment of ambulance handover collaborative and associated projects, development of transfer of care hubs, maximising use of virtual wards for flow and discharge, expansion of 2-hour urgent community response, system control centre and place based tactical/silver command meetings.

Winter pressures

Winter always sees great pressure on the health system. The winter of 2022/23 has been one of the most pressured the NHS has ever seen. In Lancashire and South Cumbria, we have been able to manage the pressures within hospitals and in primary care reasonably well through a number of initiatives, such as the establishment of virtual wards and improvements to hospital discharge processes.

Our system control centre (SCC) manages demand and capacity and ensures adequate oversight of operational pressures at all times, ensuring rapid decisions are made to respond to any emerging challenges.

Bed occupancy in hospital remains high and delays in transfers from ambulance to hospital departments remain longer than they should be. In short, there are more people needing to get into hospital facing delays due to the time it takes to get people out of hospital.

A rise in flu cases over winter also placed extra pressure on services, with growing hospital admissions, along with the unanticipated increase in the number of cases of children with invasive group A strep.

Mental Health

The rate for Improving Access to Psychological Therapies (IAPT) is below target for the ICB. There is an extensive plan ongoing to work with providers to ensure more people can access services when they need them

The access rate for Children and Young People to mental health services is well above target and continues to be one of the highest nationally.

The ICB has made significant progress in reducing the number of patients placed out of area for their mental health inpatient needs and work continues to reduce this even further with a target of zero out of area placements by the end of 2023-24.

The numberof people expected to receive a dementia diagnosis is above target for the ICB and continues to perform favourably against regional and national rates.

The ICB is required to disclose and explain the amount and proportion of expenditure incurred by the ICB in relation to mental health, referring to content covered in the accountability report.

	2022/23
Mental Health Spend	£378,094
ICB Programme Allocation	£3,017,236
Mental Health Spend as a proportion of ICB Programme Allocation	12.53%

As the ICB is a new body comparative figures for previous years does not exist.

Mental health urgent assessment centres

The provider NHS Trusts worked together to develop five mental health urgent assessment centres (MHUACs) to improve care for people who are in crisis and who have attended their local Emergency Department seeking help.

Patients who attend Emergency Department in a crisis are quickly assessed by both hospital staff and the Mental Health Liaison Team. Where further mental health assessment is required and it is medically safe, they are invited to the MHUAC, which is located immediately next to Emergency Department.

The centres are transforming mental health emergency care by ensuring safe and effective assessment of both physical and mental health needs.

Learning Disabilities

The number of learning disability patients over 14 years of age receiving an annual health check is below the level expected for the ICB and below the regional and national levels. There are several key initiatives ongoing to improve the performance working with primary care colleagues and listening to the experience of patients with a learning disability.

Primary Care

Primary care covers a range of services for patients including GP practices, pharmacies, optometry and dentistry. On 01 July 2022 NHS Lancashire and South Cumbria Integrated Care board (ICB) became the accountable body, responsible for GP practices and pharmaceutical services in the area. During the reporting period for this annual report, optometry and dentistry remain the responsibility of NHS England.

In 2022-23 Lancashire and South Cumbria reported a greater number of general practice appointments per 10,000 population than the North West average with actual appointment volumes higher than originally planned and anticipated. However, despite this, the rate of appointments per 10,000 population is well below the national average. Plans are in place to improve patient communication, triage and signposting; however significant risk remains regarding GP demand and capacity and the ability to improve patient access.

Flu vaccination uptake in the over 65s in Lancashire and South Cumbria was 79.2per cent for the period between 1st September 2022 and 28th February 2023. Uptake was significantly reduced compared to 2021-22 season which appears to be a national trend.

At the end of 2021-22 Lancashire and South Cumbria reported a slightly higher proportion of patients receiving all eight care processes than the national average at 32.1 per cent. The most recent data covering Jan-Sep 2022 suggests that the position across Lancashire and South Cumbria is in line with national averages and higher than the North West position.

Restoration and recovery

Colleagues working in primary care continue to work under very challenging circumstances with the impact of the COVID-19 pandemic still influencing patient demand on these services. There is evidence to show that patients seeking a consultation with a GP do so with significantly more complex needs than prior to the pandemic. This has resulted in additional time taken for consultations and management. Patient demand has also risen for episodic care. There are also significant workforce challenges across all of primary care including a reduction in the number of GPs. This is a national challenge and in

Lancashire and South Cumbia we have been working closely with our partners in NHS E both at regional and national level on a suite of interlocking GP recruitment and retention initiatives available to help and sustain the GP workforce in Lancashire and South Cumbria including:

- **New to Partnership Payment Scheme** which aims to grow the number of partners working in primary care, stabilising the partnership model and helping to increase clinicians participation levels
- **General Practice Fellowship Programme** supports all newly-qualified GPs working substantively in general practice in their transition from training to employment and guarantees a level of support and learning
- **Supporting Mentors Scheme** upskills experienced GPs and provides portfolio working opportunities
- **Primary Care Flexible Staffing Pools** increase the capacity in general practice and create a new offer for local GPs wanting to work flexibly.

GPs in Lancashire and South Cumbria also have access to the national GP Career Support Hub which provides a range of advice, guidance and career development tools for GPs.

Workforce planning and recruitment to primary care continues to be a key priority. The Additional Roles Reimbursement Scheme provides Primary Care Networks (PCNs) with the opportunity to increase their workforce and support places to increase the uptake and implementation of these roles.

Health and Wellbeing support is available to the whole primary care workforce in Lancashire and South Cumbria through the Lancashire and South Cumbria Primary Care Training Hub. Health and Wellbeing Champions have been recruited to provide and promote the available resources and initiatives to General Practice including access to wellbeing circles and financial wellbeing.

GP Access

There have been increases in the number of appointments and consultations provided above the national average against a backdrop of a significant reduction in Full time equivalent (FTE) General Practitioners. This has resulted in an increase in GP workload intensity and a significant shift in the delivery of GP appointments across Lancashire and South Cumbria embodied by transition from a GP delivered model of care to a GP led model.

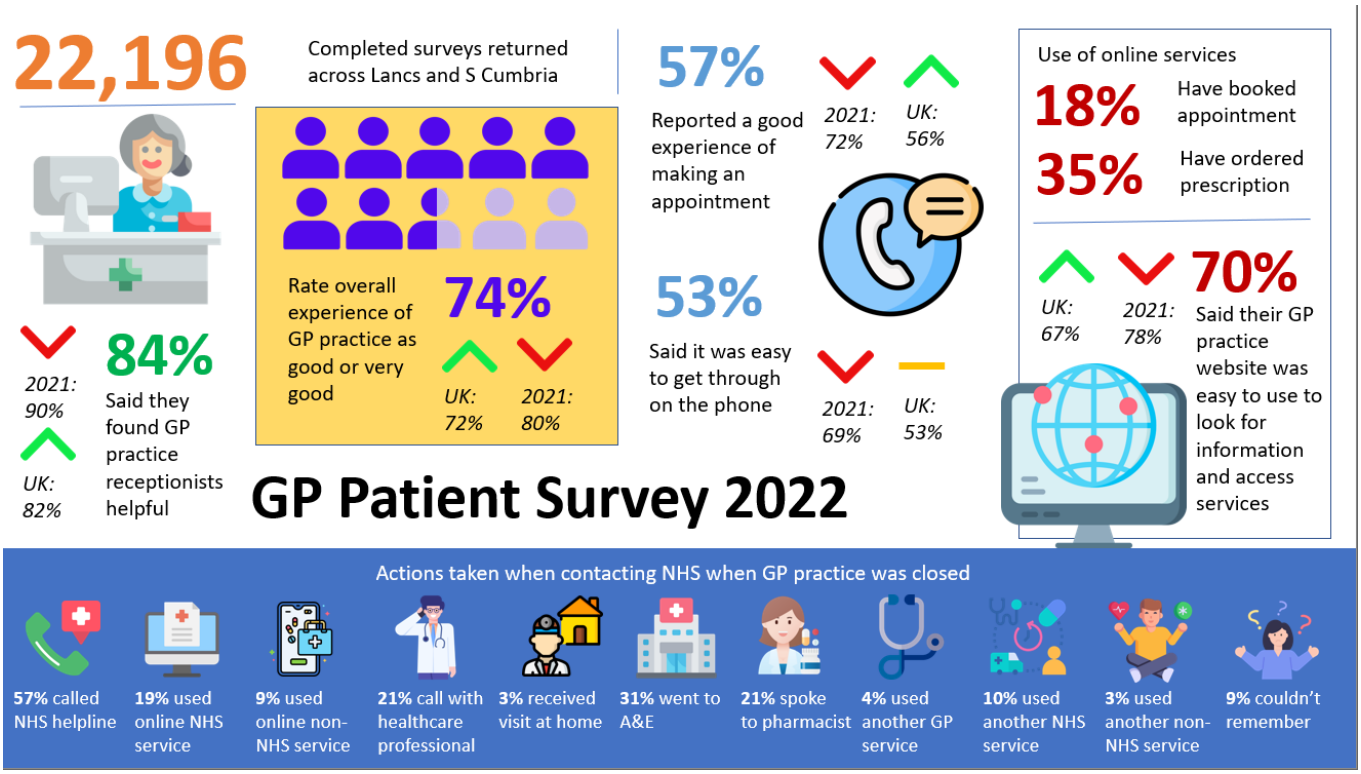
In September 2022 the Government published it plan:'Our Plan for Patients'[26] to ensure that everyone who needs an appointment with their practice within two weeks can get one and that patients with urgent needs are seen on the same day with additional appointments over winter. There was also an intention to publish data on how many appointments each GP practice delivers, and the length of waits for appointments, to enable patient choice. This data has been available from since November 2022 and NHS Lancashire and South Cumbria ICB reviews this regularly in order to provide support to those practices with the most acute access challenges to improve performance

NHS Digital[27], who publishes this data, acknowledges there are a number of changes required to make the data more robust. However, using that information we have continued to monitor and support best practice across our primary care GP providers to minimise variation in patient experience and will continue to build on this early work.

GP Patient Survey

The GP Patient Survey 2022 was published in July 2022 and reflects on people's experience of healthcare services provided by GP surgeries.

[26] https://www.gov.uk/government/publications/our-plan-for-patients/our-plan-for-patients
[27] https://digital.nhs.uk/



Integrated Neighbourhood Care Development programme

We continue to build on the work of our predecessor organisations, who for several years had been working as partners across Lancashire and South Cumbria to develop integrated neighbourhoods.

From a health and care perspective our focus has been on the development of integrated neighbourhood teams (INTs). These teams bring together teams and professionals to improve patient care for neighbourhood populations. Primary, community, secondary and social care, domiciliary and care staff and VCFSE partners form a team of teams, sharing information and resources to improve health and wellbeing and tackle health inequalities

We have made significant progress and have some great examples across the system of where INTs are well established and working well. For a range of reasons, including the impact of the pandemic, the pace of development has varied, and some areas have much further to go on their journey to integration.

The timely publication of the Fuller Stocktake report: "Next steps for integrating primary care", which was published in May 2022, provides a real opportunity for us to build on the excellent work to date and to move forwards with integrated neighbourhood care in all areas. The report, commissioned by NHS England, looked at what is working well, why it is working well and how the implementation of integrated primary care could be accelerated. It acknowledged that for generations primary care has been at the heart of our communities, with health visitors, community and district nurses, GPs, dentists, pharmacists, opticians, and social care workers being amongst the most recognisable of a multitude of dedicated staff delivering care around the clock in every neighbourhood in the country.

The report identified a 'moment of real opportunity' to streamline access to care and advice, provide more proactive, personalised care with support from a multi-disciplinary team of professionals to people with more complex needs and to help people stay well for longer as part of a more ambitious and joined-up approach to prevention.

To support this, we have developed the Lancashire and South Cumbria Integrated Neighbourhood Care Delivery Framework. Based on the Fuller stocktake report, the framework also draws on a range of other national and local documents. It builds on existing progress and good practice across the system

to create a framework to transform how we work together to provide care for our populations and to support the development of Neighbourhoods, across Lancashire and South Cumbria.

Further primary care contract delegation

We have been preparing for the formal delegation of formally approved the delegation of all pharmaceutical, general ophthalmic and dental (POD) services to Integrated Care Boards from 1 April 2023. This includes the transfer of some NHS England regional staff who are supporting POD commissioning.

NHS England have formally approved the delegation of these services which will allow the ICB to integrate services and improve patient experience, quality and health outcomes. NHS E will also delegate responsibility for specialised services that have been identified as suitable and ready for further integration subject to system readiness from 01 April 2024 and work is already underway to ensure a smooth transition.

Support and prevention of Type 2 diabetes

More than 100,000 people aged 17 and above in Lancashire and South Cumbria have Type 2 diabetes and it's estimated that more than 75,000 people are at a high risk of developing the condition.

In Lancashire and South Cumbria people identified as being at risk are offered tailored support through the local Healthier You service. Healthier You is a nationally commissioned diabetes prevention programme aimed at reducing the risk of developing or delaying the onset of Type 2 diabetes. The programme can have a major impact on people's lives with participants who complete the programme achieving an average weight loss of 3.3kg.

In April, commissioners awarded a new contract to continue the national diabetes prevention programme (NDPP) service across the region. Reed Wellbeing took over from 1 August 2022. Due to the transition, and the issues this caused with transfer of information from the outgoing provider to the new one, referrals were paused throughout June and July. Since August, work has continued to assist practices target potentially at-risk patients.

In April 2022 Lancashire and South Cumbria was named as one of 11 additional areas to take part in a pilot of a low-calorie diet scheme. The aim of the diet is to help people with diabetes lose weight and potentially help them to achieve remission of their type 2 diabetes.

Eligible patients are referred by their GP and receive low-calorie meal replacement products for 12 weeks at no cost to themselves. Following this period regular food is re-introduced in a managed way to encourage healthy, nutritious eating habits. Participants then have regular one to one coaching sessions for the rest of the year to help them maintain their diet.

According to NHS England, early data from the programme showed participants lost 7.2kg on average after one month, and 13.4kg after three months. In Lancashire and South Cumbria referrals have been low but we are working with practices to help them better understand the scheme.

Diabetes referrals at a glance

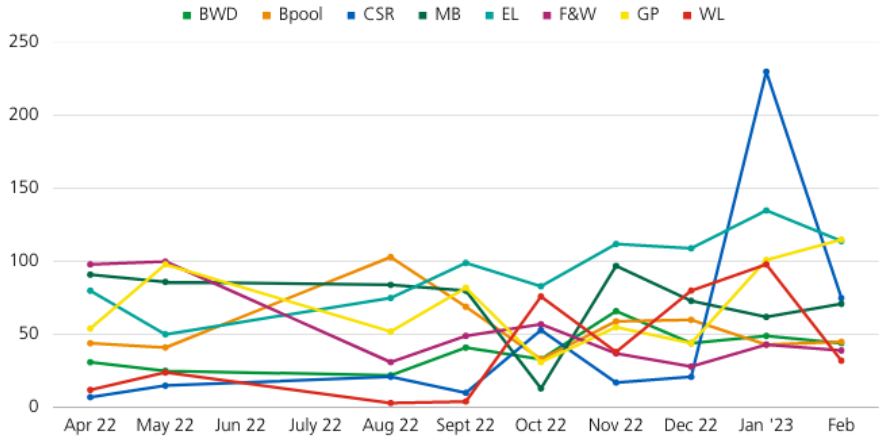
National Diabetes Prevention Programme
and Low Calorie Diet referrals 2022/23

NHS
Lancashire and South Cumbria
Integrated Care Board

NDPP referrals made
(by NHSE reporting former CCG area)

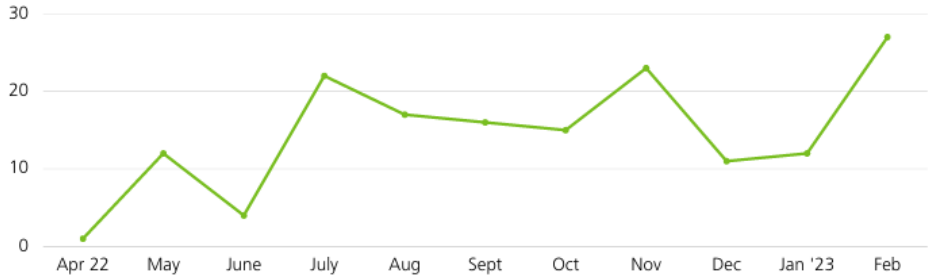
TOTAL
4,328*

*Does not include referrals made in June or July due to pause in reporting during transition to new provider



Low Calorie Diet Programme referrals

169



Digital

In 2018, Lancashire and South Cumbria published its 'Our Digital Future' [28]and set out the approach to partnership working across the local system.

It established the principles of:

- Creating digital solutions with the people who will be using them
- Judging progress against this digital strategy from the public's perspective
- Creating an environment that empowers the frontline
- Using data to prevent, predict and respond to ill-health
- Working together to reduce complexity in order to improve quality and safety

[28] https://www.healthierlsc.co.uk/download_file/force/1889/796

- Engaging with academia, industry and others to accelerate innovation

Much has happened since then and the NHS is a different place following the pandemic. A chief digital officer was appointed to the ICB in November 2022 and a new digital and data strategy is planned for Summer 2023. This is likely to focus on using data in a much more ambitious way to improve integration across our health services.

A new approach to digital patient records begins

Hospitals across Lancashire and South Cumbria are looking at setting up a new system to allow patient records to be shared effectively regardless of which health service a patient has visited.

The establishment of a single, seamless electronic patient records (EPR) system comes on the back of the introduction of a shared care record, which has already been supporting patients by bringing data together from all our different providers of care.

This innovative approach will transform how information is stored and utilised and provide the foundations to improve clinical and care pathways as well as allowing hospitals to work together far more effectively.

There are numerous methods of recording and accessing patient information across hospitals in Lancashire and South Cumbria. The aim is to capture best practice and reduce variation across hospitals to allow staff, patients and their families to dedicate more time to treatment and recovery, by streamlining the process of accessing and utilizing essential patient information.

The implementation of a single EPR system is considered a crucial milestone in advancing digital healthcare innovations and delivering integrated patient care throughout Lancashire and South Cumbria. By investing in a single system, we are making use of technology to offer the highest standard of care to patients, regardless of their location."

The EPR is the first of many ambitious steps in the Lancashire and South Cumbria Integrated Care Board's digital roadmap which promises more investment into technology and the rollout of more digital tools to improve care.

Environmental matters

Sustainability

On 1 July 2022, the NHS became the first health system in the world to embed net zero into legislation, through Health and Care Act 2022[29]. Net zero means cutting greenhouse gas emissions that cause global warming to as close to zero as possible, with any remaining emissions re-absorbed from the atmosphere by oceans and trees.

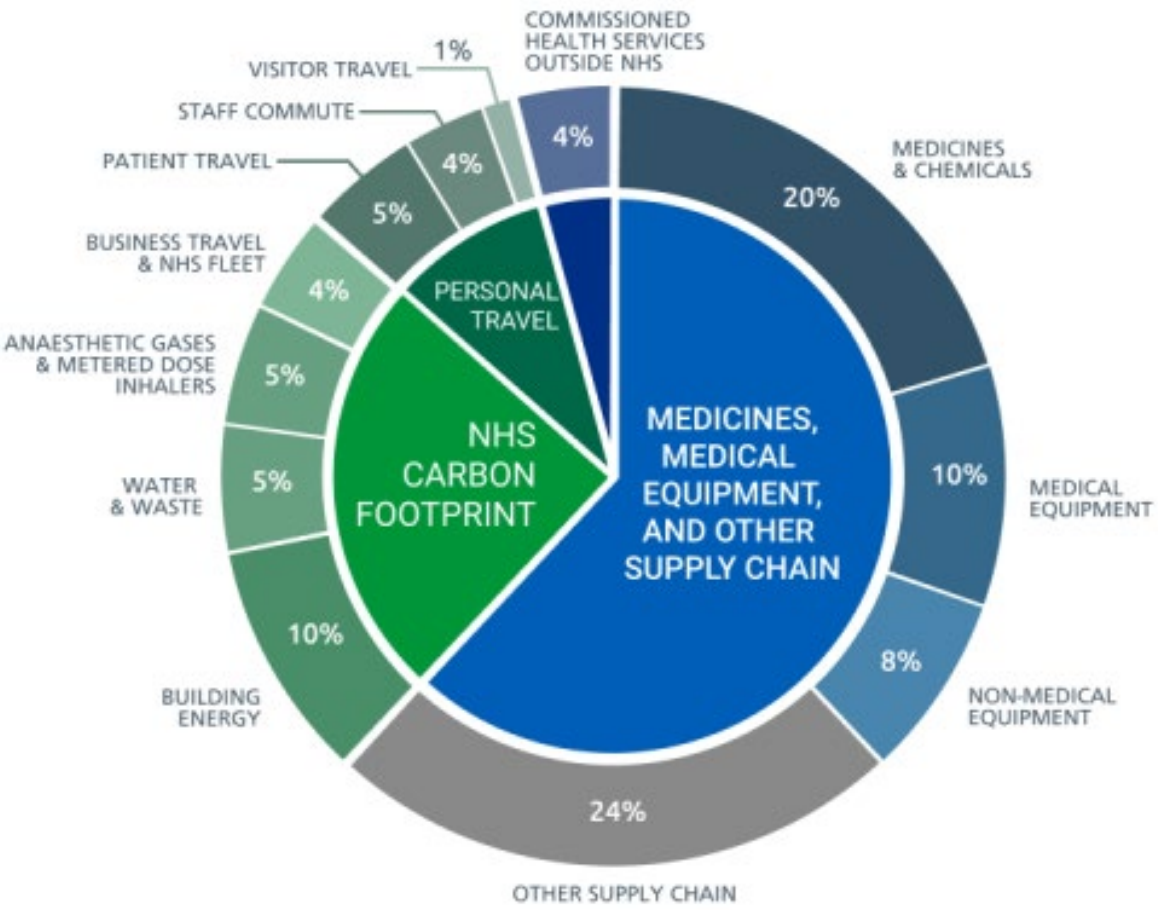
National NHS Goals:

- Emissions we control directly to be net zero by 2040, with ambition to reach an 80% reduction by 2028-2032.
- Emissions we can influence to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

By the year 2040, this trajectory would save an estimated 5,770 lives per year from reductions in air pollution alone. Delivering a 'Net Zero' National Health Service[30]

This diagram highlights the sources of carbon emissions by proportion of the NHS Carbon footprint plus. It shows where we need to focus our efforts.

[29] https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted
[30] https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/


COMMISSIONED HEALTH SERVICES OUTSIDE NHS
4%
MEDICINES & CHEMICALS
20%
MEDICAL EQUIPMENT
10%
NON-MEDICAL EQUIPMENT
8%
OTHER SUPPLY CHAIN
24%
BUILDING ENERGY
10%
WATER & WASTE
5%
ANAESTHETIC GASES & METERED DOSE INHALERS
5%
BUSINESS TRAVEL & NHS FLEET
4%
PATIENT TRAVEL
5%
STAFF COMMUTE
4%
VISITOR TRAVEL
1%
PERSONAL TRAVEL
NHS CARBON FOOTPRINT
MEDICINES, MEDICAL EQUIPMENT, AND OTHER SUPPLY CHAIN

As an ICB, we play a key role in reducing emissions, influencing our providers, and building healthier communities. Our ICB Green Plan[31] was published in March 2023 and outlines how we will support NHS England and the UK government in fulfilling these emission goals.

Our Green Plan is divided into the following nine areas of focus, each with clear goals & actions.

1. Workforce & Leadership- We must ensure everyone understands their role in reducing their carbon footprint.
2. Sustainable models of care- These models of care have less of an impact on our environment because they use less resources and cause less pollution, often focusing on preventative care.
3. Digital transformation- Technology can be used to reduce travel and paper while improving patient care. We must build on the progress that occurred during the pandemic.
4. Travel and transport -Staff and patients will be encouraged to use public transport and walk or cycle more. Car travel produces air pollution accounting for one in twenty deaths in the UK.
5. Estates and facilities -A range of interventions are planned for the next 5 to 10 years that will result in waste reduction, energy efficiency, expansion of green space and sustainable capital projects.
6. Medicines - We must avoid using those anaesthetic gases and gases in inhalers that are much worse for the environment than CO2.
7. Supply chain and procurement - Our providers will be encouraged to focus on sustainability through changes to procurement and contract monitoring.
8. Food and nutrition - Healthy, locally sourced food will be promoted to our staff & patients.
9. Adaptation (adapting to environmental change) – Introducing Adaptation Plans will ensure our healthcare facilities can withstand the impacts of climate change such as floods and heatwaves.

Achievements to date

Over the last year we have already shown evidence of delivery across the ICB and seen progress in Trusts. Some of these achievements are highlighted below.

- A process is now in place to ensure all relevant new NHS procurements include net zero and social value.
- Anaesthetic gas use is below the National target of 5% across all Trusts.
- A decarbonisation review has been undertaken for all 17 hospital sites and plans produced that demonstrate how net zero can be achieved.

[31] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/publications/strategies-and-plans/green-plan-2022-25

- Healthy/active travel plans in some Trusts with facilities and schemes in place to encourage sustainable travel.
- The proportion of Trust owned electric vehicles has increased.
- Digitisation of around 1.75m GP records completed saving storage and associated admin costs.
- Trust initiatives include SMS text reminders for patient appointments, electronic discharge letters & virtual outpatient appointments.
- Clinical pathway initiatives established across our Trusts include virtual wards, virtual outpatient appointments (BTH), a same day emergency care programme (ELHT), hospital home care service (LTH).
- ICB Exec level sustainability lead identified and a dedicated project manager.
- In primary care and Trusts, Green Champions have been trained and supported to encourage colleagues to adopt the principles of sustainability.

Actions in the coming year will build on these achievements. We will work much closely with other public services as well as voluntary and private sector providers to share learning and ensure we develop a joined-up approach to sustainability in Lancashire and South Cumbria.

Lancashire and South Cumbria New Hospitals Programme

The Lancashire and South Cumbria New Hospitals Programme plans to develop cutting-edge facilities, offering the absolute best in modern healthcare and addressing significant problems with the current ageing Royal Preston Hospital and Royal Lancaster Infirmary hospital buildings.

Following on from the announcement of the shortlist of proposals for new hospital facilities in March 2022, the Lancashire and South Cumbria New Hospitals Programme team has carried out a detailed assessment of the shortlisted options. As a reminder, the published shortlist was as follows:

- A new Royal Preston Hospital on a new site, with partial rebuild / refurbishment of Royal Lancaster Infirmary.
- A new Royal Lancaster Infirmary on a new site, with partial rebuild / refurbishment of Royal Preston Hospital
- Investment at both Royal Preston Hospital and Royal Lancaster Infirmary, allowing partial rebuilding work on both existing sites
- Two new hospitals to replace Royal Preston Hospital and Royal Lancaster Infirmary (new sites).

Each shortlisted proposal has been comprehensively assessed for deliverability, affordability, value for money, and viability, considering feedback from patients, local people and staff.

This work has resulted in recommendations for preferred options and alternative options for both Royal Preston Hospital and Royal Lancaster Infirmary. In September 2022, the NHS in Lancashire and South Cumbria stated its preference for new hospitals on new sites for both Royal Preston Hospital and Royal Lancaster Infirmary as part of the New Hospitals Programme: newhospitals.info/update[32]

The detail behind each option will continue to be expanded and refined as further work on the shortlist progresses and the required business cases are developed. No final decisions have been made and the New Hospitals Programme team will continue to involve patients, local people, staff and wider stakeholders in the development of proposals.

The New Hospitals Programme team would like to say a huge thank you to everyone who has taken the time to share their views so far. Listening to the views of people living and working here is the only way we can fully understand what is required when shaping plans and proposals for new hospital facilities

[32] https://newhospitals.info/update

Read more about what we've heard at newhospitals.info/YourHospitalsYourSay[33] or keep up to date on the latest news at newhospitals.info. [34]

Improving Quality

About the Quality Committee

The Quality Committee, which held its first formal meeting in September 2022, provides the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services. It does this against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care.

The Committee exists to scrutinise the robustness of, and provide assurance to, the ICB, that there is an effective system of quality governance and internal control. That system supports the ICB to effectively deliver its strategic objectives and provide sustainable, high-quality care.

The Quality Committee provides regular assurance updates to the ICB Board in relation to activities and items within its remit and more work about the work of the committee is included in the Corporate Governance Statement later in this report.

The Chief Nurse, Medical Director and Director of Nursing for Quality Assurance and Patient Safety are all members of the NHSE North West Regional Quality Group (RQG). The ICB provides a monthly update to the RQG regarding quality and patient safety and will escalate any areas of concern to this group and will also share any learning with this group.

The Quality Committee identifies risks and necessary escalations needed to mitigate the risks relating to patient safety, effectiveness and experience. Risks and Escalations considered include a report relating to the main providers across Lancashire and South Cumbria, focusing on primary care, medicines optimisation, community care, equality, diversity and inclusion, and urgent and emergency care.

The Quality Committee also receives Safeguarding updates covering the ICB's approach to delivering safeguarding statutory functions, changes in the NHS Safeguarding Accountability and Assurance Framework 2022 (SAF) and aspects of learning from safeguarding reviews and the ICB system response. The ICB accountabilities for safeguarding are noted by the committee which recognises the need for delivery and collaboration in the four Places.

System Quality Group

In line with guidance from the National Quality Board the ICB has established a System Quality Group. Whereas the Quality Committee has a function to assure the ICB Board on the quality and safety of services the SQG is focusing on quality improvement and learning and replaces the Quality Surveillance Groups which had more of an assurance focus. The ICB held a development workshop with partners from across the system, to agree the TOR and remit of the SQG and to date meetings have focused on Urgent and Emergency Care, Diabetes and Cancer. The SQG reports into Quality Committee and any areas of significant concern would be escalated to Quality Committee

Improvement Hub and Development of a Lancashire and South Cumbria Quality Management System

There is a strong commitment to improvement methodology and approaches in all the NHS providers in Lancashire and South Cumbria and ICB colleagues have been working with the improvement leads to establish a unified Lancashire and South Cumbria Quality Management System approach. In addition, the ICB will be establishing an Improvement Hub to be chaired by the Medical Director that will bring all the clinical networks together to share learning and outputs from clinical improvement work.

[33] https://newhospitals.info/your-hospitals-your-say
[34] https://newhospitals.info/

System Oversight Framework (SOF)

The Quality team of the ICB work very closely with NHS Trusts in SOF 4 and SOF 3 and through System Improvement Boards (SIBs) we have seen some significant progress in 2022-23.

The ICB has established a clear process and system of support to drive quality improvement in the providers.

University Hospitals of Morecambe Bay Trust is in SOF 4 and, in line with the national framework, has an SIB that is chaired and led by NHS England North West and attended by the ICB. There is a clear improvement plan and exit criteria and the national team will review progress with a view to moving into SOF 3 this year.

Blackpool Teaching Hospitals is an SOF 3 Trust and has an SIB chaired and led by NHS England North West, who are planning to hand over the leadership to the ICB in the second quarter of 2023/24.

Safeguarding

The ICB has statutory responsibility for safeguarding roles and functions in accordance with the NHS Accountability and Assurance Framework (2019), Children and Social Work Act (2017), Working Together to Safeguard Children (2018), Promoting the Health and Well-being of Children Looked After (2015) and the Care Act (2014). The responsibility for Safeguarding is held by the Chief Nursing Officer with a senior team in place and supporting governance and assurance structures.

It remains the responsibility of every NHS-funded organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied, with the wellbeing of those adults and children at the heart of what is done.

NHSE requires the ICB to submit a response to the requirements of the Safeguarding Assurance & Accountability Framework (SAAF). The ICB has submitted an annual Safeguarding Self-Assessment to provide assurance of its arrangements to NHSE/I, as well as to the Adult Safeguarding Boards and Children's Safeguarding Partnership's. With the exception of training, full compliance has been declared this year; further detailed activity will be contained in the Annual Safeguarding Report due to be published in quarter 2 of this financial year. As part of the SAAF process the ICB must ensure that health services across the system have effective safeguarding arrangements in place which is further complemented by assurance visits and Section 11 Audit.

The Quality Committee also received Safeguarding updates covering the ICB's approach to delivering safeguarding statutory functions, changes in the NHS Safeguarding Accountability and Assurance Framework 2022 (SAAF) and aspects of learning from safeguarding reviews and the ICB system response. The ICB accountabilities for safeguarding are noted by the committee which recognises the need for delivery and collaboration in the four Places; furthermore, the Quality Committee is sighted on any emerging themes and the required actions to improve and strengthen arrangements. Risks and escalations include Children In Care Health Assessments, Liberty Protection Safeguards and Court of Protection / Deprivation of Liberty Safeguards and workforce.

The geographical footprint of the ICB is such that safeguarding partners are across and inclusive of both the Cumbria, Lancashire and North Yorkshire partnership arrangements for those adults, children and families requiring support and protection. Full representation has been maintained at Safeguarding Adults Board's, Safeguarding Children's Partnership and associated subgroup meetings, to fulfil and discharge both commissioning and statutory safeguarding responsibilities. This has enabled the ICB to work with its partners to ensure learning from local and national child death and safeguarding reviews has influenced and strengthened practice.

The published Partnership arrangements and reviews can be found below:

- Cumbria: Home page (cumbriasab.org.uk) https://cumbriasafeguardingchildren.co.uk/
- Lancashire: https://www.lancashiresafeguarding.org.uk/ Lancashire Safeguarding Adults Board - Lancashire Safeguarding Children

Board https://www.blackpoolsafeguarding.org.uk/safeguarding-adults-1 https://www.blackburn.gov.uk/adult-social-care/safeguarding-adults
- North Yorkshire https://safeguardingadults.co.uk/ https://www.safeguardingchildren.co.uk/

The ICB has engaged in several initiatives across Lancashire and Cumbria to influence safeguarding practice, and has been recognised for excellence in the provision of Sudden and Unexpected Death in Children Nurse led service; it being noted as an exemplar in a parliamentary debate (Jan 2023).[1]

Engagement with and listening to children and young people, families and adults remains a priority and this year the ICB has:

- Worked directly with and listened to feedback from Children in Care and Care Leavers and activity is in progress to develop an offer for apprenticeship/employment opportunities and access to Mental Health First Aid training.
- Worked with the Safeguarding Board to; assess how to Make Safeguarding Personal, to provide assurance around compliance and understand the improvements required to strengthen care packages and the quality monitoring processes.

Going forward the work plan includes actions to address newly acquired statutory responsibilities, including significant activity to address the ICB duty to co-operate in line with the Serious Violence Duty (2022) and Domestic Abuse Act (2021),and the development and finalisation the Safeguarding and Children In Care strategies which will demonstrate the ICB commitment to listening to children and families.

> *It would be very easy to use this debate to set out all the things that went wrong and could have been done better, but I want to talk about something that went really well. Emily and Darren were given a SUDC nurse, Jo Birch, who has been a real support to the family through a year that has been, quite frankly, horrific. This is something that is in place in Lancashire, but not everywhere. I take this opportunity to thank Jo for her work and share with the House her role. Jo is part of a nurse-led SUDC service. It is the first nurse-led SUCD service in the country—most are paediatric-led. The service began in 2008 and covers the whole of Lancashire. It follows each case through until the final stage of the process, which is the child death overview panel. For the first 10 years, the service was just two nurses working Monday to Friday, but since 2018 it has become a seven-day service. I am pleased to learn that there are now a couple of other nurse-led teams, although Lancashire remains the only one like it in the north of England.*
>
> **Cat Smith MP**

Engaging with people and communities

Public involvement is an essential part of making sure that effective and efficient health and care services are delivered; by reaching, listening to, involving and empowering our people and communities, we can ensure that they are at the heart of decision making. The NHS in Lancashire and South Cumbria is committed to putting our population's needs at the heart of all we do.

The ICB has endorsed a strategy for working with people and communities which describes an ambition to develop robust and trusted relationships which empower our citizens and communities and enable a

[1] https://hansard.parliament.uk/commons/2023-01-17/debates/766901C8-5D94-4BE9-8530-7C5087ACB9E0/SuddenUnexplainedDeathInChildhood

change in culture and behaviours. The strategy is based on ten principles for public involvement and engagement. More information on the strategy is available here.

The ICB has established a Public Involvement and Engagement Advisory Committee [35](PIEAC) to support the ICB in ensuring the voice of local people and residents is actively embedded and valued in decision making of the ICB and at all levels of the system, particularly in relation to inequalities and those who are seldom heard. The Committee will support the ICB in ensuring the principles for working with people and communities are intrinsically in place across all parts of the organisation and wider integrated care system.

PIEAC first received a report about complaints received by the ICB at their initial meeting in October 2022 as part of a wider 'Insights Report'. The committee also received this information in subsequent meetings.

The content of this report has been reviewed and more detail included from the meeting in April 2023. This meeting was also provided with the number of complaints received from the inception of the ICB in July 2022 onwards. The report content will continue to be refined but will be based around the bullet point list submitted.

Both PIEAC and Quality Committee are sub-committees of the ICB Board. The Chair of PIEAC attends both committees and is an ICB Board member. They present a 'Chair's Report' at Quality Committee which includes this information, but Quality Committee does not currently receive the written report.

More information on the work of this committee can be found in the Corporate Governance Statement later in this report. Information about PIAEC, including a Terms of Reference, the schedule of meetings and agendas can be found on the PIEAC page of the ICB website. [36]

The ICB has a single point of contact for all new complaints including those received from Members of Parliament. All formal complaints are recorded on a case management system through the ICB's Patient Experience service. The ICB has an agreed and published policy, and all complaints and responses are reviewed by the Chief Nursing Officer. Each meeting of the bi-monthly PIEAC now receives a report which covers:

- The numbers of new contacts by type and comparisons to previous months.
- A summary of the type of complaints received and details of MP activity.
- Analysis of trends and themes emerging from the cases dealt with.
- Examples of learning.

Complaints are currently handled by a combination of ICB employees and Midlands and Lancashire Commissioning Support Unit (MLCSU).

Engagement and involvement toolkit and guidance for ICB staff

As part of our development of the communications and engagement team, along with a robust and resilient engagement infrastructure and process, the team have developed an engagement toolkit and guidance for use by ICB teams and to support wider partnership working across the ICS, including the Provider Collaboration Board and the wider workforce.

The toolkit aims to support teams to embed the ten principles for engagement and involvement in all areas of the organisation and partnership. Alongside this, the engagement team developed a workforce training programme that complements the toolkit and guidance The training along with learning and development training will be rolled out to the wider system throughout 2023/24 and we are considering an online option for the workforce and system partners.

[35] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/sub-committees/public-involvement-and-engagement-advisory-committee
[36] https://www.lancashireandsouthcumbria.icb.nhs.uk/get-involved/public-involvement-and-engagement-advisory-committee

Citizen's Panel – database of public connected to ICB

The ICB has developed a citizen's panel of members of the public who have agreed to participate in surveys, engagement and give their insights concerning health, wellbeing and health services in Lancashire and South Cumbria. The majority of these have been through a process of opting-in to be part of the panel from previous CCG databases. This model has been presented as good practice nationally and has been adopted by a number of ICBs. At the time of this report, the membership consists of about 1,400 members from across the region. Panel members receive a monthly bulletin with opportunities to engage with the work of the ICB, and information.

In response to demand from ICB colleagues, and interest from members of the citizen's panel, we have established a Readers' Group. The group has started to review documents, information, letters and leaflets and offers suggestions on how these can be more patient and public friendly. We currently have 62 members who have joined the group. Members of the readers group have contributed to the development of the ICB priorities and strategy, and our policy on volunteer expenses and is a good example of how policies and documents can be improved with public engagement and involvement. To support the panel, we have created pages on the ICB website, along with our strategy, and plans, and it also provides a link to join the citizen's panel which will be used as part of our proposed recruitment drive: https://www.healthierlsc.co.uk/get-involved/citizen-panel . A campaign has been developed to launch a recruitment drive to increase the membership of the panel. This has been actively promoted on social media and increased activity is planned for media and through the local engagement events.

Engagement at Place

Work has begun to develop the approach to establish engagement networks with local communities in places. These build on existing networks and groups and provide an opportunity for the ICB to listen to community representatives, including existing patient voice groups, and GP practice patient participation groups. We have held listening events in Barrow, Blackburn, Blackpool, Burnley, and Preston and will continue to roll out these events throughout 2023/24. In addition to this, the engagement team structure includes provision for an engagement coordinator aligned to each place within Lancashire and South Cumbria and these rolls will actively support the development of engagement networks, specific local projects and the listening events as a key part of our engagement at place.

Clinical and care professional leadership

A Lancashire and South Cumbria ICB ambition is to ensure that clinical and care professional leadership is a key part of everything it does. The ICB is committed to ensuring that clinicians and care professionals play an active role in the health and care system.

In September 2021, NHSE published implementation guidance on their Clinical and Care Professional Framework (CCPL)[37] to enable a multi-professional leadership to be created within ICBs.

The ICB is currently in the process of recruiting clinical and care professional lead roles across Places and the region. Information about the Clinical and Care Professional Framework can be found on the ICB website. [38]

[37] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0664-ics-clinical-and-care-professional-leadership.pdf
[38] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/clinical-and-care-professional-leadership

Reducing health inequality

The establishment of the ICB in July 2022 provided a platform for the Lancashire and South Cumbria health and care system to develop its approach to population health management, preventing ill health and address health inequalities. During 2022/23 the ICB has worked with partners across Lancashire and South Cumbria to refocus its approach and re-build its structure. Taking action on prevention and improve population health is a priority for the whole ICB. The context for this work has been clearly laid out in reports and planning documents issued nationally and locally in the past year:

- The first meeting of ICB (July 2022) confirmed health inequalities as a major structural challenge - "requiring sustained focus on a multi-year basis"
- The ICB's core purposes are to improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, enhance productivity and value for money and help the NHS support broader social and economic development.
- Prior to the establishment of the ICB the health and care partners across Lancashire and Cumbria had commissioned the Institute of Health Equity to support a Lancashire and Cumbria Health Equity Commission, chaired by Professor Michael Marmot, with members from organisations from across the Lancashire and Cumbria Region including from local government, the NHS, the VCFSE sector and universities. The commission concluded its work during 22/23, culminating in the presentation of the report to leaders in October and November 2023. The final report A Hopeful Future: Equity and the social determinants of health in Lancashire and Cumbria - IHE (instituteofhealthequity.org)[39] sets out recommendations for system-wide approaches working with partners within and beyond the NHS to achieve long-term reductions in health inequalities through action on the wider determinants of health. The recommendations have helped to shape the ICB work programme and the ICP's proposed Integrated Care Strategy.

The ICB has a comprehensive approach to improving health and tackling health inequalities. The work to start building this approach commenced as one of the accelerator programmes in preparation for the establishment of the ICB. The programme of work has become embedded within the ICB through the establishment of the Population Health Directorate and through embedding the core duties across the organisation.

The ICB is focused on driving down the inequalities in access, outcomes and experience for people in our core20plus communities in relation to the clinical priorities set out in the national Core20plus5 guidance for adults and children and through working in place-based approaches with people and their communities. Key highlights of this work are detailed below.

The ICB has made significant progress in mobilising actions in 2022/23, in line with the 2022/23 planning guidance, including:

Strengthening leadership and vision

- The establishment of leadership posts within the ICB, including the Associate Medical Director for Population Health and the Director of Population Health, in addition to a team with capacity to support work across the system and within the four places.
- The establishment of the Population Health and Health Equity Academy to provide learning and development opportunities for clinical and other professionals. A first cohort of 45 clinical leaders from PCNs are nearing completion of their intensive 9 month programme co-designed and co-delivered with the King's Fund. The Academy has also provided a series of Best Practice sessions and a number of other training and development initiatives including supporting the establishment of a quality improvement programme in collaboration with the Provider Collaborative.
- Supported Trusts in developing their health inequalities strategies and plans, leading to a growth in health inequalities-focused activities now being underway across every Trust within LSC.

[39] https://www.instituteofhealthequity.org/resources-reports/a-hopeful-future-equity-and-the-social-determinants-of-health-in-lancashire-and-cumbria

- Established funded Health Inequalities Clinical Lead posts in every Primary Care Network to take a lead in understanding needs within their communities and working with communities and partners to address needs.
- Supported people across LSC to be champions and leaders for health inequalities including, for example place-based Clinical Leads, workstream leads, Core20plus5 Ambassadors and Public Health Fellows and trainees.
- Alignment of work with the Public Health Collaborative and work on shared priorities for example refreshing and strengthening work to address tobacco dependence.

Enabling infrastructure and support

- Improving access to data, analysis & intelligence tools, skills & capacity.
- A health equity-based funding formula has been developed and tested and further work has begun to adapt it for use as an ICB funding formula to underpin our plans to improve health equity.
- A variety of bids have been successful, providing additional resource to work on specific projects, including for example the successful IHI bid with the provider collaborative to embed the use of quality improvement approaches to address health inequalities with a focus on cancer.
- Work has continued within Trusts and with partners at place to embed anchor approaches and further discussions are underway to share good practice and opportunities for joint work.
- The ICB received an allocation of new funding to address health inequalities in 2022/23. This funding was allocated against the Population Health and health inequalities work detailed in this report.
- Supporting Health Inequalities Clinical Leads in PCNs & place-based teams in approaches to community development and participation to ensure we hear the voices of those who have the worst access, experience and outcomes.
- Supporting the growth of community development and participation through spreading tools, techniques & approaches, for example training a cohort of people in Art of Hosting approaches which have subsequently been deployed to facilitate conversations with communities.
- Working across the system to enable ARRs roles to become embedded and key enablers in the building of integrated teams and working towards a continuum of delivery that includes development of a more psychosocial model of care that takes a more holistic approach to supporting the health and wellbeing of a community.
- A number of specific posts have already been established to take forward specific Core 20 plus 5 priorities, including a Learning and Disabilities and Autism Health Inequalities Lead role and a Cancer Health Inequalities Lead role.

Accelerating preventative programmes

The ICB has increased access to preventative programmes for those facing the greatest health inequalities, for example through:-

- Population Health Management - Clinical and demographic data has supported planning, enabling targeted interventions to prevent ill health, improve care and address variation.
- Improving early diagnosis of cancer – for example by establishing targeted lung health checks in Blackburn with Darwen, Blackpool and East Lancashire; improved surveillance of people with conditions that predispose to liver cancer.
- L&SC COVID 19 Vaccination Programme – Targeted initiatives to drive vaccine uptake within groups and communities displaying hesitancy with a focus on ethnicity, vaccination in pregnancy, deprivation and isolation, transient, homeless and asylum seekers. The vaccination programme has worked in partnership with the Local Authorities, Public Health, Integrated Care Boards, Volunteer, Faith, and Social Enterprise sectors, including the Preston Windrush Initiative, the Caribbean and African Health Network (CAHN), Lancashire Council of Mosques, the IMO Charity, and One Voice.
- Screening - Pilots to increase cervical and breast screening for people with Learning Disabilities; review of the data flows for screening in prisons; cervical insight work in the areas with lowest uptake.

- CVD – Establishing a CVD Prevention Strategy and commencing delivery of a programme of CVD prevention programmes.

Strengthening Population Health Management

The ICB supported the 20 per cent most deprived population, identified by the Index of Multiple Deprivation through, and "PLUS" communities/inclusion groups, for example:

- A significant programme of work is underway within the Elective Recovery Programme to understand the health inequalities across the elective workstream. A Health Inequalities Elective Recovery Network has been established and has undertaken in-depth analysis of the data. Deprivation does not appear to have a significant impact in Lancashire and South Cumbria, whereas there are evident inequalities in terms of ethnicity and age. These are now being explored and action plans being developed.
- A health inequalities approach was taken to Long Term Conditions Recovery in Primary Care, targeting particular PCNs in the Core20plus areas.
- Work has been undertaken to address key "Plus" populations including delivering significant improvements in annual health checks for people with learning disabilities and with Serious Mental Illness. Both of these are described in detail elsewhere in this report. Ethnic minorities are another key "Plus" population in Lancashire and South Cumbria and have been the focus of a number of pieces of work detailed below. At a system level there has been a focus on improving the coding so that a Population Health Management approach can be used more effectively to address inequalities for our ethnic minority population.
- An Enhanced Health Check (EHC) programme, adopting an enhanced version of the standard NHS health targeting those from the 20 per cent most deprived population and aiming to increase access to public health, lifestyle and social prescribing services such as weight management and debt support. Through this work, Primary Care Networks are detecting a greater number of people with risk factors in the Core 20 plus communities in order to increase the uptake of screening, immunisation and other preventative and support services.
- Tabletop analysis of priority and exemplar wards provided by NHSE/Improvement Equity and Health Inequality Team together with Rightcare. VCFSE partners have been commissioned to undertake an exploratory phase of work in all priority wards to understand the higher than predicted levels of non-elective admissions and a similar piece of work in exemplar wards.
- Projects focused on Core20 communities [40]to provide support, information, and advice to young people and their families who have a diagnosis of pre-diabetes or Type 2 Diabetes and to reduce the rate of increase in the numbers of young people with obesity and at risk of becoming diabetic.
- Priority wards – a programme of deep listening, building towards collaborative working between health and care teams and the populations they serve to make lasting change. Whilst the 'core20' is the starting point for this work through hyper-local approaches we seek to build stronger relationships with the communities that live there, including GRT and BAME communities and those experiencing homelessness.
- An educational / self-empowerment project for communities based upon reducing emergency admissions for children living in Core20 areas.
- Delivered winter wellness programmes using risk stratification to focus on the Core20plus communities.
- Supported community-initiated and partnership-led approaches to address the cost of living and fuel crisis.
- Work in East Burnley with the Bengali community to redesign preventative and educational programmes to be more culturally appropriate.
- Increasing the numbers and quality of the annual health checks for people with serious mental illnesses with a particular focus on addressing health inequalities Improving ethnicity recording across all services and pathways. Work is continuing to improve ethnicity data capture and improvements are being demonstrated.

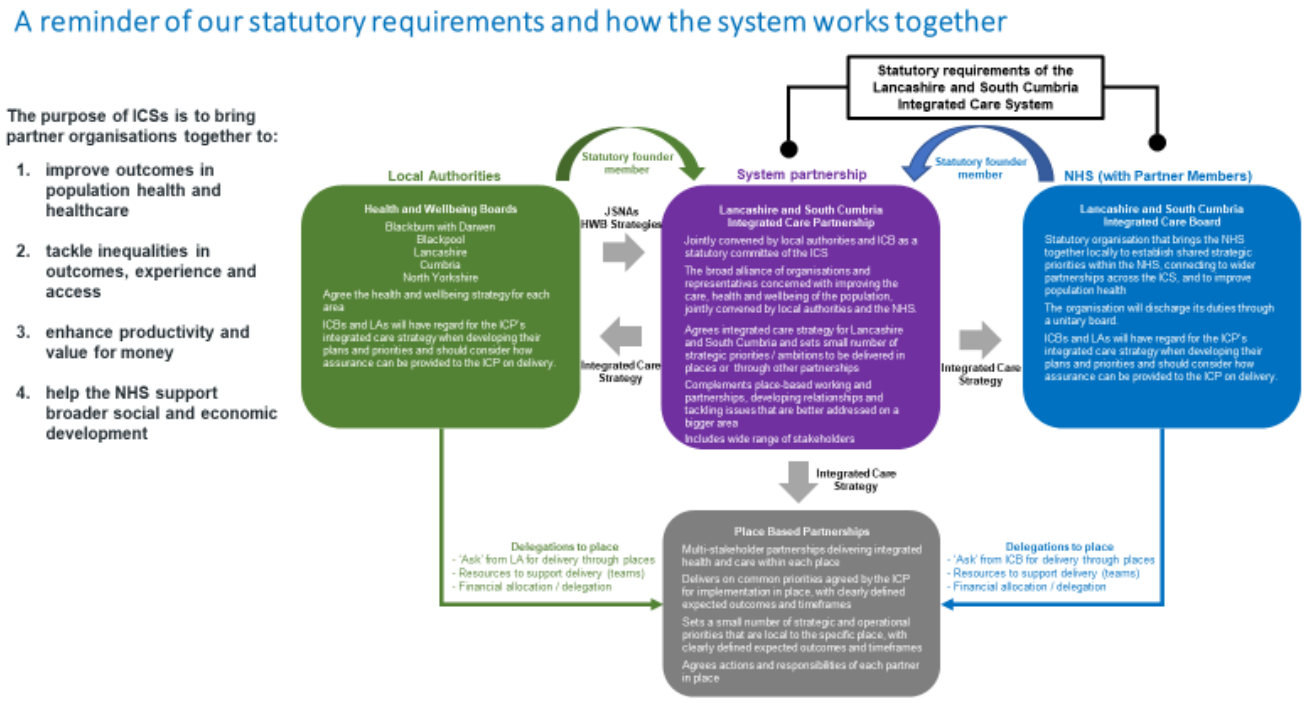
[40] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

- Mitigation against digital exclusion - The ICB has worked with the VSFSE sector to support people to improve their digital maturity levels. Key areas of work include:-
- Supporting primary care services to become sustainable with digitally qualified workforce, supporting 2,317 people (2021-2022) from protected groups to improve their knowledge, skills and confidence and become lifestyle digitally included and providing case studies and videos to improve ICS workforce digital diversity. This programme is running again this year.
- Working alongside the elective care services within the acute trusts, supporting patients to improve their digital maturity and health and wellbeing (2022 -2023).

The ICB has supported a number of programmes of work to specifically enable each Primary Care Network, place or locality to better understand and work with the most vulnerable cohorts of our population to improve their access to, experience of, and ultimately outcomes of healthcare. Examples of specific areas of focus include:-

- Gypsy Roma Traveller Women in Lancaster – a significant early death rate from breast and cervical cancer was identified. Working with women from the community led to the practice redesigning screening services with GRT women, who are now working with them as community champions.
- HARRI (health, advice, recovery, resilience, information) health and wellbeing engagement vehicle, travels across Lancashire and South Cumbria to talk with the local communities and individuals, particularly targeting people in the Core20 and plus communities
- Fylde Coast:- dedicated Homeless Health Nursing Service and additional capacity to support harm reduction initiatives and assertive outreach. These services form part of a wider Homeless Health Hub. Successful bid for NHSE System Development Funding to support the development and implementation of a dedicated Homeless Mental Health Service. This is now operational. Chair the Fylde Coast Multiple Disadvantage Strategic Group. Fund 2 full time Homeless Link Workers who sit within the Hospital Discharge Team, links with above teams to facilitate timely discharge and ongoing care needs to support clients in remaining out of hospital.
- West Lancashire: PLUS groups have been identified by engaging with all the key stakeholders (GP's, WLBC, VCFS). Key PLUS groups are: asylum seekers / refugees; Farmers / growers / migrant workers; Boatees (canal boat people); Gypsy Romany Traveller; People with LD. The plan is to target these groups through a calendar of activity supported by health checking team and GP's from that PCN. Work commencing includes:- outreaching to boatees by the canalside and encouraging access to a health check using the HARRi Bus and local nearby health centres, working with Ecumencial centre and family forge to deliver drop ins for EHCs, children's health checks and women's health (cervical smears etc) for asylum seekers / refugees.
- In total 30 projects are underway, being undertaken by health Inequalities Clinical Leads in Primary Care Networks and supported by Action Learning Sets as part of the Population Health Academy.

Health and wellbeing strategy



Health and Wellbeing Boards – what are they?

Health and wellbeing boards are a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government. They have a statutory duty to, with others, produce a joint strategic needs assessment (JSNA) and a joint local health and wellbeing strategy (JLHWS) for their local population.

Local authorities covering the Lancashire and South Cumbria area have developed, and continue to update their Health and Wellbeing strategies. The ICB is involved in this through the key leads for each of the ICB's Places, through ICB executives being members of the Health and Wellbeing Boards and being involved with development sessions and workshops to review and update the Health and Wellbeing strategies.

Health and Wellbeing Boards in Lancashire and South Cumbria.

There are 5 Health and Wellbeing Boards which are either entirely or partly within the Lancashire and South Cumbria ICB area:

- Blackpool Health and Wellbeing Board.[41]
- Lancashire Health and Wellbeing Board[42]
- Cumbria Health and Wellbeing Board[43]
- Blackburn with Darwen Health and Wellbeing Board[44]
- North Yorkshire Health and Wellbeing Board [45]

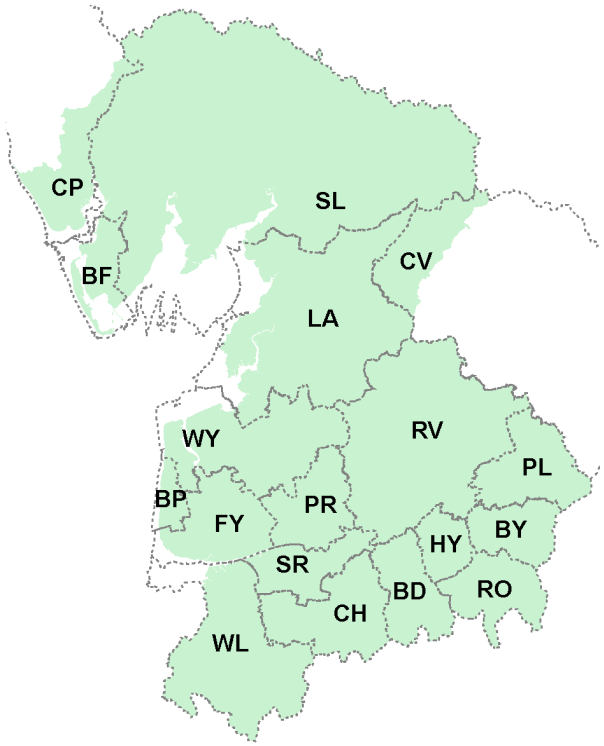
Reform of local authorities in Cumbria has seen the establishment of Cumberland Council and Westmorland and Furness Council. In Yorkshire, eight councils merge to become the unitary authority of North Yorkshire. These changes happened on 1 April 2023.

[41] https://democracy.blackpool.gov.uk/mgCommitteeDetails.aspx?ID=169
[42] https://www.lancashire.gov.uk/practitioners/health-and-social-care/health-and-wellbeing-board/
[43] https://councilportal.cumbria.gov.uk/mgChooseDocPack.aspx?ID=12148
[44] https://www.blackburn.gov.uk/health/health-strategy-and-reports/health-and-wellbeing-board
[45] https://www.nypartnerships.org.uk/hwbbstructure

Some residents of Lancashire and South Cumbria receive health services from, or in, North Yorkshire. It has been agreed that whilst there will be no member of Lancashire and South Cumbria ICB on North Yorkshire's Health and Wellbeing Board, there will be mutual engagement on matters of relevance.

Lancashire and South Cumbria ICB is represented on each Health and Wellbeing Board, except for North Yorkshire, by an ICB Director. During the year Councils have been refreshing the health and wellbeing strategies and Place leads have been involved in this work. Health and Wellbeing Boards have received updates on the establishment of the ICB and the development of its ways of working in Place and its Joint Forward Plan which is on track to be published by 30 June 2023. ICB representatives have been actively involved in shaping JLHWS. They have helped to ensure consistency and coherence across wider system strategies and to identify key areas requiring stronger focus, such as mental health and preventing homelessness.

5. Lancashire and South Cumbria Integrated Care System / ICB / ICP



Caption: Area encompassed by Lancashire and South Cumbria overlain by counties. Postcode area CV is in North Yorkshire.

Relationships

Integrated Care Board and Integrated Care Partnership leaders, informed by the people in their local communities, need to have regard for and build on the work of Health and Wellbeing Boards to maximise the value of place-based collaboration and integration, and reduce the risk of duplication. They should ensure that actions are coordinated, add and are taken in the light of a common understanding of what is best for their population.

The Integrated Care Partnership (ICP) is a statutory joint committee of the ICB and each responsible local authority (upper tier and unitary) within the Lancashire and South Cumbria area. Membership of our ICP includes elected members from local authorities.

Developing plans

The Health and Care Act 2022 requires ICPs to develop an Integrated Care Strategy which details how the assessed needs of the population, as identified in joint strategic needs assessments (JSNAs), will be met by the exercise of functions by the ICB, partner Local Authorities, and NHS England. This strategy is described in NHS England (NHSE) guidance as setting "the direction of the system … setting out how the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life".

A draft integrated care strategy was developed during the latter half of 2022/23, and the final version will be agreed by the ICP in April 2023/24. The JSNAs and existing Joint Health and Wellbeing Strategies were key to the creation of the integrated care strategy, ensuring that it was shaped around the needs of our residents.

The ICB must have regard to, and ensure alignment with, this integrated care strategy as it develops its own strategic and operational plans. Early in 2023, the ICB developed its Joint Forward Plan which starts to set out the ICBs response to agreements with Local Authority partners as set out in the integrated care strategy.

An example of collaboration and coordination can be seen in the sharing of population health intelligence by the ICB Population Health Team with the BwD JSNA Partnership Group to ensure that this informs the JSNA and vice versa.

For information, individual JSNAs can be found here:

- JSNA Cumbria[46]
- JSNA Lancashire[47]
- JSNA Blackpool[48]
- JSNA Blackburn with Darwen[49]
- JSNA North Yorkshire [50]

[46] https://www.cumbriaobservatory.org.uk/jsna/
[47] https://www.lancashire.gov.uk/lancashire-insight/jsna/
[48] https://www.blackpooljsna.org.uk/Home.aspx
[49] https://www.blackburn.gov.uk/health/health-strategy-and-reports/joint-strategic-needs-assessment
[50] https://www.datanorthyorkshire.org/JSNA/JSNA

Financial review

Performance Summary

Over the last year we have tracked the progress of our service providers (for example local hospitals, community services, primary care practices) against several national outcomes indicators and ensured that patient rights within the NHS Constitution were maintained. Additionally, we set local priorities against which provider progress was monitored. Performance reports were presented to and scrutinised the Finance and Performance Committee and a summary of key issues presented to the Governing Body.

Financial Key Performance Indicators

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

Key performance indicator	Target	Actual	Result
Revenue resource use does not exceed the amount specified in Directions	Maintain expenditure within the allocated in-year resource of £3,043.2m	Total expenditure £3,043.2m	Achieved
Maintain expenditure within cash funding received	Net cash funding received £3,054m	Cash Remaining at 31 March 2023 £0.58m	Achieved
Revenue administration resource use does not exceed the amount specified in Directions	Maintain administration (running costs) expenditure within the allocated resource of £26.5m	Total administration (running costs) expenditure £26.4m	Achieved
QIPP savings targets identified and savings achieved	Overall QIPP savings target £50.9m	Total QIPP savings £26.2m	Not achieved (shortfall covered by other mitigations - additional allocations and underspends in other areas)
Capital resource does not exceed the amount specified in Directions	Maintain expenditure within the allocated in-year resource of £3.5m	Total expenditure £3.4m	Achieved
Comply with the Better Payment Practice Code (BPPC)	Ensure 95% (by value and volume) of all valid invoices are paid by the due date or within 30 days of receipt of a valid invoice, whichever is later	NHS payables: - 99.7% by value - 99.3% by volume Non-NHS payables: - 97.2% by value - 99.5% by value	Achieved

Financial review

As a result of the ICB only becoming a statutory body on 1 July 2022, this report only covers the 9-month period from July to March of the 2022/2023 financial year.

The first 3-month period from April to June was reported by the former eight Lancashire and South Cumbria CCGs. As CCGs had to report a breakeven position at 30 June 2022, NHS England made adjustments to individual CCG allocations in month 3 to cover any deficits and to ensure that overall allocation and expenditure were matched. To ensure financial balance across the whole financial year under this arrangement, NHS England made a compensating adjustment to the ICB allocation.

For the financial year 2022/23, the previous arrangement under which NHS providers were paid a nationally determined monthly 'block' contract payment was continued, to enable a measure of financial stability for all parties.

The following section provides a brief overview of the ICB's financial performance in the 9-month period of 2022/23. The financial accounts have been prepared under a Direction issued by NHSEI under the National Health Service Act 2006 (as amended). A full set of accounts, including associated certificates, is included later in this report.

Allocation

As described above, the total in-year allocations to NHS Lancashire and South Cumbria ICB for 2022/23 relate to the 9-month period from July to March and were as follows:

- We received allocations totalling £2,719.5m for commissioning NHS services for the local community
- We received a further allocation of £236.7m for delegated commissioning of primary care medical services
- We received a further allocation of £34.5m for delegated commissioning of pharmacy services
- We received a further allocation of £26.5m from which we were expected to cover all our running costs

2022/23 financial duties

The ICB's performance against each of its financial duties, as reported in Note 2 to the Accounts, for the 9-month period from July to March 2022/23 financial year was as follows:

- The ICB remained within its cash limit.
- The ICB maintained its administration expenditure within its Running Costs Allowance.
- The ICB remained within its capital resource limit.

Financial Performance

We have faced a number of financial pressures during the 9-month period from July to March 2022/23, including the inherited position from the former eight CCGs. The revised financial regime first introduced in 2020/21 to assist organisations in dealing with the Covid-19 pandemic, was largely replaced by a return to business-as-usual arrangements, with no additional funding for the Hospital Discharge Programme and the majority of other Covid-19 related expenditure being funded from within ICB allocations. The block contract arrangements in place with NHS providers for the previous two financial years have been maintained and adapted to cover payments to providers outside of the Integrated Care Board boundary, such that any contract values above £0.500m with individual providers are subject to a formal contract, with any below that value covered by Low Value Activity (LVA) arrangements, both of which are determined at an aggregated Integrated Care Board level.

As part of the planning process, the ICB was expected to make Quality, Improvement, Productivity and Prevention (QIPP) savings during the year, based on an ICS system agreed percentage of allocation. The ICB's overall target for the 9-month period was £50.9m but, due to the constraints imposed by the introduction of the block payments to providers as part of the revised financial regime, the only schemes able to deliver significant savings were in medicines management and continuing healthcare. Overall, the ICB's delivery against these efficiency plans realised savings of £26.2m, with the shortfall having

been covered by unplanned underspends in some areas and other mitigations to ensure a breakeven position could be reported, as described above.

Analysis of Covid-19 expenditure

The CCG received no additional allocations to cover expenditure incurred as a result of the Covid-19 pandemic during the first quarter of the financial year.

Analysis of EU exit related expenditure

The CCG has not incurred any additional costs in relation to the UK exit from the EU and has not been in receipt of any additional funding.

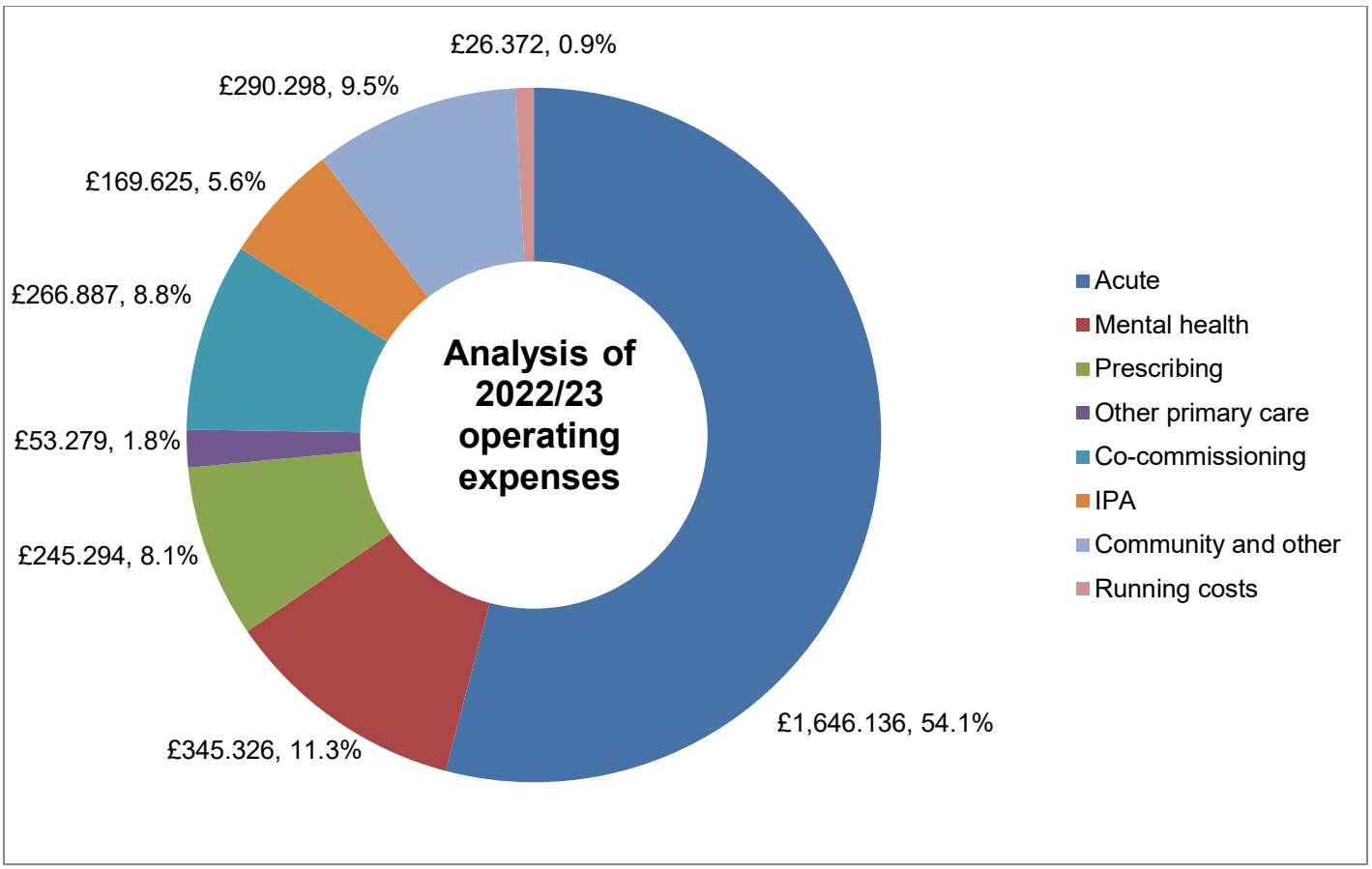
Accounting policies

The ICB's accounting policies are shown in full in Note 1 to the Annual Accounts. Following the Health and Care Act receiving Royal Assent on 28 April 2022, which allowed for the establishment of Integrated Care Boards across England and the abolition of CCGs, the ICB took on the commissioning functions of the eight former CCGs as the successor body. As a result, the functions, assets and liabilities of the eight former CCGs transferred to the Lancashire and South Cumbria ICB on 1 July 2022. The accounting policies follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury.

We have made no changes to accounting estimates during the 9-month period from July to March of the 2022/23 financial year, however, as described above, the ICB has continued to contract with NHS providers on a block basis and payments have therefore, in general, been fixed irrespective of levels of activity undertaken.

Further details of accounting estimates made are reported in Note 1.33 to the Accounts, "Critical accounting judgements and key sources of estimation uncertainty".

Analysis of 2022/23 operating expenses



ACCOUNTABILITY REPORT

Kevin Lavery

Chief Executive Officer

29th June 2023

Accountability Report

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

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 July 2022 to 31 March 2023, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

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

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

Corporate Governance Report

Lancashire and South Cumbria ICB was established on 1 July 2022. Prior to establishment there were eight Clinical Commissioning Groups (CCGs) within Lancashire and South Cumbria; these were abolished at midnight on 30 June 2022 at which stage all statutory functions, along with assets, liabilities and staff transferred to the ICB under a statutory transfer order. Due diligence was undertaken prior to the transfer, and CCG accountable officers provided written assurance of completed due diligence to NHS England.

This first financial period is one of transition and as such was a developmental period for the ICB. The complexity of reviewing and managing the eight CCGs systems, processes, operational policies, contracts, data, assets and liabilities into one operating model and governance framework has been an enormous undertaking, and there are still areas to align. The context in which the ICB is operating, given its size, demographics and in-year establishment has been challenging in our first nine months, and there are still areas for the ICB to improve and build on. The ICB inherited differing systems and processes from the predecessor CCGs such as three IT providers, eight financial ledgers, differing payroll providers and a varying model of commissioning support unit service level agreements across various functions transferred from CCGs.

Each predecessor CCG had differing risk management approaches and processes, and whilst the ICB agreed its strategic objectives and board assurance framework in December 2022, risk management is still to be fully embedded into the organisation and the board has still to agree its risk appetite statement. This will be a key priority in early 2023/24.

Understanding and mitigating risks within the ICB and the wider Integrated Care System across Lancashire and South Cumbria is a key factor to supporting the ICB in delivering its strategic objectives. Developing a level of openness, honesty, collaboration, and trust between system partners in risk management approaches is an important part of the system's maturity. This will be an area of focus for the ICB in 2023/24.

The ICB inherited a challenging aggregated financial position from the eight CCGs along with a reduction in allocations to reflect the convergence adjustment and reduced funding for Covid related costs incurred by providers. Despite this challenging starting position, the ICB has successfully managed a high level of risk to deliver a balanced year end position, with the Board and Finance and Performance Committee being routinely updated on progress against the mitigation plan.

The board and its committees were newly established on 1 July 2022, and recognising the need for development, various workshops have been held for each to build a common understanding of purpose and a cohesive approach to decision making for each, and to build relationships and trust within and across each membership group. The Board maintained direct oversight of the ICB's and system partner's financial position in the first four months of establishment, and as the organisation matured this was transferred in November to the Finance and Performance Committee.

A full staff consultation has been undertaken in our first financial year, to ensure our staff have a sense of belonging and to align our workforce to the priorities and delivery plans of the ICB. This has been a challenging and time-consuming exercise that has impacted on the progression of joined-up working across the ICB and the capacity to develop our new ways of working and embed our governance structures.

The ICB's operating model is still emerging and no delegations outside of the board, committees, or ICB executive officers have been progressed in the period of this annual report. An early review of Places in July 2022 led to a reconfiguration from five places to four to fully align to our local authorities, and whilst this slowed the development of our places, 2023/24 will see a devolvement strategy progressed at pace.

Our focus for the coming financial year will incorporate a full review of governance arrangements, including assessing where assurances can be strengthened to the board and across the committees, whilst accelerating the delegation of functions and resources to our four Places, underpinned by place-level governance arrangements.

Members Report

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

Member practices

There are currently 198 GP Practices across the ICB footprint. The list of Providers of Primary Medical Services is held in the Governance Handbook and can be accessed via the following link:

Appendix_F_Eligible_Providers_of_Primary_Medical_Services.pdf (healthierlsc.co.uk) [51]

Register of Interests

The ICB holds a register of interests for the board, each committee and all individuals who are engaged by the ICB. Registers for the board, committees and those defined as decision making staff are published here: LSC Integrated Care Board :: Lists and registers (icb.nhs.uk) and are available on request at the ICB Headquarters.

Personal data related incidents

There have been no Information Governance incidents in the period of this annual report that met the criteria for reporting through the Data Protection and Security Toolkit to the Information Commissioner's Office.

Modern Slavery Act

NHS Lancashire and South Cumbria ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2023 is published on our website at LSC Integrated Care Board :: Modern slavery statement (icb.nhs.uk)[52]

[51] Appendix_F_Eligible_Providers_of_Primary_Medical_Services.pdf (healthierlsc.co.uk)
[52] LSC Integrated Care Board :: Modern slavery statement (icb.nhs.uk)

Statement of Accountable Officer's Responsibilities

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

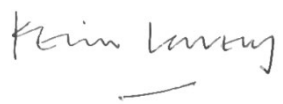
In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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

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

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



Kevin Lavery
Chief executive officer
29 June 2023

Governance Statement

Introduction and context

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

The ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

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

Between 1 July 2022 and 31 March 2023, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Lancashire and South Cumbria ICB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Lancashire and South Cumbria ICB's Accountable Officer Appointment Letter.

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

Governance arrangements and effectiveness

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

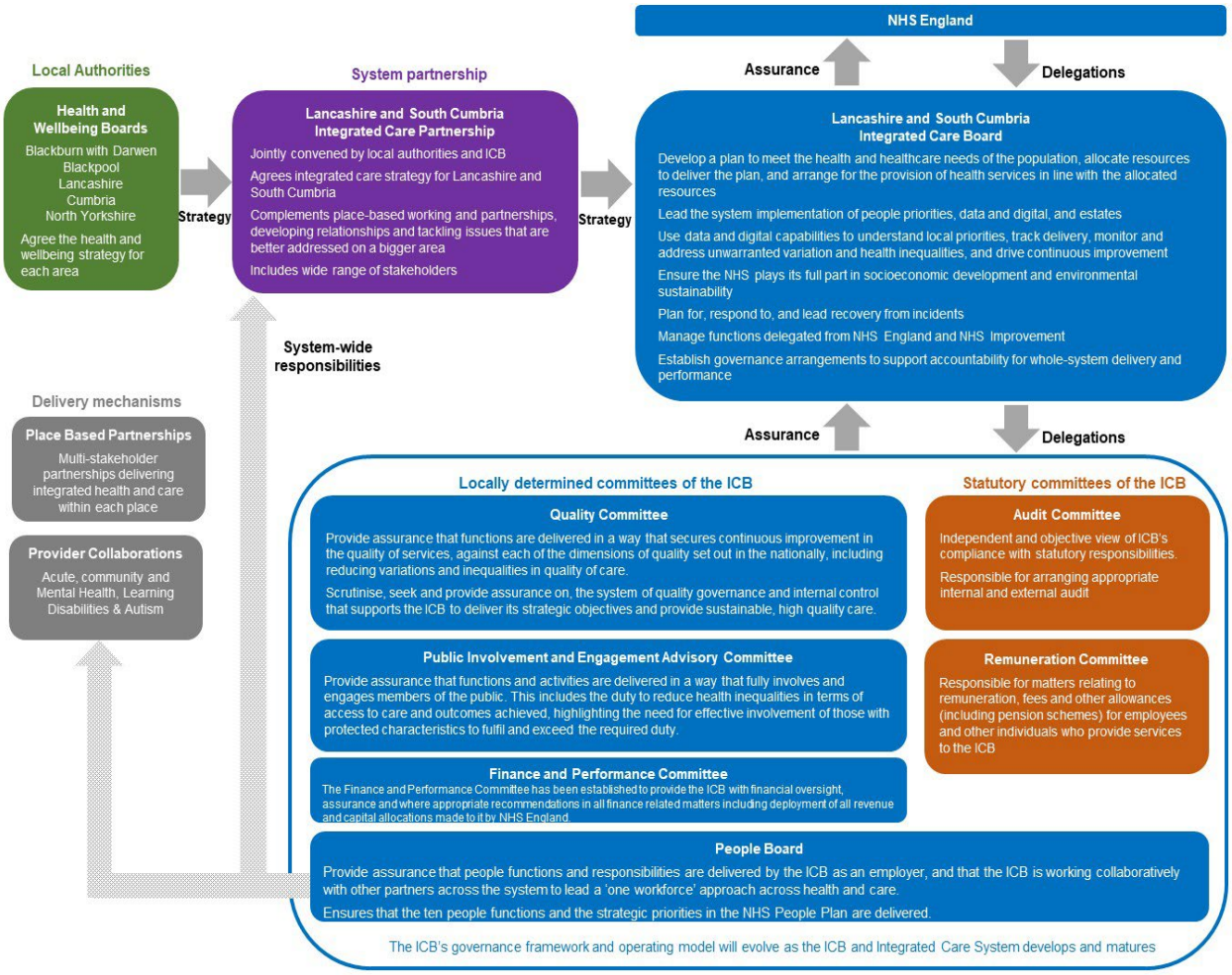
Constitution and Governance Handbook

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

The Constitution incorporates the ICB's Standing Orders, which form a central part of the ICB's governance framework.

The ICB's Governance Handbook brings together all the ICB's governance documents, and includes:

- A Scheme of Reservation and Delegation which sets out key functions reserved to the board of the ICB; functions delegated to committees and individuals; functions delegated jointly or outside of the ICB, and any functions delegated to the ICB
- Financial scheme of delegation
- Standing Financial Instructions – which set out the arrangements for managing the ICB's financial affairs
- Terms of Reference for all committees of the Board or joint committees of the ICB
- Delegation arrangements where ICB functions are delegated in accordance with section 65Z5 of the 2006 Act
- Key policy documents
- A Functions and Decisions Map, which is a high-level structural chart that sets out the committees of the ICB, and where decision making is taken by which part or parts of the Integrated Care System:



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

Corporate Governance Handbook [53]

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

The mechanisms described above have enabled the Board and its committees to take the effective decisions as described in the next section of this report.

The Board

The Integrated Care Board is a unitary board, and its members are collectively accountable for the performance of the ICB's functions. The board is responsible for:

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

The appointment process for board members varies according to the role they undertake and the appointment process specific to each role is specified in detail within section 3 of the ICB's constitution. In accordance with paragraph 3 of Schedule 1B to the 2006 Act, membership of the Board must consist of at least a Chair; a Chief Executive and at least three Ordinary Members. NHS England policy requires the ICB to appoint the following additional Ordinary Members:

- Three executive members, namely:
- Chief Finance Officer
- Medical Director
- Chief Nurse
- At least two Non-executive Members

The Ordinary Members must include at least three members who will bring knowledge and a perspective of their sectors. These members are known as Partner members, who are jointly nominated by their respective organisations.

Composition of the Lancashire and South Cumbria Integrate Care Board

The Board is made up of 14 members:

Board Member	Position
David Flory CBE	Chair
Kevin Lavery	Chief Executive
Professor Ebrahim Adia (From 1 September 2022)	Non-Executive Member
Jim Birrell	Non-Executive Member
Sheena Cumiskey	Non-Executive Member
Roy Fisher	Non-Executive Member
Professor Jane O'Brien	Non-Executive Member
Dr David Levy	Medical Director
Professor Sarah O'Brien	Chief Nurse
Samantha Proffitt	Chief Finance Officer
Caroline Donovan (From 1 July 2022 - 30 Sept 2022)	Partner Member, Mental Health Services
Chris Oliver (From 1 October 2022 to date)	
Dr Geoff Jolliffe	Partner Member, Primary Medical Services
Kevin McGee	Partner Member, NHS Trusts
Angie Ridgwell	Partner member, Local Authority

The ICB is committed to tackling health inequalities and ensuring its board membership brings a balance of perspectives and the Board is made up from diverse individuals, backgrounds and perspectives to all the best decisions for its communities.

The Chair of the board keeps under review the skills, knowledge and experience considered necessary for members of the board to possess collectively in order for the board to carry out its functions effectively and take such steps to address or mitigate any shortfalls.

Regular Participants

Participants are individuals who the board invite to make an informal contribution to their discussions on a regular basis. These individuals are invited to all meetings, receive copies of the papers and may take part in discussions. Because they are not a member, they cannot vote, and they have no accountability for decisions made by the board. Since establishment, the board has invited the following regular participant to board meetings:

Regular Participant	Position
David Blacklock	Healthwatch Chief Executive
Debbie Corcoran	Non-Executive/Chair of Public Involvement and Engagement Advisory Committee
James Fleet	ICB Chief People Officer
Professor Craig Harris	ICB Chief of Health and Care Integration
Tracy Hopkins	Chief Executive Officer – Citizens Advice, Blackpool representing Voluntary, Community, Faith and Social Enterprise sector
Maggie Oldham	ICB Chief Planning, Performance and Strategy Officer/Deputy Chief Executive
Asim Patel	ICB Chief Digital Officer
Abdul Razaq	Director of Public Health
John Readman	Director of Adult and Social Care Services

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

The board has met in public on eight occasions between 1 July 2022 and 31 March 2023. All meetings were fully quorate, and all meetings held in public. Other than the first day board meeting on 1 July 2022 all meetings have been livestreamed.

Attendance at Board Meetings for the period 1 July 2022 to 31 March 2023:

Member	1 July 2022	27 July 2022	7 Sept 2022	12 Oct 2022	2 Nov 2022	7 Dec 2022	1 Feb 2023	29 March 2023
David Flory CBE	✓	✓	✓	✓	✓	✓	✓	✓
Kevin Lavery	✓	✓	✓	✓	✓	✓	✓	✓
Professor Ebrahim Adia	-	-	x	✓	✓	✓	✓	x
Jim Birrell	✓	✓	✓	✓	✓	✓	✓	✓
Sheena Cumiskey	✓	✓	✓	✓	✓	✓	✓	✓
Roy Fisher	✓	✓	✓	✓	✓	✓	✓	✓
Professor Jane O'Brien	✓	✓	✓	✓	✓	✓	✓	✓
Dr David Levy	✓	✓	✓	✓	✓	✓	✓	✓
Professor Sarah O'Brien	✓	✓	✓	✓	✓	✓	✓	✓
Samantha Proffitt	✓	✓	✓	✓	✓	✓	✓	✓
Caroline Donovan	✓	x	x	-	-	-	-	-
Chris Oliver	-	-	-	✓	✓	✓	✓	✓
Dr Geoff Jolliffe	✓	✓	✓	✓	✓	✓	✓	✓
Kevin McGee	✓	✓	✓	✓	✓	✓	✓	✓
Angie Ridgwell	✓	✓	✓	✓	✓	✓	✓	x

Board Performance

In readiness for establishment on 1 July 2022, designate board appointments commenced in quarter four of 2021 and quarter one of 2022. As a new statutory body on 1 July 2022, the Chair of the Board approved the appointment of the Accountable officer. The Chair and Accountable Officer then approved the appointments of all other board members and the board met for its first meeting to agree and establish the core governance documents and arrangements and committees of the board.

Each meeting begins with a patient story, that sets the focus of the meeting and allows the board to reflect on where both learning and good practice can be shared.

To ensure the board had direct oversight of the ICB's and system partner's financial position as the ICB matured, the Chair and the Chief Executive Officer took a decision to not establish a Finance and Performance Committee for the first part of the year. Several private sessions have been held with the Board over this period, including Board to Board sessions with providers, to focus on the financial position, given the level of risk in terms of the ICB and the wider system position.

Each meeting held in public includes a report from the Chief Executive, a finance report, and a performance report.

Within its first nine months the Board has reviewed and approved significant areas of business including:

- System diagnostic: Inherited risks and issues, strategic aims, and early priorities for the Integrated Care Board
- Place-based Partnerships: Review of configuration from five to four to be conterminous with local authority boundaries
- Continuing Health Care: Transformation of Model of Delivery
- Establishment of the Lancashire and South Cumbria Health and Care Partnership and Development of our Integrated Care Strategy
- Emergency Preparedness, Resilience and Response Polices and Plans

- In lieu of Lancashire and South Cumbria Clinical Commissioning Group Annual General Meetings, the Annual Reports and Accounts for 2021/22 were collectively brought to the ICB Board to note and publish on the ICB's website
- Annual Review of Declarations of Interest Registers
- Risk Management Strategy and Policy, including the ICB's proposed Strategic Objectives and Board Assurance Framework
- Urgent and Emergency Care Board Assurance Framework and Winter Resilience Plans
- Transformation Programmes: Progress Update
- Operating Model for the ICB and Provider Collaborative Board
- State of Our System Annual Report
- Draft Lancashire and South Cumbria NHS Joint Forward Plan
- High-level budget for 2023/24
- Specialised Commissioning: Joint Working Arrangements
- ICB Green Plan and Sustainability Strategy
- 2022/23 financial plan

The board has also received updates on the following areas:

- Deep dives on Primary Care Access, Cancer, Urgent and Emergency Care, Learning Disability and Autism
- Reading the signals Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation
- Quality of Mental Health, Learning Disability and Autism Inpatient Services – Response to National Director
- Patient Safety Incident Response Framework
- Cancer Recovery Plan
- Finance Monthly Position Reports

The board has met informally on five occasions, and development sessions took place over the period.

These focused specifically on development of the ICB, with an emphasis on:

- Board Seminar: Health Equity Commission
- Setting Our Strategic Objectives and Approach to Risk Management
- Non-Executive Session: Fraud, bribery and corruption, cyber fraud techniques and conflicts of interest / gifts and hospitality
- Board Seminar: Making Data Count and Information Governance
- Strategic Intent: Five Year Joint Forward Plan and Three Year Financial Strategy

The board has also held board to board sessions with University Hospitals Morecambe Bay NHS Foundation Trust, Blackpool Teaching Hospitals NHS Foundation Trust, and Lancashire Teaching Hospitals NHS Foundation Trust with the focus being specific to the position of each Trust

Agendas, papers and place and time for each meeting in public are published on the ICB website seven days in advance of the meeting, and members of the public are able to attend to observe the meeting and can submit public questions for items relating to the agenda. Further details can be accessed via the following link:

LSC Integrated Care Board :: Meetings and papers (icb.nhs.uk)

Committees of the Board

To support the board in carrying out its duties effectively, a number of committees reporting to the board have been formally established. Each committee receives and considers regular reports, as outlined within their Terms of Reference. The minutes of the meetings are presented to the Board, and they also provide highlight reports to board in the form of 'Triple A' reports; Advise, Assure and Alert.

Given that each committee has been newly formed, preparatory sessions, workshops and informal meetings have been held at varying levels across each committee. All committees of the board are chaired by a non-executive board member and the non-executives meet regularly to discuss any areas of concern.

At its first day board meeting on 1 July 2022, the following committees were established:

Statutory committees

- Audit Committee
- Remuneration Committee

Non-statutory committees

- Remuneration Panel
- Quality Committee
- People Board
- Public Involvement and Engagement Advisory Committee (PIEAC)

Other decision making groups

- Primary Care Contracting Group

Since establishment a further committee was established on 28 November 2022:

- Finance and Performance Committee

Ratified committee minutes are formally recorded and submitted to the Board in its meeting in public, wherever possible as soon as practicable after the meetings have taken place.

As a final agenda item, the committees are asked to consider which matters should be presented to the board in the form of an Alert/Assure/Advise, (AAA), report. This allows for business to be rapidly escalated to the Board. The chair of each committee is also invited to provide verbal updates at each board meeting.

Audit Committee

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

The Audit Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, including quality governance, risk management and internal control processes within the ICB. The duties of the committee are driven by the organisation's objectives and the associated risks. The committee agrees an annual audit plan with sufficient flexibility to be able to respond to new and emerging priorities and risks.

The Audit Committee has no executive powers, other than those delegated in the Scheme of Reservation and Delegation and specified in its terms of reference. The Board approved the Terms of Reference for the Audit Committee, which includes its membership.

During 2022/23, there was a requirement for the Audit Committee to have responsibility and oversight of the Quarter 1 (April to June 2022) former CCG's Annual Reports and Accounts process for submission in June 2023. A co-opted independent lay member joined the Audit Committee to provide oversight and advice in this respect.

The Audit Committee agreed a workplan for 2022/23 which was regularly monitored and updated as required.

Audit Committee Membership

Member	Position
Jim Birrell	Non-Executive Member (Chair)
Sheena Cumiskey	Non-Executive Member
Roy Fisher	Non-Executive Member
Ian Cherry	Co-opted Independent Lay Member

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

The committee met four times over the 9-month period and all meetings were fully quorate. The quorum necessary for the transaction of business is two members.

Attendance at Audit Committee meetings for the period 1 July 2022 to 31 March 2023:

Member	26 July 2022	29 September 2022	15 December 2022	16 March 2023
Jim Birrell	✓	✓	✓	✓
Sheena Cumiskey	✓	✓	✓	✓
Roy Fisher	✓	✓	✓	✓
Ian Cherry	✓	✓	✓	✓

Audit Committee Performance

The Audit Committee has an annual workplan that incorporates the review of reports and positive assurances from Executives, managers, Internal Audit and External Audit on the overall arrangements for governance, risk management and internal control. Significant items that were considered during 2022/23 are shown below:

Governance, risk management and internal control:

- Appointment of internal and external auditors
- ICB policies for risk management, managing conflicts of interest (including gift and hospitality), Freedom to Speak Up (policy and system approach) and core financial policies
- Board Assurance Framework and Corporate Risk Registers
- ICB registers of interests, gifts and hospitality and procurement decisions
- Single tender waivers
- Losses and special payments
- Standardisation of financial systems and controls
- ICB Q2-Q4 2022/23 Annual Report and Annual Governance Statement
- Predecessor CCG Q1 Annual Report assurance and 3 months accounts

- Information Governance Assurance Reports
- Review of Audit Committee Terms of Reference

Internal Audit (MIAA):

- Internal audit plan and progress reports
- Completion of checklist reviews against core controls including conflicts of interest, governance, quality governance, risk management, financial sustainability
- The Internal Audit Network Insight Reports
- Interim Head of Internal Audit Opinion for all 8 predecessor CCGs and the ICB
- Assurance reports to the committee and onward reporting to the Board

External Audit (KPMG):

- ICB Audit Plan and Strategy Overview for 9 months from 1 July 2022 to 31 March 2023
- ICB Audit Plan and Strategy Overview for 3 months ending 30 June 2022
- Health Technical Updates
- Assurance reports to the committee and onward reporting to the Board

External Audit CCG Q1 Accounts

Grant Thornton LLP undertook the audit work for 5 of the Lancashire and South Cumbria CCGs, namely

- NHS Blackburn with Darwen CCG
- NHS East Lancashire CCG
- NHS Chorley and South Ribble CCG
- NHS Greater Preston CCG
- NHS West Lancashire CCG

KPMG undertook the audit work for 3 of the Lancashire and South Cumbria CCGs, namely

- NHS Morecambe Bay CCG
- NHS Blackpool CCG
- NHS Fylde and Wyre CCG

Anti-fraud (MIAA):

- Annual work plan and progress reports
- ICB Anti-Fraud, Bribery and Corruption Policy and Response Plan

The terms of reference of the Audit Committee were reviewed upon establishment and can be accessed via the following link:

LSC Integrated Care Board :: Corporate Governance Handbook (icb.nhs.uk) [54]

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

Remuneration Committee

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

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

- Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) but excluding the Chair and Non-Executive Members of the board.
- Where matters are discussed relating to Non-Executive Members of the ICB, a Remuneration Panel has been established and will be convened under its own Terms of Reference.
- The Board has also delegated the following functions to the Committee:
    - Elements of the nominations and appointments process for Board members
    - Oversight of executive directors' performance and appraisal

The committee meets in private at least twice a year and membership comprise three Non-Executive Board Members. During 2022/23 the committee met on eight occasions and was quorate for each meeting.

Remuneration Committee Membership

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

Remuneration Committee Performance

Within its first nine months the Remuneration Committee has reviewed and approved significant areas of business including:

- ICB Remuneration Policy fand Framework for Non-Agenda for Change Positions
- Remuneration Framework for Very Senior Managers
- Proposed Redundancies and a Mutually Agreed Resignation Scheme
- Clinical and Care Professionals Leadership model and remuneration

The terms of reference of the Remuneration Committee have been reviewing during its first year of establishment and can be accessed via the following link:

LSC Integrated Care Board:: Corporate Governance Handbook (icb.nhs.uk)

Quality Committee

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

The Quality Committee provides the board with assurance that the ICB is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the shared commitment to quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

During 2022/23 the committee met on seven occasions including a preparatory session in August 2022 and a development session in October 2022.

Quality Committee Membership

Member	Position
Sheena Cumiskey	Non-Executive Member (Chair)
Roy Fisher	Non-Executive Member
Jane O'Brien	Non-Executive Member
David Eva (From 15 February 2023)	Independent Lay Member
David Levy	Medical Director
Sarah O'Brien	Chief Nursing Officer
Debbie Corcoran	Chair of Patient Involvement and Engagement Advisory Committee
Geoff Jolliffe	Primary Care Partner Member
Kathryn Lord	Director, Quality Assurance and Safety
Mark Warren	Local Authority Lead

The chair of the committee is also the ICB's Senior Non Executive member.

Quality Committee Performance

Each meeting begins with a patient story, that sets the focus of the meeting and allows the committee to reflect on where both learning and good practice can be shared.

Within its first five formal meetings the Quality Committee has reviewed and approved significant areas of business including:

- Continuing Health Care/Individual Patient Activity – Case for Change
- The Patient Safety Incident Response Framework.
- Quarterly quality and safety reports including lessons learnt and outcomes
- Emerging risks, escalations and 'never events'
- Children in care and deprivation of liberty safeguards
- Special Educational Needs and Disabilities (SEND)
- Update on Lancashire and South Cumbria Integrated Stroke and Neurodevelopment Network.
- Infection prevention and control
- Lancashire and South Cumbria Medicines Management
- Approval of key strategy and policy documents including:
    - Mental Health, Learning Disabilities and Autism Strategies
    - Policy on sponsorship and joint working with the pharmaceutical industry and other commercial organisations
    - Domestic Abuse and Workplace Policy
    - Mental Capacity Act Policy.

The committee also considered safeguarding concerns relating to children in care assessments, the profile of individuals referred to PREVENT and of Domestic Homicide reviews.

Other specific items the committee has considered include the Care Quality Commission (CQC) Inspection Report - Maternity Services, Blackpool Victoria Hospital (Blackpool Teaching Hospitals NHSFT) – which gave maternity services at Blackpool Victoria Hospital an overall rating as inadequate. The committee received the report, noting that the Hospitals

Trust has a System Improvement Board (SIB) in place and that both the Trust and the SIB will have oversight of improvement.

Committee Development

The Quality Committee takes steps to ensure its own continuous development with particular regard to the need to deliver ambitions which have impact for the whole system as well as for smaller units such as the Foxton Centre. The committee held a development session in October 2022 facilitated by Advancing Quality (AQuA).

Since establishment, one of the Quality Committee's aims has been whether it has made a difference and reflection and reviews of each meeting are undertaken. There have been threads and themes within reports presented at meetings, e.g., via patient stories. Collaborative working across the Lancashire and South Cumbria integrated care system continues.

Links with other committees

The Quality Committee recognises the links it has with the Public Involvement and Advisory Engagement Committee (PIEAC) in respect of patient experience and involvement. The Quality Committee seeks to focus on effectiveness and safety whilst the PIAEC focuses on patient and public experience.

System Quality Group

In line with guidance from the National Quality Board the ICB has established a System Quality Group, (SQG). Whereas the Quality Committee has a function to assure the Board on the quality and safety of services, the SQG is focusing on quality improvement and learning and replaces the Quality Surveillance Groups which had more of an assurance focus. The ICB held a development workshop with partners form across the system, to agree the TOR and remit of the SQG and to date meetings have focused on Urgent and Emergency Care, Diabetes and Cancer. The SQG reports into Quality Committee and any areas of significant concern would be escalated to Quality Committee.

Minutes and attendance at the Quality Committee meetings are published on the ICB's website via the Board meeting papers at: LSC Integrated Care Board :: Meetings and papers (icb.nhs.uk) [55]

The terms of reference of the Quality Committee have been regularly reviewing during its first year of establishment and the membership strengthened. They can be accessed via the following link: LSC Integrated Care Board :: Corporate Governance Handbook (icb.nhs.uk).[56]

Finance and Performance Committee

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

The ICB did not establish a Finance and Performance Committee for the first part of the year, to ensure the board had direct oversight of the ICB's and system partner's financial position.

[55] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers
[56] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook

The committee oversees the performance of the ICB in delivering its statutory financial duties, national targets and objectives, ensuring the effective and efficient use of resources, whilst delivering financial balance.

The committee contributes to the overall oversight of the ICB objectives through the development and delivery of:

- A robust, viable and sustainable system financial plan. This includes financial performance of the ICB and financial performance of the NHS provider organisations within the ICB footprint.
- ICB performance monitoring and mitigation against mandated national and regional metrics as well as locally agreed indicators that ensure the ICB is meeting its defined objectives.

During 2022/23 the committee met on three occasions and held its inaugural meeting in November 2022.

Finance and Performance Committee Membership

Member	Position
Roy Fisher	Non-Executive Member (Chair)
Jim Birrell	Non-Executive Member
Debbie Corcoran	Non-Executive/Chair of Public Involvement and Engagement Advisory Committee
Maggie Oldham	Chief Planning, Performance and Strategy Officer
Asim Patel	Chief Digital Officer
Samantha Proffitt	Chief Finance Officer
Debra Atkinson	Company Secretary/Director of Corporate Governance
Katherine Disley	Director of Operational Finance
Stephen Downs	Director of Strategic Finance
Andrew Harrison	Director of Place and Programme Finance
Roger Parr	Director of Performance and Assurance

Finance and Performance Committee Performance

Monthly financial performance is scrutinised by the Finance and Performance Committee and reported to the Board. Significant items that were discussed and approved following the establishment of the committee in November 2022 are shown below:

- Financial Assurance Framework
- In-year financial performance of the ICB including QIPP delivery
- Financial performance of the NHS provider organisations within the ICB's footprint including CIP delivery
- Resource allocation (capital and revenue)
- ICB Recovery Plan
- 2023/24 Planning Update and Assumptions
- Continuing Health Care Business Case
- Establishing an effective system PMO – priority programmes for financial sustainability
- System Oversight Framework and performance monitoring and mitigation against mandated national and regional metrics, locally agreed performance indicators and review of progress against improvement
- Protocol for in-year changes to revenue financial forecast
- ICB Contracts Oversight
- Review of the Terms of Reference of the committee

Minutes and attendance at the Finance and Performance Committee meetings are published on the ICB's website via the Board meeting papers at: LSC Integrated Care Board :: Meetings and papers (icb.nhs.uk) [57]

The terms of reference of the Finance and Performance Committee have been reviewed during its first year of establishment and the membership strengthened. They can be accessed via the following link: LSC Integrated Care Board :: Corporate Governance Handbook (icb.nhs.uk) [58]

People Board

The People Board is a formal committee of the ICB and is a non-executive chaired committee that provides the Board with assurance that it is delivering its functions and undertaking its responsibilities to deliver the workforce-related activities that are both carried out by the ICB as an employer, and collaboratively with other partners across the Integrated Care System.

The People Board acts as a system board to ensure system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the Integrated Care System to develop and support 'one workforce', where it makes sense and is safe to do so, including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers. The Board is also responsible for the oversight and assurance of Freedom to Speak Up, and the ICB's adherence to its statutory equality duty.

The people board ensures that the ten people functions are delivered and that the ICB and system partners are meeting the strategic workforce priorities in the NHS, as set out in the People Plan. These include improving people's experience of working within the NHS, enabling them to provide the best possible care and health outcomes for patients and citizens; transforming and growing the workforce to make use of the skills of staff and meet changing health needs; and developing a compassionate and inclusive culture that drives positive change for staff.

The board provides regular assurance updates to the Board and system partners, in relation to activities and items within its remit.

The People Board meets bi-monthly and during 2022/23 has met five times since the ICB was established. It is chaired by a non-executive of the Board and has 19 members.

People Board Membership

Member	Position
Professor Ebrahim Adia	Non-Executive Member (Chair)
Professor Jane O'Brien	Non-Executive Member
James Fleet	Chief People Officer
David Levy	Medical Director
Sarah O'Brien	Chief Nursing Officer
Trish Armstrong-Child	Provider Collaborative CEO Lead
Samantha Baron	Local Authority Workforce/People Director
Catherine Whalley	Local Authority Workforce/People Director

[57] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers
[58] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook

Debbie Corcoran	Non Executive/Chair of Patient Involvement and Engagement Advisory Committee
Two from the following attended meetings: Joe Hannett (Up to 31 March 2023), Angela Allen and Tracy Hopkins	Voluntary Sector Workforce Lead x 2
Kevin Moynes	Provider Collaborative Workforce/People Director
Kate Smyth (From 22 March 2023)	Provider Non-Executive Director representing disability inclusion
Andrea Anderson	Director of Place and Programmes (Workforce)
Aisha Chaudhary	Director of Culture and Inclusion
Sonya Clarkson	People Director
Emma Davies	Director of Workforce Delivery
Peter Gregory	Primary Care Workforce Lead
Lee Radford	Director of Organisational Development and Education

The chair of the committee is also the ICB's Deputy Chair of the Board, EDI Lead and Health and Wellbeing Guardian.

People Board Performance

Since establishment, the People Board has made great strides in delivering its business bringing together representatives across the Lancashire and South Cumbria integrated care system.

Significant items discussed and approved during 2022/23 include:

- Lancashire and South Cumbria people and workforce analytics and insight reports
- Baseline activity reports against the People Plan and the 10 ICS People Functions
- Equality, Diversity and Inclusion Interim Strategy
- Freedom to Speak Up Policy
- "Belonging Framework" the culture and inclusion operating model
- Regional talent updates including inspiring leaders, leading systems change and organisational development programmes
- Workforce Race Equality and Workforce Disability Equality Standards – system reports
- North West ICS and ICB Staff Survey results
- System wide workforce priorities

A number of workforce priorities will be taken forward into 2023/24.

The terms of reference of the People Board have been reviewed during its first year of establishment and the membership strengthened. They can be accessed via the following link: LSC Integrated Care Board :: Corporate Governance Handbook (icb.nhs.uk) [59]

Minutes and attendance at the People Board meetings are published on the ICB's website via the Board meeting papers at: LSC Integrated Care Board :Meetings and papers [60]

[59] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook
[60] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers

Public Involvement and Engagement Advisory Committee

The Public Involvement and Engagement Advisory Committee has been established to support the ICB in ensuring the voice of local people and residents is actively embedded and valued in decision making of the ICB and at all levels of the system, particularly in relation to inequalities and those who are seldom heard.

The committee provides regular assurance updates to the board in relation to activities and items within its remit.

The committee usually meets bi-monthly and during 2022/23 the committee met on five occasions including two development sessions in August and September 2022.

Public Involvement and Engagement Advisory Committee Membership

Member	Position
Debbie Corcoran	Non-Executive (Chair)
Roy Fisher	Non-Executive Member
Professor Sarah O'Brien	Chief Nursing Officer
Dr Lindsey Dickinson	Representative from Primary Care
Neil Greaves	Director of Communications and Engagement
David Rogers	Head of Communication and Engagement
Sam Plum	Partner Member representing Local Authorities
Tricia Whiteside	Non-Executive Member with a role for patient experience or public engagement from an NHS provider
Sarah James	Representative from Place-based Partnership - Lancashire
Karen Kyle	Representative from Place-based Partnership – South Cumbria
Pauline Wigglesworth	Representative from Place-based Partnership - Blackpool
To be confirmed	Representative from Place-based Partnership – Blackburn with Darwen

The committee supports the board in ensuring the principles for working with people and communities are intrinsically in place across all parts of the organisation and wider integrated care system. The committee defines best practice in terms of public engagement, involvement and communications and support other committees and parts of system in how the local voice is embedded and valued in all aspects of the ICB at different levels of the system including within place-based partnerships.

Public Involvement and Engagement Advisory Committee Performance

Significant items that were discussed and approved during 2022/23 are shown below:

- Strategy for working with people and communities
- A developing model for engagement, involvement and co-production for the ICB
- Engagement and involvement approaches for the New Hospitals Programme
- Engagement approaches for primary care transformation and existing insight
- Engagement and involvement approach and insight in the development of the integrated care strategy for Lancashire and South Cumbria
- Approaches and insights from capturing lived experience to support population health improvement through the example of three initiatives in Lancashire and South Cumbria

Since October 2022 the Public Involvement and Engagement Advisory Committee (PIEAC) has received summaries of public and community insights captured by the ICB, along with an engagement and involvement assurance report.

The ICB is aiming to increase the impact of engagements with the public through the use of a number of methods, including the website and social media – particularly in relation to mental health, suicide prevention and primary care. The majority of feedback suggests that the ICB's key messages are generally well received. More insight will be captured as the ICB engagement infrastructure is developed.

The Communication and Engagement team collates the outcomes and insights from completed engagement programmes and initiatives and reports these to PIEAC.

Specific insights are obtained from -

- Patient Experience
- Freedom of information (FoI) requests.
- MP and councillor interest
- Media interest and response
- Online and social engagement
- Survey responses
- Patient stories

Patient stories are sourced by the Communications and Engagement team to bring real life experience directly to the ICB Board and Quality Committee, as well as specific meetings focused on quality improvement.

The Public Involvement and Engagement Advisory Committee agreed a workplan for 2022/23 which was regularly monitored and updated as required and would be reviewed in the early part of Quarter 1 2023/24.

Links with other committees

The PIEAC recognises the links it has with the Quality Committee in respect of patient experience and involvement. The PIAEC seeks to focus on patient and public experience, whilst the Quality Committee seeks to focus on effectiveness and safety.

Information on the committee members and attendees, terms of reference, upcoming meeting dates, agendas and papers and approved minutes can be accessed at: LSC Integrated Care Board :: Public Involvement and Engagement Advisory Committee (icb.nhs.uk) [61]

Primary Care Contracting Group

At establishment of the ICB on 1 July 2022, in accordance with the powers under section 65Z5 of the NHS Act, NHS England (NHSE) delegated the exercise of commissioning of Primary Medical Services and Community Pharmaceutical Services functions to Lancashire and South Cumbria (LSC) Integrated Care Board (ICB).

The ICB, with agreement from NHSE, established a Primary Care Commissioning Group to act as an expert panel to ensure consistent decision making across the ICB with regards to delegated primary care services.

[61] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/sub-committees/public-involvement-and-engagement-advisory-committee

Whilst not a committee of the board, the group reports to the executive management group, and to the board through a regular summary report of the groups business.

From April 2023 NHSE will also delegate the exercise of Primary Dental and Primary Ophthalmic services functions to the ICB and the ICB will hold over 1000 core primary care contracts, resulting in a significant number of contract related decisions needing to be made.

To ensure robust governance arrangements for all these functions, a review of primary care commissioning governance and decision-making arrangements and a full review of the Terms of Reference (ToR) of the Primary Care Commissioning Group (PCCG) has been undertaken. From April 2023 the group will become a formal committee of the Board, meeting in public where appropriate and with a revised membership to include further lay member involvement.

Special Lead Roles

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

Senior Independent Risk Owner (SIRO)

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

Chief Finance Officer, Sam Proffitt, undertook this role until the appointment of Asim Patel, Chief Digital Officer in November 2022 who is the ICB's named SIRO.

Caldicott Guardian

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

David Levy, Medical Director, undertakes this role on behalf of the ICB.

Freedom to Speak up (FtSU) Lead

The role of the FtSU Guardian is to provide independent support and advice to staff who want to raise concerns, enabling NHS organisations to be more open and transparent and for employees to raise concerns without fearing the consequences. Whilst organisations will have multiple FtSU Guardians it is recommended that organisations have both an Executive and Non-Executive Lead Guardian.

James Fleet, Chief People Officer, and Professor Jane O'Brien, Non-Executive Member undertake these role on behalf of the ICB.

Equality, Diversity and Inclusion (EDI) Lead

It is important that the ICB ensure that its services and employment practices are fair, accessible, and inclusive for the diverse communities it serves and the workforce it employs.

In recognition of that need, it is best practice to have both and named Executive and Non-Executive Lead for EDI.

James Fleet, Chief People Officer, and Professor Ebrahim Adia, Non-Executive Member both undertake this role on behalf of the ICB.

Conflicts of Interest Guardian

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

The role of the Conflicts of Interest Guardian is to strengthen the scrutiny and transparency of the organisation's decision-making processes.

It is commonly considered best practice for the Conflicts of Interest Guardian to be the Audit Chair, and Jim Birrell Audit Chair undertakes this role on behalf of the ICB.

Senior Non-Executive Director

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

Sheena Cumiskey, Non-Executive Member of the Board undertakes the role of Senior Non-Executive Director on behalf of the ICB.

Health and Wellbeing Guardian

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

The role of the Health and Wellbeing Guardian is to support with oversight of the organisational culture to ensure that the health and wellbeing of the workforce is considered routinely across all organisational activities.

Professor Ebrahim Adia, Non-Executive Member of the Board undertakes the role of Health and Wellbeing Guardian on behalf of the ICB.

Other Population Groups and Functions

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

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

These roles ensure visible and effective board-level leadership for addressing issues faced by the groups outlined above, and to ensure that statutory duties related to safeguarding and SEND receive sufficient focus.

Professor Sarah O'Brien, Chief Nurse is the named board member with responsibility these areas.

The guidance also includes the requirement of at least one member of the board who has knowledge and experience in connection with services relating to the prevention, diagnosis, and treatment of mental illness.

Mental Health Lead board members for the ICB are David Levy Medical Director and Chris Oliver, Partner Member for Mental Health.

UK Corporate Governance Code

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

Discharge of Statutory Functions

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

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

Risk management arrangements and effectiveness

At its first full business meeting on 27 July 2022, the Chief Executive presented a System Diagnostic Report to the board which identified a number of risks and issues inherited by the ICB upon its establishment. Throughout the transitional year, the board also received regular monthly update reports which highlighted key issues and opportunities around workforce, quality, performance, inequalities, financial sustainability, and strategic direction. Reports presented to board and its committees have informed the development of the Board Assurance Framework (BAF).

A development session took place with board members in October 2022 to agree the principal risks to the ICB meeting its strategic objectives. This informed the development of a BAF and strategic objectives, which was approved by the Board in December 2022, along with the risk management strategy.

Corporate risk registers (CCR) transferred from the eight CCGs continued to be in operation throughout the transitional period, and a comprehensive review was undertaken in Q4 of 2022/23 to fully amalgamate these into a single ICB CRR. The review considered legacy risks captured as part of the CCGs handover processes and enabled a rationalisation and review of transferred legacy risks, which were then aligned to the ICB's Strategic Objectives and assigned to the relevant executive director.

Further updates were provided to the audit committee in January 2023 and March 2023 to provide assurance of progress against the development and oversight of the BAF and Corporate Risk Register.

The ICB's Risk Management Strategy and Policy sets out the responsibilities of individuals, the ICB and its committees for managing risks associated with meeting its strategic objectives. It aims to create a framework to achieve a culture that encourages staff to:

- Identify and control risks which may adversely affect the operational ability of the ICB and the achievement of its strategic objectives.
- Score risks consistently using a grading matrix.

- Where possible, eliminate or transfer risks, or reduce them to an acceptable and cost-effective level (otherwise ensure the organisation openly accepts the remaining risk).
- Identify risks which are common across functions and explore the management of these collectively.

Risks are identified from a number of sources, including the Board, committees, staff of all levels, internal and external audit reports.

All identified strategic or corporate risks scored 9 and above are included on the corporate risk register or Board assurance framework. Directorates and/or functional areas oversee and manage operational risks assessed as 8 or below with Senior Responsible Officer oversight.

The ICB has made reasonable progress on the governance and oversight for strategic and operational risk management. Each predecessor CCG had differing risk management approaches and processes, and whilst the ICB agreed its strategic objectives and board assurance framework in December 2022, the embedding of a fully operational risk management framework will be a key priority for 2023/24.

A strengthened monthly cycle of risk management oversight and reporting has been developed towards the end of this part-year. This will support timely escalation and de-escalation of risks to the board, committees and Executives; moreover, it will enable an ongoing holistic approach to risk management and oversight across the organisation.

Given the BAF and strategic objectives were agreed in quarter three of 2022/23, during 2023/24 the board will review each of the strategic objectives to ensure alignment to the ICB's Five Year Joint Forward Plan, that will be approved in early July 2023. The board will also generate a risk appetite statement, to inform decision making in connection with risk. The board will also undertake an annual assessment of its risk appetite and will determine appropriate action to progress from its current position.

Capacity to Handle Risk

The responsibility for risk management is clearly defined at all levels within the organisation. The ICB's Risk Management Strategy clearly outlines the roles and responsibilities of the Board, its committees, the Chief Executive Officer, the Chief Finance Officer and other staff within the ICB. Committee terms of reference include the review and monitor those risks on the BAF and Corporate Risk Register which relate to each committee.

The Audit Committee is responsible for reviewing the adequacy and effectiveness of the ICB's risk management arrangements and noted the ICBs Risk Management Strategy and Policy in September 2022 and received a full progress update on the development of risk management arrangements in December 2022 and March 2023.

The ICB uses a web-based application to record and monitor risks. This is available to risk owners to enable risk updates to be provided in a timely manner. Whilst this system is ready to operate, the risk management cycle of review is still to be fully embedded and from 2023/24 a monthly gateway cycle will include an at least monthly review of all risks held on the CRR and BAF, with exception reports to the Executive Leadership Team and live dashboards have also been established to support with functional oversight of risks specific to the strategic objectives of the ICB. There will be quarterly updates to the Board for those risks held on the BAF, with a particular focus on impact of risks that could affect the delivery of the strategic objectives and where there are opportunities to achieve delivery.

Support and training have been provided to the executives and their teams over this period and a series of engagement sessions have been held during January and February 2023 with lead executives and their senior responsible officers (SROs).

Risk Assessment

Monitoring, evaluation and control of significant risks has continued to be developed throughout the transitional year.

To ensure appropriate assessment of risks, Individual sessions were held with SROs to undertake further review and triangulation of the open risks to determine which would remain open and held on the BAF (score of 15 or over) and those which would remain open and transfer to the ICB's corporate risk register (score of 9 or over).

The leadership team have also identified new risks and they have been supported to develop these for inclusion on the CRR or BAF as appropriate.

The ICB and wider system have navigated significant operational pressures throughout the winter including strike events, which have been managed both strategically and operationally with executive oversight. The risk profile of the ICB has changed throughout the transitional year. Initially the risk profile primarily reflected the adoption of the operational risks handed over by the CCGs; however, following the rationalisation of the legacy risks, the development and implementation of the risk management processes and strategic objectives, the risk profile now reflects the ICB's focus on its statutory duties and the success of its strategic objectives and vision.

Through the period of this annual report, the persistent risks related to:

- A balanced financial plan that delivers five per cent recurrent efficiencies for all providers and the ICB.
- Quality, financial and reputational risks of not meeting NHS Continuing Healthcare statutory responsibilities relating to assessment, eligibility, reviews, personal health budgets and commissioning and contracting.
- Improvement and sustainability of NHS trust performance when key measures (particularly urgent and emergency care, discharge and elective care recovery) are not achieved; constitutional targets may not be delivered in 22/23; national targets for 78 week waits and cancer 62 days are under pressure to be delivered.
- Primary care development, including the recommendations contained in the national Fuller Report.
- Delivery of strategic workforce transformation priorities as set out in the NHS People Plan.
- Estates infrastructure and facilities in some areas hinder the ability to deliver consistently high-quality care.

Other sources of assurance

Internal Control Framework

The ICB has a system of internal control based upon the processes and procedures in place to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

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

Control mechanisms are embedded within all aspects of the ICBs governance, with the oversight of risk management within the organisation being one of them. There were no instances during the reporting period where the control environment was breached. The control mechanisms include:

- Suite of organisational policies ensuring that the ICB is compliant with national and legal standards such as Health and Safety Act, Standards of Business Conduct, Freedom to Speak Up, and Conflicts of Interest.
- The Constitution describe how we organise ourselves together to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and populations we serve. The Constitution is underpinned by the duty that requires NHS bodies to consider the effects of their decisions on the health and wellbeing of the people of England, the quality of services and the sustainable and efficient use of resources.
- The ICB's Governance Handbook includes key documents that underpin our governance framework, including our Scheme of Reservation and Delegation (SoRD) and Scheme of Operational financial Delegation (SoFD). The SoRD sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoFD clearly sets out the financial delegated limited for individual officers and functions.
- There is a clear process for reporting, management, investigation and learning from incidents. The ICB has a Senior Information Risk Owner (SIRO) to support the arrangements for managing and controlling risks relating to information/ data security, who is also a member of the Audit Committee. The Chief Medical Officer is the Caldicott Guardian to ensure that patient confidentiality is protected. The sections of this report entitled 'governance arrangements and effectiveness' and 'delegation of functions' describe how the internal control arrangements operate in more detail.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support ICBs to undertake this task, NHS England has published a template audit framework.

For the 2022/23 reporting year, Mersey Internal Audit Agency (MIAA) has developed a checklist to support newly formed ICBs in establishing their conflicts of interest arrangements, specifically to ensure that they are in line with the national guidance issued by NHS England.

The checklist was undertaken in two phases and focused upon the establishment of core controls in relation to Conflicts of Interest. MIAA has completed the checklist for the Lancashire and South Cumbria ICB, and this has confirmed the position as follows:

Phase one of the checklist focused on implementation of core controls and was undertaken and reported in November 2022. The statement provided was as follows:

- The ICB has significantly progressed its development and implementation of core controls

Phase two of the checklist focused upon assessing the design and operation of the controls in place for conflicts of interest. MIAA have confirmed:

- The control framework for conflicts of interest has continued to significantly progress, both in design and operation of controls.

Overall, MIAA noted the controls in place to be well designed and mostly operating effectively. Key areas for further action were:

- Conflicts of Interest policy –the policy could be further improved through inclusion of roles and responsibilities of Corporate Governance team and line managers.
- Sample testing of 10 new starters found that for four, the declaration of interest form had not been completed within 28 days of their start date.
- The register for Gifts and Hospitality should be published on the ICB's website even if there have been no declarations.
- The Register of Procurement Decisions should be published on the ICB website following its presentation to Audit Committee.

All of these actions have been taken forward.

Data Quality

Information is generated, and processed, for a broad variety of uses, and therefore the ICB employs varied techniques in assuring data quality across those different contexts. Where the ICB receives datasets from its service providers or external parties, a culture of routine data validation is promoted. The ICB and its data processors endeavour to both ensure that timescales for submission of information are adhered to, and that the quality & accuracy of such submissions is monitored and any issues fed back to relevant forums as appropriate.

The board receives a report on performance at each of its meetings and nationally published data is used to ensure accurate information is provided and offer a benchmarked position. In instances where data is provided to offer a more real-time position, a caveat is provided that the data is subject to validation.

The board acknowledges that these reports are still in development and the presentation of meaningful data and local narrative has been continually reviewed. The Finance and Performance Committee received these reports at every meeting and the committee has driven improvements to the quality of data presentation, with the intention that a fully integrated performance report will be accessible to the board and its committees in early 2023/24.

The board held a development session on 9 March 2023 which included a presentation on 'Making Data Count' from the NHS England team. Work is on-going to refine the data presentation utilised by the ICB to provide greater assurance to the board and that actions are underway to improve performance where necessary.

Information Governance

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

The Data Security and Protection Toolkit (DSPT) is the officially recognised self-assessment tool on data protection and cyber security. It was originally developed by NHS Digital for all

NHS organisations to measure compliance against the ten National Data Security Standards (DSSP), and in turn compliance with their statutory responsibilities and Data Protection legislation. Within the ten data standards there are mandatory assertions items to meet to ensure compliance with their statutory responsibilities.

The deadline for the completion and submission of the DSPT is 30 June 2023 with a baseline assessment submitted for the ICB on 28 February, and evidence is being collated to ensure the ICB completes a 'Standards Met' submission by the end of June 2023. The ICB Chief Digital Officer (and Senior Information Risk Officer) is responsible for ensuring information governance processes are fully embedded; to support this area of work, a new governance structure for the management and oversight of delivery of the information governance agenda has been developed. A monthly Information Governance (IG) Operational Group meeting has been established to support the operational delivery of the DSPT, policies and incidents. This Group feeds into a quarterly IG Oversight Group that is chaired by the Senior Information Risk Officer (SIRO) for the ICB. This Group provide assurance to the Audit Committee on progress of the IG Agenda to include cyber security.

The key objectives of these Groups are:

- To oversee the implementation and submission of the Data Security and Protection Toolkit across the organisation
- To develop, implement and monitor the organisations Information Governance framework
- To develop and maintain Information Governance policies
- To work with other member organisations groups and independent contractors to promote and advise on Information Governance issues
- To prepare the annual Information Governance assessment
- To work closely with the SIRO and Caldicott Guardian, offering support and seeking advice where appropriate
- To oversee incidents relating to information governance and cyber security and manage risk
- To monitor, control and advise on Information issues

Midlands and Lancashire Commissioning Support Unit (MLCSU) IG team provide the ICB with the Information Governance service delivery. The team support the ICB to collate, review and advise on all evidence required for the DSPT submission.

As at 31 March 2023 the ICB was confident that structures were in place in order for the organisation to be compliant with the DSPT requirements by the 30 June 2023 submission date. This is based on the number of assertions whereby evidence was firmly in place to signify the ICBs compliance with an individual mandatory assertion.

An internal DSPT delivery plan has been created, with internal timescales in place to ensure that evidence is firmly in place by the end of May 2023. This timeframe is to ensure that all evidence is firmly in place to ensure the ICBs compliance. Similarly, the timeframe allows sufficient time for the ICBs Quarterly IG Oversight Group to meet to review and gain assurance on the evidence collated.

In total there are 88 mandatory assertions whereby evidence is required from the ICBs three IT providers. Midlands and Lancashire commissioning support unit (MLCSU) Information Governance team are co-ordinating the collation of evidence from each provider. The team are required to review all responses and create one single response for the ICBs DSPT for submission.

There are DSPT requirements that relate to larger programmes of work where engagement from ICB staff is key when collating evidence required for the mandatory assertions. This includes areas such as, training needs analysis, asset registers systems and software and data flow mapping. Annual IG training and a new starter IG induction programme is in place to ensure that staff recognise the importance of protecting personal information and ensuring that data protection is embedded in the organisation in all processes, both by design and default.

Any recommendations received from MIAA as an outcome of their DSPT audit will be addressed prior to the final submission.

There are several processes undertaken and supported directly with by the MLCSU IG team, whereby evidence is directly collected and created by the team. Areas include, breach confidentiality reporting and investigation, IG induction programme, specialist IG training, Data Protection Impact Assessments (DPIAs) and data sharing/processing agreements and physical controls on site spot checks. Evidence is routinely refreshed throughout the year.

There are robust processes in place to ensure that all personal data breaches are reported and investigated by MLCSU IG team. Recommendations are presented to ensure that further breaches of the same nature are prevented.

To date, the ICB has had no reportable IG breaches to the Information Commissioners Office (ICO). All near miss incidents have been managed and investigated appropriately by undertaking low level root cause analysis and subsequent action plans to mitigate any further risk.

The IG Code of Conduct, the IG Data Security and Protection policies and the IG Handbook have been reviewed to reflect the requirements of the ICB. These documents are available on the ICB Intranet that detail the standards and expectations of the organisation and its staff in relation to information governance.

The Audit Committee also receives a quarterly update on progress against the DSPT and overall IG agenda, including data and security incidents.

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, I can confirm that a framework and environment is in place to provide assurance of business-critical models. In this transition year, further work is still to be done, and a programme of work will commence in April 2023 in relation to business continuity planning, which supports business impact analysis and resilience planning to ensure critical services are maintained. Planning is also underway to review digital resilience and to undertake a multi-professional exercise to test that resilience.

The ICBs Information Governance framework ensures that business critical systems are identified and managed effectively. As part of this framework and the programme of work commencing in April 2023, information asset owners will be appointed and trained to cover a range of business systems used by the ICB. Their responsibility in relation to business-critical systems will involve the maintenance of an information asset register relevant to their organisational remit, the maintenance of service continuity plans and the continuity of key skills to operate such systems.

There is still work to be done in this area in 2023/24, and once business critical services have been identified and continuity plans are in place, the Emergency Planning Resilience and Response team will undertake a quality assurance process to ensure that the plans are reviewed and strengthened.

Third party assurances

The ICB currently contracts with a number of external organisations for the provision of back-office services and functions. Assurances on the effectiveness of the controls in place for these are received in part from an annual Service Auditor Report from the relevant service.

The organisations concerned are:

Service	Provider	Assurances
Finance and Accounting Services	NHS Shared Business Services	Service Auditor Report
Payroll Management	Lancashire Teaching Hospitals	Service Auditor Report
IT Services	Blackpool Teaching Hospital	Service Auditor Report
IT Services	University Hospitals Morecambe Bay	Service Auditor Report
IT Services	MLCSU	Service Auditor Report
Various	MLCSU	Service Auditor Report

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

Control Issues

The month 9 Governance Statement (December 2023) return reported control issues under six categories. Each of these issues could undermine the reputation of the ICB and wider NHS if not resolved and could put at risk delivery of the standards expected of the Chief Executive. These control issues have no bearing on fraud, material impact of the accounts or national security of data.

Access to services/capacity

The ICB reported control issues under this category due to breaches in diagnostics and cancer. Plans are in place in each area of diagnostics affected to improve position.

Regulators

The ICB reported control issues under this category due to never events and serious incidents reported. Each incident had a thorough investigation undertaken with lessons learnt identified and a mitigating action plan implemented.

Mental Health and Dementia

The ICB reported control issues under this category due to issues with retaining workforce in mental health services and recovery plans being in place for Individual Placement Support and Improving Access to Psychological Therapies.

Accident and Emergency

The ICB reported control issues under this category due to difficulties in meeting the 4 hour target. A range of strategies and approaches are being utilised to try to tackle the identified challenges with Urgent and Emergency Care access including:

- Access to urgent care advice through the NHS 111 online service
- NHS 111 clinical assessment can offer immediate advice or referred to the appropriate clinician for a face-to-face consultation
- Urgent treatment centres providing locally accessible and convenient diagnosis and treatment services diverting patients away from A&E
- Use of Same Day Emergency Care (SDEC) services allowing for the rapid assessment, diagnosis, and treatment of patients presenting with certain conditions, and discharge home same day if clinically appropriate

- Establishment of an Acute Frailty programme
- Working closely with primary and community care services
- Specific projects to deliver 2 Hour Urgent Community Response, Virtual Wards, Intermediate Care and Transfer of Care Hub

Referral to treatment

The ICB reported control issues under this category due to difficulties in meeting the referral to treatment targets. Actions that are being undertaken to improve this position include, Theatre transformation, Chatbot, Mutual aid, Outpatient transformation, Referral optimization, Clinical networks and Surgical hubs.

Ambulance services

The ICB reported control issues under this category due to daily average volumes for 30-60 min delays increasing throughout the year. In addition to increased acuity and increased call volume/ demand, NWAS have experienced significant challenges with staffing capacity (absences linked to covid, those self-isolating and non-covid).

The range of strategies and approaches being utilised to try to tackle the identified challenges are aligned to those detailed above within the Accident and Emergency section.

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

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

The ICB has a strategic objective to 'meet financial targets and deliver improved productivity', and there is a risk on the Board Assurance Framework in this regard. Robust controls are in place such as; Standing Financial Instructions; Scheme of Reservation and Delegation; a financial budget for 2022-23 has been agreed; a single Lancashire and South Cumbria system plan has been submitted to NHSE detailing all commissioning and provider plans agreed by individual organisations within the system; additional financial controls have been implemented across the system (with peer review in place). The risk also has a mitigation plan to manage the gaps in assurance and control to mitigate the risk against this.

Monthly financial performance is scrutinised by the Finance and Performance Committee and reported to the Board. Internal and External Audit arrangements give a view to the Audit Committee on the delivery of the ICB's statutory financial responsibilities and the achievement of value for money. The ICB complies with the NHS Pension Scheme regulations. Performance reports are reviewed at the Board and Finance and Performance Committee.

The ICB has undertaken a Mutually Agreed Resignation Scheme (MARS) and a formal management of change process for an organisational restructure. This has enabled the organisation to remain within a reducing running cost allocation, in real terms, releasing recurrent efficiency savings from 1 April 2023.

The ICB has received its national NHS Staff Survey results and has established a multi-professional engagement group to analyse these and to design and implement a broad range of OD, leadership, engagement listening events and cultural initiatives to help improve our staff experience. The ICB is working with system partners to develop a bespoke systems

leadership programme in conjunction with the NHS NW Leadership Academy based upon the national NHS Leading for System Change programme.

The architecture for system delivery of efficiencies was established early in 2022/23 and is now fully embedded. Representatives of the ICB and provider partners contribute to each of the following groups:

- Delivery Boards to oversee the delivery of in year plans;
- Improvement Hubs to deliver on medium term projects; and
- A Transformation function overseeing longer term projects delivered over multiple years.

Going forward there is a clear focus on how these groups will deliver on programmes and projects underpinning the five priority savings programmes agreed by the ICB Board and System Delivery Board.

Delegation of functions

In line with NHSE policy, the ICB has not delegated any of its functions in its transitional year.

Counter fraud arrangements

The ICB Chief Finance Officer is responsible for ensuring appropriate arrangements are in place to comply with the Government Functional Standard 013: Counter Fraud within the NHS. An accredited Counter Fraud Specialist is contracted to undertake counter fraud work proportionate to identified risks via the contract the ICB holds with Mersey Internal Audit Agency.

The ICB Audit Committee receives a quarterly progress report against each of the Standards for Commissioners and a final one within an annual report. The Chief Finance Officer (CFO) provides executive support, and a proactive work plan is in place to address identified risks.

The CFO is proactively and demonstrably responsible for tackling fraud, bribery and corruption. Regular meetings are held with the Anti-Fraud Specialist and the CFO throughout the year.

Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations via alerts, Fraud Prevention Notices or Local Proactive Exercises, which are cascaded to the relevant departments within the ICB.

The Anti-Fraud Specialist has received four referral queries since July 2022. Two have been closed, as no fraud was identified after further checks conducted by the ICB. Two are still awaiting further information from the ICB to determine if there is any substance to the allegation. One of these referrals is regarding alleged abuse of annual leave by a member of staff and the second regarding a care provider receiving payments for care that has not been delivered. The ICB are undertaking further enquiries which will enable the AFS to determine if any fraud has occurred.

One fraud investigation (transferred from Chorley and South Ribble CCG) has been closed, as it couldn't be proven beyond all reasonable doubt (threshold for a criminal case) that an offence has been committed. £64,000 has been recovered by Civil recovery route.

'The ICB contracts an accredited counter fraud specialist to undertake counter fraud work. The counter fraud specialist has regular meetings with the Chief Finance Officer.

The anti-fraud work plan, which is approved by the Audit Committee, is risk based.

The Anti-Fraud Specialist provides regular updates on the progress of the anti-fraud plan to the Audit Committee via Progress Reports, which details the ongoing self-assessment against the 12 components of the Government Functional Standard 013 Counter Fraud'.

Freedom to Speak Up (FtSU)

At its first meeting on 1 July 2022, the Board approved it's Freedom to Speak up Policy (whistleblowing/raising concerns) and appointed James Fleet, Chief People Officer to undertake the lead Executive FtSU role and Professor Jane O'Brien as the lead non-executive member on behalf of the ICB.

NHS England published an updated FtSU policy in June 2022, with the expectation that all NHS organisations have the updated policy in place by 31 January 2024. The ICB People Board approved the adoption of this policy in November 2022 and announced the ICB's ambition to establish a robust FtSU process to ensure everyone working within the organisation feels safe and confident to raise a concern. The aim is for speaking up to become business as usual and valued as an opportunity to engage, learn and improve.

The ICB's FtSU function has both an internal ICB role, as well as taking on a system wide FtSU co-ordinating responsibility. This includes sharing good practice and learning from across the system. The ICB FtSU function will report into the ICB People Board.

From January to March 2023, a freedom to speak up process was established which planned for the recruitment of several FtSU guardians, as well as a network of champions, in April 2023. This would allow the organisation to be more open and transparent and for staff to raise concerns without fearing any consequences.

There are several ways ICB staff can raise issues and concerns, including:

- Speaking to FtSU guardians or champions
- 1:1s with line managers
- A conversation with a health and wellbeing champion
- Listening rooms
- Coffee and chat sessions with executives
- Staff side representatives/trade unions
- Anonymously (or openly) at all staff briefings

The ICB is committed to listening to its staff, learning lessons and improving patient care and the services we commission. Over the reporting period of this annual report, no formal whistleblowing concerns have been raised.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 July 2022 to 31 March 2023 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

The overall opinion for the period 1 July 2022 to 31 March 2023 is:

Limited Assurance: there is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls impacts on the overall system of internal control and puts the achievement of the organisation's objectives at risk.
The opinion is not limited in scope but is provided in the context of the maturity of the organisation during the time of reporting.

The complexity of the ICB, in terms of bringing together 8 CCGs to form the ICB, together with its maturity have been significant factors in determining the Head of Internal Audit Opinion. It is fully acknowledged that positive assurances have been provided for the core systems of finance and payroll and that progress continues regarding the development and embedding of the control framework. However, this opinion covers the period from establishment until the 31 March 2023 and for the majority of the core areas reviewed by internal audit, the outcomes have highlighted that whilst the development and embedding of the control framework has continued to progress, this hasn't been fully operational for the period under review.

Review coverage has been focused on:

- The organisation's Assurance Framework and strategic risk management arrangements;
- Core and mandated reviews, including follow up; and
- A range of individual risk-based assurance reviews focusing on priority assurance areas

Assurance Framework (AF)

Structure	The organisation's AF is structured to meet the NHS requirements.
Risk Appetite	The organisation has not agreed its risk appetite and as such, has not been used to inform the management of the AF.
Engagement	There could be greater visibility of the use of the AF by the Board.
Quality & Alignment	The AF generally reflects the risks discussed by the Board.

During the period, Internal Audit issued the following:

Core & Risk-Based Reviews Issued	
Risk Management Core Controls*	The control framework has **continued to progress**, both in design and implementation
Governance Core Controls*	The control framework has **continued to progress**, both in design and implementation

Conflicts of Interest Core Controls*	The control framework has **significantly progressed** its development and implementation of core controls.
Quality Governance Core Controls*	The control framework has **continued to progress**, both in design and implementation
Information Governance Core Controls*	The ICB has provided **reasonable evidence of progress** in establishing its IG and Digital governance frameworks and associated processes. At this point in time (March 2023) there are a number of core IG and IT controls to be further developed and implemented.
HfMA Improving NHS Financial Sustainability Checklist*	Self-assessment was not fully complete at the time of initial submission Self-assessment was appropriately approved Self-assessments against the 12 NHSE specified questions reviewed by internal audit were deemed to be reasonable
Financial Governance*	**Reasonable progress** in progressing actions (ref to above review on HfMA Improving Financial Sustainability Checklist)
Key Financial Systems* General Ledger Treasury Management Accounts Payable Accounts Receivable Budgetary Control & Financial Reporting	**Substantial**
ESR HR / Payroll*	**Substantial Assurance**
Data Security & Protection Toolkit*	**N/A** *Feedback provided to support the submission to NHSD in line with their timescales (30 June 2023)*
NICHE Urology Assurance Review	**Substantial Assurance**
Pre-Delegation Assessments for Direct Commissioning Support	**Assurance that effective processes** have been established for the completion and monitoring of transition plans

* *identified priority areas for in year delivery to the Head of Internal Audit Opinion for 2022/23*

Follow Up

During the course of the year, we have undertaken follow up reviews and can conclude that the organisation has made reasonable with regards to the implementation of recommendations. We will continue to track and follow up outstanding actions.

Chris Harrop

Managing Director, MIAA
March 2023

Louise Cobain

Assurance Director, MIAA
March 2023

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

The ICB was established on 1 July 2022 and this financial part year is one of transition. The complexity of establishing our organisation, whilst reviewing and managing the 8 predecessor CCGs systems, processes, operational policies, contracts, data, assets and liabilities into one operating model and governance framework has been an enormous undertaking. We inherited a challenging financial position, and we are still developing our operating model.

Within this context, my review of the effectiveness of the system of internal control is informed by the work of the internal auditors, and executive officers within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on the limited information available to me, and my review is also informed by comments made by the external auditors in their annual auditor report and other reports, and the work of the board and its committees.

Whilst the Board, its committees and the executive team have had good oversight of the principal risks and issues impacting on the ICB's ability to deliver and achieve its objectives, the board assurance framework was not established until December 2022, and other information available to me leads me to conclude there are limitations in the design and application of controls, which have impacted on the ICB's overall system of internal control and this will be subject to much more scrutiny in 2023/24.

Kevin Lavery
Chief Executive Officer
29th June 2023

Remuneration and Staff Report

Remuneration Committee

The makeup of the remuneration committee can be found earlier in this report.

Percentage change in remuneration of highest paid director

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

	Salary and allowances	**Performance pay and bonuses**
The percentage change from the previous financial year in respect of the highest paid director	N/A	N/A
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	N/A	N/A

The ICB was formed on 1 July 2022 and therefore cannot provide a percentage change in remuneration from the previous financial year.

Pay ratio information

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

The banded remuneration of the highest paid director / member in NHS Lancashire and South Cumbria in the reporting period 1 July 2022 – 31st March 2023 was £255,000 - £260,000.

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

2022/23	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	£39,523	£50,847	£72,921
Salary component of total remuneration (£)	£37,633	£50,847	£69,855
Pay ratio information	6.84:1	5.06:1	3.53:1

During the reporting period 2022/23, no employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £20,000 - £25,000 to £255,000 - £260,000.

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

Policy on the remuneration of senior managers

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

Remuneration of Very Senior Managers

We are obliged to review the remuneration of all our Senior Executives (non-agenda for change) on an annual basis and in accordance with NHS England's (NHSE) Guidance on ICB Executive Director pay.

NHSE has ranked all Integrated Care Systems in size order according to weighted population, with four categories, A,B,C and D, with A being the smallest and D the largest. This pay framework determines the pay range for the Chief Executive, and the proportionate minimum and operational maximum of statutory executive board roles and other board level executives. LSC ICB is ranked as band D, meaning that the Remuneration Committee can make decisions on board level executive pay, subject to this remaining under £170,000 per annum or the operational maximum, whichever is the lower. Pay proposals exceeding £170k or the operational maximum is subject to NHSE and Department of Health and Social Care approval.

The ICB has also adopted a local pay framework for other VSM roles, and all VSM pay is considered and agreed by the ICB's Remuneration Committee.

Senior manager remuneration (including salary and pension entitlements)

Name	Title	1 July 2022 to 31 March 2023					
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Kevin Lavery	Chief Executive Officer	190 - 195	1,300				195 - 200
Samantha Proffitt	Chief Finance Officer	130 – 135				117.5-120	245 - 250
David Levy	Chief Medical Director	105 – 110					105 – 110
Sarah O'Brien	Chief Nursing Officer	120 – 125				85 – 87.5	205 - 210
Maggie Oldham	Chief Planning, Performance and Strategy Officer – from 11/09/22	115 – 120					115 – 120
James Fleet	Chief People Officer	115 - 120	2,300			25 – 27.5	145 – 150
Asim Patel	Chief Digital Officer – from 01/11/22	55 – 60	300			27.5 – 30	85 – 90
Craig Harris	Chief of Health and Care Integration – from 01/11/22	60 – 65				30 – 32.5	95 - 100
Geoff Jolliffe	Partner Member - Primary Medical Services	10 – 15					10 – 15
David Flory	Chair	55 – 60					55 – 60
Ebrahim Adia	Non-Executive Member	5 – 10					5 – 10
Jim Birrell	Non-Executive Member	10 – 15					10 – 15
Sheena Cumiskey	Non-Executive Member	10 – 15					10 – 15
Roy Fisher	Non-Executive Member	10 – 15					10 – 15
Jane O'Brien	Non-Executive Member	5 – 10					5 – 10

Notes:

1. All senior managers were in post from 1st July 2022 to 31st March 2023 unless specified above.
2. The full year equivalent salaries are as follows (bands of £5,000):

Kevin Lavery	£255,000 - £260,000
Samantha Proffitt	£175,000 - £180,000
David Levy	£140,000 - £145,000
Sarah O'Brien	£155,000 - £160,000
Maggie Oldham	£200,000 - £205,000
James Fleet	£155,000 - £160,000
Asim Patel	£140,000 - £145,000
Craig Harris	£150,000 - £155,000
Geoff Jolliffe	£15,000 - £20,000
David Flory	£75,000 - £80,000
Ebrahim Adia	£15,000 - £20,000
Jim Birrell	£15,000 - £20,000
Sheena Cumiskey	£15,000 - £20,000
Roy Fisher	£10,000 - £15,000
Jane O'Brien	£10,000 - £15,000

3. Maggie Oldham is on secondment from Isle of Wight NHS Trust from 11th September 2022.
4. Expense payments (taxable) to the nearest £100 relate to the net taxable benefit of the use of lease cars.
5. The ICB does not have a performance-related pay scheme; the performance of staff is measured through the ICB's annual appraisal process. There is therefore no reference to performance-related bonuses.
6. Pension-related benefits are calculated as follows:

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

   Where:

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

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

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

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

   Ees cont = employee pension contributions for the financial year.

   To adjust PB and LSB for inflation the Consumer Prices Index (CPI) of 3.1% has been used.

Pension benefits

Name	Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2023 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 July 2022	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2023	(h) Employers Contribution to partnership pension
		£000	£000	£000	£000	£000	£000	£000	£000
Samantha Proffitt	Chief Finance Officer	5 – 7.5	10 – 12.5	65 – 70	130 – 135	1,075	1,244	109	0
Sarah O'Brien	Chief Nursing Officer	2.5 – 5	5 – 7.5	55 – 60	110 – 115	882	1,099	79	0
James Fleet	Chief People Officer	0 – 2.5	0 – 2.5	10 – 15	15 – 20	160	191	9	0
Asim Patel	Chief Digital Officer	0 – 2.5	0 – 2.5	40 – 45	70 – 75	557	625	21	0
Craig Harris	Chief of Health and Care Integration	0 – 2.5	0 – 2.5	40 – 45	70 – 75	564	634	21	0

Notes:

1. The payments made to the Lay Members do not include pension contributions. These persons have therefore been excluded from the above table.
2. Any Officers who are not members of the pension scheme have been excluded from the above table.
3. Ms Maggie Oldham is on secondment from Isle of Wight NHS Trust from 11 September 2023. Ms Maggie Oldham remains on the payroll of Isle of Wight NHS Trust.
4. For comparative purposes the CETV figures at 31 March 2022 have been inflated by 3.1%. The real increase in CETV is calculated as follows:

   {CETV at 31/03/2023 – (CETV at 31/03/2022 + 3.1%)} / 365 x 264 - 2022/2023 Employee superannuation contributions

   Where 264 represents the number of days between 1 June 2022 to 31 March 2023.
5. The Integrated Care Board was only able to obtain confirmation of the movement in the cash equivalent transfer values for the Directors' pension entitlements for the period from 1 April 2022 to 31 March 2023. As a result, the Integrated Care Board has apportioned the

movement on a straight line basis to estimate the cash equivalent transfer value at 31 March 2023 (as described in 4. above). This is considered to be a reasonable approximation of the movement in the value of the entitlements during the year.

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2023; this guidance will be used in the calculation of 2023/24 CETV figures.

Staff Report

Number of senior managers

The following table details the breakdown of ICB staffing by pay band as at the 31st March 2023, including the number of senior managers (represented as 'very senior managers').

Pay Band	Headcount
Apprentice	0
Band 1	0
Band 2	0
Band 3	14
Band 4	38
Band 5	59
Band 6	52
Band 7	80
Band 8 - Range A	86
Band 8 - Range B	56
Band 8 - Range C	37
Band 8 - Range D	25
Band 9	29
Medical	34
Very Senior Managers	38
Grand Total	**548**

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

	Total number	Permanently employed number	Other number	2021/22 total number
Total	492.74	446.27	46.47	n/a
Costs:	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and wages	24,199	20,560	3,639	n/a
Social security cost	2,395	2,395	0	n/a
NHS pension cost	3,542	3,542	0	n/a
Other pension cost	0	0	0	n/a
Apprenticeship levy	31	31	0	n/a
Recoveries in respect of employee benefits	0	0	0	n/a
Total costs	32,866	29,226	3,639	n/a
Of the above, number of whole time equivalent people engaged on capital projects	0	0	0	0

Staff composition

The following sections provide an overview of diversity within our existing ICB workforce as at 31 March 2023. Please note – we are unable to report on gender reassignment as this data is not routinely collected via the national NHS Electronic Staff Record.

As an ICB, we recognise the need for our workforce to be representative of our resident population. Furthermore, we recognise that we need to do far more to attract and retain a workforce that is representative of the communities we serve, retain the existing diversity within our workforce, and improve the experiences of our diverse staff. Within our existing workforce, there are significant issues with under-reporting of diversity monitoring data which means we need to work harder to encourage our employees to share this information with us so that we are able to understand their needs and the challenges they may face.

Gender

The following table details the breakdown of total ICB staffing by gender as at the 31st March 2023:

Gender	FTE	Headcount
Female	372.79	420
Male	113.74	128
Grand Total	486.52	548

The following table details the gender split of the ICB Executive Director team (those who are directly employed by the ICB) as at the 31st March 2023:

Gender	FTE	Headcount
Female	2	2
Male	5	5
Grand Total	7	7

Disability

Census 2021 data tells us that 19.7% of the total resident population of Lancashire and South Cumbria are disabled under the Equality Act, and 8.8% of those individuals, report that their disability limits their day-to-day activities a lot.

In total, 3.2 per cent of Lancashire and South Cumbria ICB's combined workforce has declared that they have a disability. However, 39.1 per cent of the workforce has not declared their disability status which means that the actual number of disabled staff is likely to be higher. This is further supported by the fact that there are a significantly higher number of staff members who have required reasonable adjustments to be made in the workplace due to a disability or long-term condition. Staff are also encouraged to discuss any needs or requests for reasonable adjustments as part of their health and wellbeing conversations with line managers.

Ethnicity

The proportion of Lancashire and South Cumbria's resident population who are from an ethnically diverse background (i.e., non-White British) is currently 10.1 per cent. In comparison, 4.9 per cent of Lancashire and South Cumbria ICB's combined workforce self-reported as coming from ethnically diverse backgrounds. However, it should be noted that 13.6 per cent of the workforce has not stated their ethnicity so the actual proportion is likely to be slightly higher.

Religion and Belief

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

Religion and Belief	% ICB Workforce	% Population of Lancashire and South Cumbria
Atheism	8.4%	32%
Christianity	38.8%	52.8%
Islam	3.2%	8.3%
Other	3.6%	1.4%
Not declared	45%	5.4%

Sexual Orientation

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

Religion and Belief	% ICB Workforce	% Population of Lancashire and South Cumbria
Gay or Lesbian	1.4%	1.5%
Heterosexual / Straight	57.7%	90.2%
Other	0.5%	1.4%
Not declared	40.4%	6.9%

Sickness absence data

The following table details the monthly ICB sickness absence rate between 1st July 2022 (the formation of the ICB) and 31st March 2023, including a 12 month cumulative percentage:

Month	Monthly %	12 Month Cumulative %
July-22	2.52	2.52
August-22	2.23	2.37
September-22	3.08	2.61
October-22	2.30	2.53
November-22	3.04	2.63
December-22	3.34	2.75
January-23	2.85	2.77
February-23	2.05	2.68
March-23	1.99	2.60

Staff turnover percentages

The following table details the leavers by month and the staff turnover rate across the ICB between 1st July 2022 (the formation of the ICB) and 31st March 2023. March 2023 saw a significant increase in the number of leavers which was largely as a consequence of a time-limited Mutually Agreed Resignation Scheme operated by the ICB whereby 45 employees voluntarily left the organisation. There were also five Board level voluntary redundancies

(legacy CCG roles) and one additional redundancy scenario due to the ending of a fixed term contract in March 2023.

Month	Leavers by Month	Overall Turnover Rate
July-22	5.50	1.16
August-22	4.80	1.01
September-22	6.47	1.36
October-22	4.48	0.93
November-22	4.40	0.91
December-22	9.63	1.97
January-23	3.80	0.78
February-23	3.02	0.62
March-23	53.07	10.93
Grand Total	95.18	19.74

Staff engagement percentages

Lancashire and South Cumbria ICB took part in its first national NHS staff survey in September 2022. The response rate to the survey was 84% against a 73% response rate benchmark across other similar organisations.

The organisation is currently running a 'Big Conversations' engagement programme to explore key themes from the survey and encourage staff to share more about their experiences, ideas, suggestions, and solutions. These sessions have been conducted at both are either by directorate or whole ICB levels, for the purpose of bringing for staff to come together to co-design interventions to improve the working lives of our staff across the organisation.

The ICB level Big Conversations have focused on specific areas/themes that emerged from analysis for the survey results, including: within their teams or alternatively organisation wide conversations are available for all staff with a focus on topic areas such as health and wellbeing, organisational leadership and culture.

Staff policies

The ICB Board agreed to adopt the following corporate and staff policies upon the establishment of the ICB on the 1st July 2022:

- Complaints Policy
- Standards of Business & Conduct Policy
- Conflicts of Interest Policy
- Public Involvement & Engagement Policy
- Security Management
- Incident, Accident and 'Near Miss' Policy and Procedure
- Information Governance Staff Code of Conduct
- Information Governance & Data Security and Protection Policies
- Information Governance Handbook
- Bad debts
- Absence Management Policy
- Adoption Policy
- Annual Leave Policy
- Career Break Policy
- Disciplinary Policy
- Equality and Inclusion Policy

- Grievance Policy
- Harassment and Bullying at Work Policy
- Induction Policy
- Agenda for Change Job Evaluation and Re-banding Policy
- Managing Work Performance Policy
- Maternity Policy
- Appraisal objectives and performance review (including pay progression) policy
- Organisational Change Policy
- Parental Leave Policy
- Paternity Leave Policy
- Professional Registration Policy
- Recruiting Ex-Offenders Policy
- Recruitment and Selection Policy
- Retirement Policy
- Shared Parental Leave Policy
- Substance Misuse Policy
- Training and Development Policy
- Secondment Policy
- Temporary Promotion Policy
- Freedom to Speak up Policy (Whistleblowing / Raising Concerns)
- Human Rights Policy
- Lone Worker Policy and Procedure

The following list of policies have also been developed or reviewed throughout the reporting period by the ICB:

- Policy for the Development and Management of Policy and Procedural Documents (Policy for Policies)
- Social Media and Digital Content Policy
- Media Relations Policy
- Policy on Sponsorship and Joint Working with the Pharmaceutical Industry and other Commercial Organisations
- ICB Risk Management Strategy and Policy
- Business Continuity Policy
- Emergency Preparedness, Resilience and Response Policy
- Agile Working Guidance
- Anti-Fraud, Bribery and Corruption Policy & response Plan
- Section 106 Monies Community Infrastructure Levy Funding
- Mental Capacity Act
- Safeguarding Children and Adults
- Domestic Abuse and the Workplace Policy

Trade Union Facility Time Reporting Requirements

The number of employees who were relevant Trade Union officials during the relevant period is 1.

Whilst the ICB does not currently have any formal agreed Trade Union Facility Time agreements in place, regular weekly staff side engagements are in place and facility time for accredited representatives is supported by the ICB.

Off-payroll engagements

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

For all off-payroll engagements as at 31 March 2023, for more than £245(1) per day:

	Number
Number of existing engagements as of 31 March 2023	**11**
Of which, the number that have existed:	
• **for less than one year at the time of reporting**	**11**
• **for between one and two years at the time of reporting**	**0**
• **for between two and three years at the time of reporting**	**0**
• **for between three and four years at the time of reporting**	**0**
• **for four or more years at the time of reporting**	**0**

Note:

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

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

(3) Of the eleven individuals outlined above, the individuals are employed by and on the payroll of an agency and therefore the off-payroll legislation does not apply.

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

For all off-payroll engagements between 1 July 2022 and 31 March 2023, for more than £245(1) per day:

	Number
Number of temporary off-payroll workers engaged between 1 July 2022 and 31 March 2023	23
Of which:	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	0
Number subject to off-payroll legislation and determined as out of scope of IR35	23
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

Note:

1. The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
2. A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: off-payroll board member /senior official engagements

For any off-payroll engagements of board members and / or senior officials with significant financial responsibility, between 1 July 2022 and 31 March 2023:

	Number
Number of off-payroll engagements of board members, and / or senior officers with significant financial responsibility, during the reporting period	**0**
Total number of individuals on payroll and off-payroll that have been deemed "board members and / or senior officials with significant financial responsibility" during the reporting period ***see note 1 below**	**9**

Note:

1: The total figure of 9 above includes Ms Maggie Oldham, who was on secondment from Isle of Wight NHS Trust in the post of Chief Planning, Performance and Strategy Officer.

Exit packages, including special (non-contractual) payments

Table 1: Exit Packages

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	**1**	4,385	**5**	27,544	**6**	31,929	**0**	**0**
£10,000 - £25,000	**2**	33,740	**10**	168,978	**12**	202,717	**0**	**0**
£25,001 - £50,000	**0**	**0**	**19**	671,308	**19**	671,308	**0**	**0**
£50,001 - £100,000	**0**	**0**	**18**	1,152,448	**18**	1,152,448	**0**	**0**
£100,001 - £150,000	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
£150,001 – £200,000	**4**	640,000	**0**	**0**	**4**	640,000	**0**	**0**
>£200,000	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTALS	**7**	**678,125**	**52**	**2,020,277**	**59**	**2,698,401**	**0**	**0**

Redundancy and other departure cost have been paid in accordance with the provisions of NHS Business Services Authority relevant pension scheme regulations and with due note to Agenda for Change Section 16. Exit costs in this note are accounted for in full in the year of departure.

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	**0**	**0**
Mutually agreed resignations (MARS) contractual costs	**46**	1,830,423
Early retirements in the efficiency of the service contractual costs	**0**	**0**
Contractual payments in lieu of notice*	**6**	189,854
Exit payments following Employment Tribunals or court orders	**0**	**0**
Non-contractual payments requiring HMT approval	**0**	**0**
TOTAL	**52**	**2,020,277**

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 5.3 which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under "non-contracted payments requiring HMT approval" below.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Compensation on early retirement or for loss of office (subject to audit)

The ICB made no payments for early retirement or for loss of office during the financial year.

Payments to past Directors (subject to audit)

The ICB made no payments to past Directors during the financial year.

Related party transactions

Information in respect of related party transactions is detailed in Note 19 to the Annual Accounts.

Better Payment Practice Code (BPPC)

Information in respect of the Better Payment Practice Code (BPPC) is detailed in Note 7 to the Annual Accounts.

Consultancy expenditure

During the financial period 1 July 2022 to 31 March 2023 we have spent £339k on external consultancy services.

Kevin Lavery
Chief Executive Officer
29th June 2023

Parliamentary Accountability and Audit Report

NHS Lancashire and South Cumbria ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements with this report. An audit certificate and report are also included in this Annual Report.

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Lancashire and South Cumbria Integrated Care Board ("the ICB") for the nine month period ended 31 March 2023 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the ICB's affairs as at 31 March 2023 and of its income and expenditure for the nine month period then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 26 April 2023 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the ICB in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis, as they have not been informed by the relevant national body of the intention to either cease the ICB's services or dissolve the ICB without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the ICB will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit as to the ICB's high-level policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the ICB by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls, in particular the risk that ICB management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity.

We also identified a fraud risk related to the completeness of accrued expenditure at period end, in response to the pressure on the ICB to achieve statutory targets delegated by NHS England.

In determining the audit procedures, we took into account the results of our evaluation of some of the ICB-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals which reduced the reported expenditure close to the period end and those which reclassify expenditure from admin to programme.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- In response to the fraud risk related to the completeness of accrued expenditure, we performed procedures including a search for unrecorded liabilities and testing of purchase invoices recognised before and after the period end to identify any invoices recognised in the incorrect reporting period.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the ICB is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the ICB is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery and employment law, recognising the regulated nature of the ICB's activities and its legal form. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial period is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022/23. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 54, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the ICB or dissolve the ICB without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Report on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

Significant weaknesses

The ICB faces a significant challenge in achieving its financial plan for 2023/24. The ICB must deliver Quality, Innovation, Productivity and Prevention Plans (QIPP) of c£170m, of which around 35% was at high risk at the end of the first quarter of the year. The ICB is responsible for ensuring that the Lancashire and South Cumbria system as a whole meets the forecast deficit of £80m, which is also subject to considerable financial risk in the form of high-risk identified Cost Improvement Programmes (CIPs) within the providers and a system stretch target. The ICB has only partial control over how the providers deliver on their CIPs, but there are system-wide interdependencies underpinning these plans that the ICB has a key role in enabling.

We have identified a significant weakness in relation to the financial sustainability of the ICB and the wider system. The significant weakness relates to the level and risk associated with the savings identified within the financial plan that could substantially threaten the delivery of the plan.

We recognise that the system is developing a recovery response that aims to restore financial balance to the system over a three-year period.

We have also identified a significant weakness in the ICB's arrangements in relation to key aspects of its governance arrangements The Board Assurance Framework (BAF), as well as the wider Risk Management Strategy and Policy, were not formally in place until December 2022 and were still not in effective operation at 31 March 2023. Further, the ICB's "Freedom to Speak Up" arrangements were not fully implemented until after March 2023, which is an important aspect of the overall system of internal control in respect of prevention and detection of fraud.

While formal governance features were absent, there is clear evidence from the Board papers and minutes that the matters considered during the year broadly align with the key risks identified through the 'stock take' of risks faced by the ICB, conducted in June 2022.

Recommendations

- We recommend that the ICB ensures that resource is allocated appropriately to ensure that each element of the financial plan gains momentum during Q2 of 2023/24 and begins to deliver on the required system-wide financial improvement.
- In relation to the Board Assurance Framework, management should address the concerns raised in relation to comprehensive identification and documentation of key risks, how these link to the ICB's strategic priorities and how the Audit Committee will gain assurance over the effective management of risks where appropriate controls are still to be identified. "Freedom to Speak Up" arrangements should be fully embedded as soon as possible.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 54, the Accountable Officer is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the ICB had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS Lancashire and South Cumbria Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Lancashire and South Cumbria ICB for the nine month period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Timothy Cutler
for and on behalf of KPMG LLP
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

3 July 2023

Data entered below will be used throughout the workbook:

Entity name:	NHS Lancashire and South Cumbria Integrated Care Board
This year	2022-23
Last year	2021-22
This year ended *	31 March 2023
This year commencing:	01-July-2022

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the period ended 31 March 2023

	Note	2022-23 £'000
Income from sale of goods and services	3	(21,053)
Other operating income	3	(6,881)
Total operating income		**(27,934)**
Staff costs	5	32,865
Purchase of goods and services	6	3,038,204
Depreciation and impairment charges	6	193
Provision expense	6	(1,754)
Other Operating Expenditure	6	1,639
Total operating expenditure		**3,071,147**
Net Operating Expenditure		**3,043,213**
Finance expense		4
Net expenditure for the period		**3,043,217**
Comprehensive Expenditure for the period		**3,043,217**

Statement of Financial Position as at 31 March 2023

	Note	2022-23 £'000
Non-current assets:		
Right-of-use assets	11	3,383
Intangible assets	12	0
Total non-current assets		**3,383**
Current assets:		
Inventories	13	6,292
Trade and other receivables	14	57,797
Cash and cash equivalents	15	580
Total current assets		**64,669**
Total assets		**68,052**
Current liabilities		
Trade and other payables	16	(209,947)
Lease liabilities	11	(353)
Provisions	17	0
Total current liabilities		**(210,300)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(142,248)**
Non-current liabilities		
Lease liabilities	11	(3,034)
Total non-current liabilities		**(3,034)**
Assets less Liabilities		**(145,282)**
Financed by Taxpayers' Equity		
General fund		(145,282)
Total taxpayers' equity:		**(145,282)**

The notes on pages 5 to 31 form part of this statement

The financial statements on pages 1 to 4 have been approved in line with delegated authority granted by the Board on 21 June 2023 and signed on its behalf by:

Kevin Lavery
Chief Executive Officer

Statement of Changes In Taxpayers Equity for the period ended 31 March 2023

	General fund £'000	Total reserves £'000
Changes in NHS Integrated Care Board taxpayers' equity for 2022-23		
Net operating expenditure for the financial period	(3,043,217)	**(3,043,217)**
Transfers by absorption to (from) other bodies	(156,949)	(156,949)
Net Recognised NHS Integrated Care Board Expenditure for the Financial period	**(3,200,166)**	**(3,200,166)**
Net funding	3,054,884	**3,054,884**
Balance at 31 March 2023	**(145,282)**	**(145,282)**

The notes on pages 5 to 31 form part of this statement

Statement of Cash Flows for the period ended 31 March 2023

	Note	2022-23 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial period		(3,043,217)
Depreciation and amortisation	6	193
Movement due to transfer by Modified Absorption		(146,949)
Interest paid		4
Other Gains & Losses		(1)
(Increase)/decrease in inventories		(6,292)
(Increase)/decrease in trade & other receivables	14	(57,797)
Increase/(decrease) in trade & other payables	16	209,947
Provisions utilised	17	(8,273)
Increase/(decrease) in provisions	17	(1,754)
Net Cash Inflow (Outflow) from Operating Activities		**(3,054,139)**
Net Cash Inflow (Outflow) before Financing		**(3,054,139)**
Cash Flows from Financing Activities		
Drawdown Funding Received		3,054,884
Repayment of lease liabilities		(165)
Net Cash Inflow (Outflow) from Financing Activities		**3,054,719**
Net Increase (Decrease) in Cash & Cash Equivalents	15	**580**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period		**580**

The notes on pages 5 to 31 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Integrated Care Boards (ICBS) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis**.**

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). ICBs took on the commissioning functions of CCGs. CCG functions, assets and liabilities were transferred to ICBs on 1 July 2022.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

When clinical commissioning group ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Joint arrangements**

Arrangements over which the ICB has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the ICB is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

The ICB's pooled budget arrangements are considered to fall under the provisions of a joint operation.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

The ICB does not consider itself to be involved in any joint ventures.

1.5 **Pooled Budgets**

The ICB has entered into pooled budget arrangements with local authorities in Lancashire and Cumbria. Under the arrangements, funds are pooled in respect of services for adults with learning disabilities, services to support integrated hospital discharges and the Better Care Fund (BCF) initiative. The BCF is designed to create a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

Note 21 to the accounts provides details of the ICB's share of the assets, liabilities, income and expenditure for the ICB's pooled fund arrangements.

1.6 **Operating Segments**

The ICB considers itself to have one operating segment which is healthcare for its population.

1.7 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Notes to the financial statements

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Notes to the financial statements

1.12 **Intangible Assets**

1.12.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.12.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.13 **Donated Assets**

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 **Non-current Assets Held For Sale**

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve. Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

Notes to the financial statements

1.16 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.16.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.
Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.
Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.
Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.17 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

1.18 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.19 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 3.27% (2021-22: -0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 3.20% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 3.51% (2021-22 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 3.00% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

Notes to the financial statements

1.20 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

1.21 **Non-clinical Risk Pooling**

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.22 **Carbon Reduction Commitment Scheme**

The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The ICB is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

1.23 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.24 **Financial Assets**

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.24.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.24.2 **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.24.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.24.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.25 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Notes to the financial statements

1.25.1 **Financial Guarantee Contract Liabilities**
Financial guarantee contract liabilities are subsequently measured at the higher of:
· The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
· The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.25.2 **Financial Liabilities at Fair Value Through Profit and Loss**
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.25.3 **Other Financial Liabilities**
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.26 **Value Added Tax**
Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.27 **Foreign Currencies**
The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB's surplus/deficit in the period in which they arise.

1.28 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the ICB has no beneficial interest in them.

1.29 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.30 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.30.1 **Critical accounting judgements in applying accounting policies**
The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.
The ICB's management has reviewed the organisation's lease arrangements and judged that two new right of use assets should be recognised in the financial statements under IFRS16: leases.

1.30.2 **Sources of estimation uncertainty**
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.
There are a number of accruals within the Statement of Financial Position where estimation techniques are applied. This is because the outturn information is not available at the time of preparation of the financial statements. Examples of significant accruals involving estimates are prescribing costs and continuing healthcare costs.

1.31 **Gifts**
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.32 **New and revised IFRS Standards in issue but not yet effective**

● IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted. It is not expected that adoption of this standard would have a material impact on the ICB accounts.

Note 2: Financial performance targets

NHS Integrated Care Boards have a number of financial duties under the NHS Act 2006 (as amended).
The NHS Integrated Care Board's performance against those duties was as follows:

	2022-23 Target	2022-23 Performance	Target Achieved
Capital resource use does not exceed the amount specified in Directions	3,504	3,383	Yes
Revenue resource use does not exceed the amount specified in Directions	3,043,217	3,043,217	Yes
Revenue administration resource use does not exceed the amount specified in Directions	26,450	26,372	Yes

3 Other Operating Revenue

	2022-23 Total £'000
Income from sale of goods and services (contracts)	
Education, training and research	**1,961**
Non-patient care services to other bodies	**1,561**
Prescription fees and charges	**17,520**
Other Contract income	**11**
Total Income from sale of goods and services	**21,053**
Other operating income	
Other non contract revenue	**6,881**
Total Other operating income	**6,881**
Total Operating Income	**27,934**

4 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	1,961	(5)	0	0
Non NHS	0	1,566	17,520	11
Total	**1,961**	**1,561**	**17,520**	**11**

	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	1,961	1,561	17,520	11
Over time	0	0	0	0
Total	**1,961**	**1,561**	**17,520**	**11**

5. Employee benefits and staff numbers

5.1 Employee benefits

	Total 2022-23		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	20,560	3,639	**24,199**
Social security costs	2,395	0	**2,395**
Employer Contributions to NHS Pension scheme	3,542	0	**3,542**
Apprenticeship Levy	31	0	**31**
Termination benefits	2,698	0	**2,698**
Gross employee benefits expenditure	**29,226**	**3,639**	**32,865**

5.2 Average number of people employed

	2022-23		
	Permanently employed Number	Other Number	Total Number
Total	**446.27**	**46.56**	**492.83**

5.3 Exit packages agreed in the financial period

	2022-23 Compulsory redundancies		2022-23 Other agreed departures		2022-23 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	4,385	5	27,544	6	31,929
£10,001 to £25,000	2	33,740	10	168,977	12	202,717
£25,001 to £50,000	0	0	19	671,308	19	671,308
£50,001 to £100,000	0	0	18	1,152,448	18	1,152,448
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	4	640,000	0	0	4	640,000
Total	**7**	**678,125**	**52**	**2,020,277**	**59**	**2,698,402**

Analysis of Other Agreed Departures

	2022-23 Other agreed departures	
	Number	£
Mutually agreed resignations (MARS) contractual costs	46	1,830,423
Contractual payments in lieu of notice	6	189,854
Total	**52**	**2,020,277**

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where **entities** has agreed early retirements, the additional costs are met by NHS **Entities** and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

5.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

5.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

5.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

6. Operating expenses

	2022-23 Total £'000
Purchase of goods and services	
Services from other ICBs, CCGs and NHS England	20,927
Services from foundation trusts	1,378,292
Services from other NHS trusts	588,654
Purchase of healthcare from non-NHS bodies	426,110
Purchase of social care	34,516
Prescribing costs	246,002
Pharmaceutical services	50,051
General Ophthalmic services	80
GPMS/APMS and PCTMS	261,929
Supplies and services – clinical	811
Supplies and services – general	11,949
Consultancy services	339
Establishment	3,207
Transport	312
Premises	11,669
Audit fees	290
Other non statutory audit expenditure	
· Other services	42
Other professional fees	2,174
Legal fees	456
Education, training and conferences	394
Total Purchase of goods and services	**3,038,204**
Depreciation and impairment charges	
Depreciation	165
Amortisation	28
Total Depreciation and impairment charges	**193**
Provision expense	
Provisions	(1,754)
Total Provision expense	**(1,754)**
Other Operating Expenditure	
Chair and Non Executive Members	166
Grants to Other bodies	1,444
Inventories consumed	29
Total Other Operating Expenditure	**1,639**
Total operating expenditure	**3,038,282**

The Integrated Care Board's contract with its external auditors (KPMG LLP) provides for a limitation of the auditor’s liability. The principal terms of this limitation are as follows:
Liability for all defaults resulting in direct loss or damage to the property of the other party shall be subject to a limit of £1M. In respect of all other defaults, claims, losses or damages the liability shall not exceed £1M.

7 Better Payment Practice Code

Measure of compliance	2022-23 Number	2022-23 £'000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	110,454	866,162
Total Non-NHS Trade Invoices paid within target	109,891	842,139
Percentage of Non-NHS Trade invoices paid within target	**99.49%**	**97.23%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	4,981	2,016,998
Total NHS Trade Invoices Paid within target	4,945	2,011,676
Percentage of NHS Trade Invoices paid within target	**99.28%**	**99.74%**

8. Other gains and losses

	2022-23 £'000
Gain/(loss) on disposal of right-of-use assets other than by sale	(1)
Total	**(1)**

9 Finance costs

	2022-23 £'000
Interest	
Interest on lease liabilities	4
Total interest	**4**
Total finance costs	**4**

10. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

	2022-23		
	Total	NHS England Parent Entities	NHS England Group Entities (non parent)
	£'000	**£'000**	**£'000**
Transfer of Right of Use assets	326	0	326
Transfer of intangibles	28	0	28
Transfer of inventories	6,321	0	6,321
Transfer of cash and cash equivalents	898	0	898
Transfer of receivables	13,934	0	13,934
Transfer of payables	(168,005)	0	(168,005)
Transfer of provisions	(10,027)	0	(10,027)
Transfer of Right Of Use liabilities	(326)	0	(326)
Transfer of PUPOC provision	(98)	(98)	0
Net loss on transfers by absorption	**(156,949)**	**(98)**	**(156,851)**

11 Leases

The ICB's right-of-use assets and associated lease liabilities reflect lease arrangements associated with ICB headquarters accommodation.

11.1 Right-of-use assets

2022-23	Buildings excluding dwellings £'000
Cost or valuation at 01 July 2022	0
Additions	3,385
Disposals on expiry of lease term	(380)
Transfer (to) from other public sector body	380
Cost/Valuation at 31 March 2023	**3,385**
Depreciation 01 July 2022	0
Charged during the year	165
Disposals on expiry of lease term	(217)
Transfer (to) from other public sector body	54
Depreciation at 31 March 2023	**2**
Net Book Value at 31 March 2023	**3,383**

11.2 Lease liabilities

2022-23	2022-23 £'000
Lease liabilities at 01 July 2022	0
Additions purchased	(3,385)
Interest expense relating to lease liabilities	(4)
Repayment of lease liabilities (including interest)	165
Disposals on expiry of lease term	163
Transfer (to) from other public sector body	(326)
Lease liabilities at 31 March 2023	**(3,387)**

11.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2022-23 £'000
Within one year	(548)
Between one and five years	(1,467)
After five years	(1,686)
Balance at 31 March 2023	**(3,701)**

All lease liabilities are with external counterparties i.e. outside of the NHS and DHSC group.

11.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2022-23	2022-23 £'000
Depreciation expense on right-of-use assets	165
Interest expense on lease liabilities	4

11.5 Amounts recognised in Statement of Cash Flows

	2022-23 £'000
Total cash outflow on leases under IFRS 16	165

12 Intangible non-current assets

2022-23	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 July 2022	**0**	**0**
Transfer (to)/from other public sector body	188	**188**
Cost / Valuation At 31 March 2023	**188**	**188**
Amortisation 01 July 2022	**0**	**0**
Charged during the year	28	**28**
Transfer (to) from other public sector body	160	**160**
Amortisation At 31 March 2023	**188**	**188**
Net Book Value at 31 March 2023	**0**	**0**

13 Inventories

	Loan Equipment
	£'000
Balance at 01 July 2022	0
Additions	(29)
Inventories recognised as an expense in the period	0
Transfer (to) from other public sector body by Absorption	6,321
Balance at 31 March 2023	**6,292**

14.1 Trade and other receivables

	Current 2022-23 £'000
NHS receivables: Revenue	9,354
NHS prepayments	152
NHS accrued income	163
Non-NHS and Other WGA receivables: Revenue	32,756
Non-NHS and Other WGA prepayments	4,980
Non-NHS and Other WGA accrued income	10,136
VAT	125
Other receivables and accruals	131
Total Trade & other receivables	**57,797**
Total current and non current	**57,797**

14.2 Receivables past their due date but not impaired

	2022-23 DHSC Group Bodies	2022-23 Non DHSC Group Bodies
	£'000	£'000
By up to three months	459	5,157
By three to six months	27	3,648
By more than six months	82	96
Total	**568**	**8,901**

The ICB reviewed its financial assets at 31 March 2023 and did not consider it to be necessary to provide for losses based on its portfolio.

15 Cash and cash equivalents

	2022-23 £'000
Balance at 01 July 2022	0
Net change in accounting period	580
Balance at 31 March 2023	**580**
Made up of:	
Cash with the Government Banking Service	580
Cash and cash equivalents as in statement of financial position	**580**
Balance at 31 March 2023	**580**

16 Trade and other payables	Current 2022-23 £'000
NHS payables: Revenue	31,554
NHS accruals	7,325
Non-NHS and Other WGA payables: Revenue	46,941
Non-NHS and Other WGA accruals	99,725
Non-NHS and Other WGA deferred income	49
Social security costs	521
Tax	986
Other payables and accruals	22,846
Total Trade & Other Payables	**209,947**
Total current and non-current	**209,947**

Other payables include £2,354k outstanding pension contributions at 31 March 2023.

17 Provisions

	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 July 2022	**0**	**0**	**0**
Utilised during the financial period	(8,022)	(251)	**(8,273)**
Reversed unused	(1,754)	0	**(1,754)**
Transfer (to) from other public sector body under absorption	9,776	251	**10,027**
Balance at 31 March 2023	**0**	**0**	**0**

The continuing care provision balance transferred from CCGs to the ICB was in respect of packages of continuing healthcare that were funded by local authorities. The funding for these cases however should have been provided by the NHS, according to national CHC framework guidance.

The continuing care provision has been used to settle the claims from the local authorities in this accounting period and the element of the balance that was not required has been reversed.

18 Contingencies

The Integrated Care Board had no contingent liabilities as at 31 March 2023.

19 Commitments

19.1 Capital commitments

The NHS Integrated Care Board had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2023.

19.2 Other financial commitments

The NHS Integrated Care Board had no non-cancellable contracts (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2023.

20 Financial instruments

20.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

20.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

20.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

20.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

20.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

20.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

20.2 Financial assets

	Financial Assets measured at amortised cost 2022-23 £'000	Total 2022-23 £'000
Trade and other receivables with NHSE bodies	422	422
Trade and other receivables with other DHSC group bodies	19,257	19,257
Trade and other receivables with external bodies	32,861	32,861
Cash and cash equivalents	580	580
Total at 31 March 2023	**53,120**	**53,120**

20.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2022-23 £'000	Total 2022-23 £'000
Trade and other payables with NHSE bodies	3,543	**3,543**
Trade and other payables with other DHSC group bodies	37,726	**37,726**
Trade and other payables with external bodies	170,509	**170,509**
Total at 31 March 2023	**211,778**	**211,778**

21 Joint arrangements - interests in joint operations

The ICB has entered into pooled budget arrangements for services for adults with learning disabilities, services to support integrated hospital discharges and Better Care Fund (BCF). The BCF is an integrated commissioning approach between local authorities and the ICB to help jointly plan and deliver local services.

The ICB's share of the assets, liabilities, income and expenditure handled by the pooled budget in the accounting period were:

			Amounts recognised in ICB Accounts 2022-23			
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Assets**	**Liabilities**	**Income**	**Expenditure**
			£'000	**£'000**	**£'000**	**£'000**
Learning Disabilities Pool	Lancashire County Council NHS Lancashire and South Cumbria Integrated Care Board	Services for Adults with Learning Disabilities	0	0	-1,564	9,355
Learning Disabilities Pool	Cumbria County Council NHS Lancashire and South Cumbria Integrated Care Board	Services for Adults with Learning Disabilities	0	-149	0	1,467
Better Care Fund	Lancashire County Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Lancashire County Council	0	-2,660	-66,498	78,366
Better Care Fund	Cumbria County Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Lancashire County Council	0	0	0	7,509
Better Care Fund	Blackpool Borough Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Lancashire County Council	0	0	-16,431	16,457
Better Care Fund	Blackburn with Darwen Borough Council NHS Lancashire and South Cumbria Integrated Care Board	Services supporting the integration of Health and Social Care hosted by Lancashire County Council	516	0	-8,173	9,383
Hospital Discharge Fund	Lancashire County Council NHS Lancashire and South Cumbria Integrated Care Board	Services to support integrated hospital discharges	0	0	-315	315
Hospital Discharge Fund	Cumbria County Council NHS Lancashire and South Cumbria Integrated Care Board	Services to support integrated hospital discharges	0	0	-931	931
Hospital Discharge Fund	Blackpool Borough Council NHS Lancashire and South Cumbria Integrated Care Board	Services to support integrated hospital discharges	0	0	-1,982	1,982
Hospital Discharge Fund	Blackburn with Darwen Borough Council NHS Lancashire and South Cumbria Integrated Care Board	Services to support integrated hospital discharges	0	0	-5,151	5,151

22 Related party transactions

Details of related party transactions with individuals during the financial period are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Ebrahim Adia - Non Executive Member - Deputy ICB Chair People - Pro Vice Chancellor UCLAN (University of Central Lancashire)	62	0	0	0
Caroline Donovan (ICB Partner Board Member): Chief Executive of NHS Lancashire and South Cumbria Foundation Trust	293,920	(3,607)	7,997	(5,331)
David Flory - Chair - Chair of Lancashire Football Association	1	0	0	0
David Flory (ICB Chair): Chair of Liverpool University Hospitals NHS Foundation Trust	11,547	0	703	0
Dr Geoff Jolliffe (ICB GP Partner Member): Employed GP by Cumbria Health on Call (CHOC)	3,980	0	0	0
Dr Geoff Jolliffe (ICB GP Partner Member): Employed GP by Highland Health Board	109	0	0	0
Dr Geoff Jolliffe (ICB GP Partner Member): Wife is employed at Risedale Surgery	853	0	41	0
Dr Geoff Jolliffe (ICB GP Partner Member): Daughter is employed by University Hospitals of Morecambe Bay NHS Foundation Trust	315,132	(64)	4,446	0
Kevin McGee (ICB Partner Board Member): Chief Executive of Lancashire Teaching Hospitals NHS Foundation Trust	330,526	(72)	7,225	(98)
Jane O'Brien - Non Executive Member - Emeritus Professor Lancaster University	34	0	0	0
Maggie Oldham (ICB Chief Planning, Performance and Strategy Officer - secondment): substantive role is Chief Executive Officer Isle of Wright NHS Trust	21	0	134	0
Samantha Proffitt (ICB Chief Finance Offer): Common law partner is Deputy Chief Executive of Mersey Care NHS Foundation Trust	5,577	0	288	0
Angie Ridgwell - Partner Member Local Authorities - Chief Executive Officer Lancashire County Council	52,073	(1,564)	24,776	(36,641)
Angie Ridgwell - Partner Member Local Authorities - Director of Resources Lancashire County Council	52,073	(1,564)	24,776	(36,641)

Please note that the above figures represent the total value of transactions between the ICB and the organisations identified as an interest. The values do
The above table concentrates on the interests and related transactions of the members of the ICB Governing Body only.

22 Related party transactions continued

The Department of Health and Social Care is regarded as a related party.
During the period the ICB had a significant number of material transactions with entities for which the Department is
Those bodies not already included in the table above with transactions greater than £1 million are:

East Lancashire Hospitals NHS Trust
North West Ambulance Service NHS Trust
Lancashire and South Cumbria NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
NHS Midlands & Lancashire CSU
Leeds Teaching Hospitals NHS Trust
Southport & Ormskirk Hospital NHS Trust
St Helens and Knowsley Hospital Services NHS Trust
Liverpool University Hospitals NHS Foundation Trust
Airedale NHS Foundation Trust
Alder Hey Children's NHS Foundation Trust
Blackpool Teaching Hospitals NHS Foundation Trust
Bolton NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
North Cumbria Integrated Care NHS Foundation Trust
Liverpool Heart & Chest Hospital NHS Foundation Trust
Manchester University NHS Foundation Trust
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Northern Care Alliance NHS Foundation Trust
The Christie NHS Foundation Trust
Wrightington, Wigan & Leigh NHS Foundation Trust
NHS Property Services
Community Health Partnerships

In addition, the ICB has had a number of transactions with other government departments and other
Blackpool Borough Council
Cumbria County Council
Blackburn with Darwen Council

23 Events after the end of the reporting period

There were no events after the end of the reporting period.

24 Losses and special payments

Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2022-23 Number	Total Value of Cases 2022-23 £'000
Fruitless payments	5	0
Total	**5**	**0**