

Approved 21 November 2025

**Minutes of the ICB Finance and Contracting Committee
Held on Wednesday 22 October 2025 at 2 pm
by MS Teams**

| Members | | |
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| Steve Igoe | Chair/Non-Executive Member | L&SC ICB |
| Jim Birrell | Non-Executive Member | L&SC ICB |
| Debbie Corcoran | Non-Executive Member | L&SC ICB |
| Mark Bakewell | Interim Chief Finance Officer | L&SC ICB |
| Asim Patel | Chief Digital Officer | L&SC ICB |
| Craig Harris | Chief Operating Officer/Chief Commissioner | L&SC ICB |
| Jane Scattergood | Interim Chief Nursing Officer | L&SC ICB |
| Andrew White (for Andy Knox) | Chief Pharmacist | L&SC ICB |
| Regular Participants | | |
| Neil Greaves | Director of Communications and Engagement | L&SC ICB |
| Debra Atkinson | Director of Corporate Governance/ Company Secretary | L&SC ICB |
| Peter Tinson (from item 118) | Director of Primary and Community Care | L&SC ICB |
| Attendees | | |
| Stephen Downs | Director of Strategic Finance | L&SC ICB |
| Nancy Park (for item 121) | All Age Continuing Care Turnaround Director | Pricewaterhouse Coopers LLP (PwC) |
| Saba Sadiq (for item 121) | Director of Finance | L&SC ICB |
| Adrian Mills (observing) | Principal Auditor | MIAA |
| Sandra Lishman (minutes) | Committee and Governance Officer | L&SC ICB |

| No | Item | Action |
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| 114 25/26 | <p><u>Welcome, Introductions and Chair's Remarks</u></p> <p>The Chair welcomed everyone to the meeting, including A Mills, MIAA who joined to observe the meeting as part of MIAA's audit of financial governance and A White, deputising for the ICB Medical Director. Members noted that N Park and S Sadiq would join the meeting for the All Age Continuing Care update.</p> <p>It was acknowledged that this would be S Downs' last committee meeting and M Bakewell was welcomed as the ICB's Interim Chief Finance Officer.</p> <p>Members were in agreement that Copilot transcription would be used throughout the meeting to aid in the production of the meeting minutes.</p> | |
| 115 25/26 | <p><u>Apologies for Absence/Quoracy of Meeting</u></p> <p>Apologies had been received from Andy Knox and Elaine Collier. Craig Harris would leave the meeting at around 3 pm.</p> <p>The meeting was quorate throughout.</p> | |
| 116 25/26 | <p><u>Declarations of Interest</u></p> <p>(a) Finance and Performance Committee Register of Interests – Noted.</p> | |

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| | <p>S Igoe declared an interest as he had recently been appointed as Chair of Wirral University Teaching Hospital NHS Foundation Trust and Wirral Community Trust. The conflict was noted and there were no items on the agenda that this interest would relate to.</p> <p>D Corcoran declared a conflict of interest for the digital and data strategy update discussion – a family member is employed by a commercial business delivering electronic records and shared care records. There was no direct conflict. The conflict was noted and it was agreed that D Corcoran would step out of the meeting if a conflict arose during presentation of the report or discussion.</p> <p>RESOLVED: That other than the above declarations, there were no further declarations of interest raised. Should any other conflicts arise during the meeting, the Chair should be advised accordingly.</p> | |
| <p>117 25/26</p> | <p>(a) <u>Minutes of the Meeting held on 22 September 2025 and Matters Arising</u></p> <p>RESOLVED: That the committee approve the minutes as a true and accurate record of the meeting held on 22 September 2025.</p> <p>(b) <u>Action Log</u></p> <p>Ref 19, 24, 25, 27 – Not yet due and progress updates had been provided within the action log.</p> <p>Ref 12 Digital and data strategy update – On this meeting agenda. Agreed to close.</p> <p>Ref 16 Grip and control committee oversight – Agreed to remain open. This was discussed at item 120 25/26 at today’s meeting.</p> <p>Ref 17 – AACC reporting – A meeting was held on 1 October 2025 to discuss the committee’s reporting requirements on the financial information for All Age Continuing Care. It was agreed that this item would remain open until the 21 November committee meeting, to ensure reporting had reached the required reporting level.</p> <p>Ref 22 Primary care and LES – On this meeting agenda. Agreed to close.</p> <p>Ref 23 AACC reporting – A comparison analysis would be reported to the 21 November committee meeting, benchmarking against metrics for the north of England or Midlands.</p> <p>Ref 26 Future reporting – Cash savings to date and the projected delivery forecast to the end of the year was included as part of the finance and waste reduction programme reports at today’s meeting. Agreed to close.</p> <p>Ref 28 2025/26 contract and contract monitoring - The contract monitoring paper at today’s meeting described detail on evidence-based exception reporting, providing a report as appendix B that is used in the Commissioning and Contracting Assurance meetings. The committee agreed that the item remain open as is ongoing.</p> <p>11C to C – Transfer of specialist learning disability service to a new provider – Costs were currently being worked out and the new service was expected to start on 1 December 2025. Agreed that the item remain open until an update is received on</p> | |

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| | closure. | |
| 118 25/26 | <p><u>Month 6 Finance Report – ICB and Provider</u></p> <p>M Bakewell provided an update to the committee on the month 6 system finance position, with the following key highlights:</p> <ul style="list-style-type: none"> - At month 6, the ICB was reporting a balanced position for both year to date and forecast outturn - Key drivers were the continuation of pressures and challenges within acute contracts around the independent sector, mental health and learning disability, packages of care and continuing care costs and prescribing. These areas were pressure points nationally as well as regionally - Waste reduction programme (WRP) were challenging, being slightly behind year-to-date savings. It was hoped to have achieved around £66m worth of savings at this point in the year, however, the ICB was around £11.5m behind plan. This was contributing to some of the year-to-date pressures - As a result of the challenged WRP, more mitigations had been consumed than expected at this point in the year - Delivery of the plan position requires management of significant risk within the WRP position / operational pressures in the second half of the year - These risks were being considered and discussed regularly at the Incident Management Team and Executive Management Team meetings reporting into this committee - An assessment of risk was undertaken at month 5 and suggested that around £92m of risk would need to be managed. The position had slightly extended to around £105m, as a combination of the WRP movement / operational pressures between months 5 and 6, and some management teams continue to lead actions to reduce this - With regards to the wider system, Lancashire and South Cumbria providers were showing a cumulative year-to-date deficit position of around £27.8m worse than plan, driven by shortfall on the efficiency plan of around £29.8m and other mitigations being driven into that position - Pricewaterhouse Coopers (PwC) colleagues continued to work from a turnaround perspective and Improvement and Assurance Group meetings remained in place. <p>J Birrell raised concern that the reporting was on the optimistic side, particularly given the lack of progress being made month on month, and the ability to move WRP from high risk into delivery.</p> <p>J Birrell also stated he felt that whilst financial reporting was clear on the current and projected position it was unclear whether deficit support funding (DSF) figures were included in the numbers within the report. He suggested that further clarity was needed around the proposed mitigations and the impact of the full year effect and resulting position for next year. He added that there was an overlap between the finance and WRP reports; noting that there did not appear to be much of a pipeline for the rest of this year and the impact on next year was not included within the WRP report and needed to be progressed.</p> <p>Concern was also expressed around the All Age Continuing Care (AACC) overspend and the projected overspend at year end.</p> <p>The committee requested further assurance around mitigations as the traction expected previously had not been achieved, asking what would make the difference that would provide confidence this month compared to month 5.</p> | |

In response, M Bakewell explained that there had been some movement in last few months and mitigations were building on the detailed work that had taken place on month 5. There was an acknowledgment that there was a high degree of risk and the level of required mitigations in the plan but the approach / reporting through the Incident Management Teams (IMT) meeting was providing effective oversight.

M Bakewell explained that deficit support funding (DSF) was a particular feature of the systems financial position and that provider reporting would usually have this excluded, however, agreed that future reporting would be clear whether / where this was included.

With regards to future financial plans, monthly finance returns now include an assessment of the underlying exit run rate and this would be reported to the committee in due course but was still early days in terms of data collection.

M Bakewell continued that the AACC report at this meeting described the various factors behind the overspend (including the impact of prior year costs / WRP delivery) but it was acknowledged that day-to-day expenditure in AACC needs to continue to be reduced as the system remains a national outlier.

A number of non-executive members commented that it was recognised that a lot of good work was being undertaken internally, and that there remained challenging areas in respect of delivery and implementation with external organisations. M Bakewell felt there was a good plan in place with the right components, the requirement now is to deliver the plan.

S Downs added that there were still a number of issues to be resolved but that these had factored into the likely reporting position, as an example prior year charges were still being validated. He acknowledged that delivering the WRP was becoming more difficult and noted that detailed planning for the 2026/27 WRP had not yet commenced but in part this was down to gaps in knowledge on national guidance.

S Downs provided context regarding the historical development of the ICB plan, noting that the allocation of DSF was not determined by the ICB and there was limited flexibility for ICB decisions. He emphasised the need for the ICB to take greater ownership of the 2026/27 plan, rather than being directed externally.

S Downs added that the exit position would continue to be looked at with due consideration that a number of in-year mitigations were non-recurrent. There was a process to work through and take forward the mitigation schedule, including Community Diagnostic Centre (CDC) underspend where the expectation of spend would be managed to prevent claw back. He felt the biggest risk was assuming the delivery of the WRP on prescribing and continuing health care. It was noted that the independent sector had seen improvement between months 4 and 5.

The Chair recognised the degree of complexity in reporting and understood that the best-case forecast was £80.2m, the most likely being £150.4m and worst case £198.4m, with further mitigations to be applied. He asked how the ICB was taking positive steps towards the year end of position, ensuring that mitigations required would be made.

P Tinson joined the meeting.

M Bakewell acknowledged the risk within the position, reiterating that the task for the organisation was to deliver the mitigations and manage the operational pressures and this was being worked on with all budget holders.

S Sadiq and N Park joined the meeting.

M Bakewell added that early mitigation strategies were taking effect in the independent sector contracts and that the ICB were following the national contract rules regarding activity management plans.

Reflecting on the slide presented in relation to mitigations and the net risk position, D Corcoran asked how quickly the independent sector could be brought back to the best-case position and if this could be enacted quicker to ensure more direct control. She recognised there were issues with this but sought more assurance.

M Bakewell responded that there was risk with this with an expectation of challenge back from the independent sector providers in relation to the contract approach the ICB would take. As shown in the reports, the independent sector had overperformed against expected contract levels in the first 3-4 months, and this in part was due to the national contract being delayed and activity management approach / controls being very different to what was first expected. Activity managed processes had been instigated that would bring activity back to a different level than a straight forecast, however, it was noted that this remained high risk as providers were expected to challenge the activity management approach.

S Downs added that there was an additional issue in that a number of independent sector providers were able to currently treat patients referred within a significantly shorter timeframe than NHS providers. The intention behind the original plan was to standardise treatment timelines, particularly for certain specialties, to align with the contracted 18-week pathway. This was similar to ADHD referral pressures, which although there was less pressure in Lancashire and South Cumbria, remained a significant issue in Greater Manchester and Cheshire and Mersey. The ICB executive team were currently looking at a prioritisation framework around curtailing spending in areas where financial commitments had not been made. Difficult discussions were being held in the ICB Commissioning Resource Group regarding the best use of resources.

The Chair summarised that there remained an immense amount of risk and that non-executive members were concerned about suggested levels based on recent experience, and the scale of financial pressures. In terms of the financial outlook, members reflected that the most optimistic scenario appeared unlikely, with the more probable outcome being one with further downside of risk. Non-recurrent measures were being used and reducing flexibility for 2026/27. There was concern around the realism of some financial assumptions and whether they could be achieved. Whilst efforts were ongoing, the committee remained cautious about the likelihood of full delivery. However, the committee acknowledged the diligent work being undertaken in this area and the varying difficulties around it at this time.

C Harris reflected that delivery of some of the mitigations were challenging when some aspects were out of direct control, for example with regards to activity management arrangements this requires a number of nationally dictated steps, which take time and hampers immediate action.

The committee discussed the need to explore all available schemes and suggested that there was scope to enhance current reporting by incorporating other measures, which could be more appropriately cross referenced within the financial report. These metrics would reflect activity growth, such as elective care or A&E, performance and the associated financial implications, including contract arrangements.

It was noted that A Patel would discuss potential adaptations in reporting with M Bakewell.

AP/MB
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| | <p>Members recognised that the independent sector continued to support waiting list management, and patient choice remained a factor in referrals to the independent providers. The committee acknowledged the importance of understanding the impact of decisions on performance metrics.</p> <p>The committee acknowledged the value of constructive challenge from colleagues, and M Bakewell expressed appreciation for the scrutiny and commentary received. The input was welcomed as part of ensuring the organisation remained on track and making the right decisions. It was noted that historical issues within the organisation and the wider system had contributed to the current financial position. M Bakewell highlighted the ongoing journey of improvement, referencing positive developments in areas such as prescribing and continuing healthcare, which were evident in the other reports presented at today's meeting.</p> <p>The Chair recognised the amount of work involved, but emphasised the committee's responsibility to the ICB Board in terms of scrutiny.</p> <p>The Chair supported the ICB executives work throughout the year to manage costs, acknowledging that many of the financial pressures were outside of their control. He expressed gratitude for the comprehensive report and the opportunity for an open discussion, to support planning for 2026//27. Similar challenges being faced across the system were recognised.</p> <p>RESOLVED: That the Finance and Contracting Committee note the content of this report.</p> | |
| <p>119 25/26</p> | <p><u>Integrated Planning Round 2026/27</u></p> <p>S Downs explained that the meeting report set out the planning position in terms of expectations for the ICB. There would effectively be 4 mandated outputs – the 5-year ICB strategic plan, 5-year plans from providers, operational activity and neighborhood health plans. It is the intention to align the ICB and provider plans to ensure that income and expenditure between providers and commissioners are aligned. There would be no system capital, NHS England would be responsible for the operational capital. Whilst the national planning timetable was awaited, teams were working with providers on commissioning intentions and a workshop was planned to be held next week around this. Detail on convergence had been shared with providers to enable their planning to move forward. The main focus for the ICB was expenditure. The report set out governance, however, the role of NHS England was yet to be clarified at this stage.</p> <p>Due to a lack of internal capacity, Public Sector Consulting (PSC Ltd) had been brought in to support the planning process and was being funded via vacant posts.</p> <p>For committee assurance, J Birrell asked whether the ICB was on course for delivering the requirement by the end of December 2025.</p> <p>In response, S Downs reported that work was taking place with providers on the anticipated level of activity demand for 2026/27, and for the next 5 years, using demographics and the current trend to create a baseline on which a model could be built. Plans could then start to be overlaid.</p> <p>The committee requested a regular update at this meeting and were particularly interested in assumptions. M Bakewell confirmed that the committee would be updated in due course.</p> <p>RESOLVED: That the committee note the report.</p> | <p>MB (action)</p> |

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| <p>120 25/26</p> | <p><u>Grip and Control (Acute and Mental Health) Quarterly Update</u></p> <p>S Downs provided an overview of the current position in addressing the recommendations from the Pricewaterhouse Cooper (PwC) Grip and Control (acute and mental health), explaining that a number of recommendations had now been addressed, and a report on acute contracts was now presented to this committee on a regular basis. S Downs was mindful that a clear audit trail and tracking was required on the processes in place.</p> <p>A Patel queried whether the recommendations in the Grip and Control report had been superseded by the Integrated Improvement Plan as part of the exit criteria and Recovery Support Programme. S Downs agreed that there was potential overlap and confirmed that processes were in place to pick up the recommendations; the committee would provide oversight as to the effectiveness of this.</p> <p>The committee supported the approach for oversight, noting that most recommendations were considered closed. For formal closure, it was agreed that the committee receive an update in due course to ensure actions were being implemented.</p> <p>RESOLVED: That the Finance and Contracting Committee note the contents of the report and the progress made.</p> | <p>MB (action)</p> |
| <p>121 25/26</p> | <p><u>All Age Continuing Care (AACC) Update</u></p> <p>M Bakewell introduced the item updating the committee to the month 6 AACC financial position and highlighting ongoing challenges, particularly the current level of risk within the waste reduction programme (WRP). He acknowledged the work undertaken by the AACC team in accelerating savings delivery and framed the paper as part of a broader financial position.</p> <p>The report asked the committee to consider a range of options on how to improve financial performance and mitigate current pressures.</p> <p>N Park highlighted the following key points within the meeting report:</p> <ul style="list-style-type: none"> - Following month 6, there remained a high-risk gap of approximately £14m within the AACC/WRP - Proposals had been invited from 2 main delivery providers to set out how they could support the ROI and potential savings - No new WRP areas had been identified by delivery providers, however, the proposals and the way they could strengthen and accelerate the pace of delivery could help to mitigate the position in year - A hybrid support model combining the two suppliers and off-payroll workers (OPW) was proposed and through this approach expectations were that between £8m-£14m could be mitigated. <p>J Birrell made a number of comments with regards to the report:</p> <ul style="list-style-type: none"> - That the stated month 6 overspend of £24m may increase to £104m, as per the report in today's meeting - Questioned the impact of local authority recharge assumption - Noted ongoing issues with the Adam system - Noted that eligibility rates for packages were reducing - That some of the recommendations in the meeting report fell outside of the committee's remit to approve. <p>N Park acknowledged the points raised and invited S Sadiq to address the comments</p> | |

about the Adam system.

N Park confirmed that discussions were ongoing with local authorities and further savings still need be validated and are not yet reflected in the figures within the report.

S Sadiq reported that work continued on the Adam system, with operational colleagues inputting information into improving the different modules with a recognition that the system had previously not been implemented in a robust way. The work being undertaken would ensure the system was more fit for purpose for the Lancashire and South Cumbria ICB geography.

S Sadiq updated that these improvements were expected to be completed by the end of the financial year and clarified that the issue with prior year invoices was not an issue with Adam, but that the invoices had been sent to the ICB later than scheduled and some costs were retrospective.

The Chair reflected that a lot of work had been undertaken in recent months on the Adam system, which had made the system much cleaner, and should result in year end accrual being more accurate. A large amount of last year's costs were taken into this year, which had caused an impact.

N Park explained that a lot of time had been dedicated to analysing the run rate position and it was noted that the position for the current financial year had been distorted due to prior year pressures. The normalised outturn for 2023/24 was circa £561m, in comparison, the projected outturn for the current year, assuming no further changes, was £541m, indicating that the actual challenge was to reduce in-year expenditure by £60m rather than the previously assumed £20m, resulting in further mitigations being required. It was acknowledged that the key challenge would be the pace at which this reduction could be achieved. The financial trajectory aligned with other performance metrics currently being monitored.

M Bakewell confirmed that conversations continued to be held with local authorities in relation to transactions which were in both directions.

Committee members were assured that external suppliers had not indicated that any areas of further opportunity had been overlooked, however, there was a desire to accelerate.

In terms of the recommendations in the paper presented today, M Bakewell highlighted that each option came with its own set of advantages and disadvantages. A hybrid model was proposed to identify and adopt the most effective model moving forward, being mindful of quality and stakeholder experience issues which would then form the basis of a wider ICB Board decision.

D Corcan expressed her uneasiness around the committee being asked to support that high-cost package reviews remain paused whilst outstanding disputes from suppliers on reviews were resolved. She emphasised that AACC should be a holistic conversation and that the committee should consider this from a financial perspective but reiterated that there was a quality and outcomes issue that should be considered as well, which was being managed through the Quality and Outcomes Committee.

It was confirmed that a report would be presented to the ICB Board at its private meeting on 30 October 2025, which would bring together both aspects.

The committee acknowledged that significant financial pressures remained within AACC and work needed to continue to reduce numbers. It was recognised that a substantial

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| | <p>amount of work had been undertaken to date and further rapid action was required to address the ongoing financial challenges.</p> <p>The Chair reflected that it would be remis of the committee not to support actions that contribute to achieving the necessary savings, recognising that this was a multifaceted issue. It was agreed that the committee could support a hybrid model in terms of its financial benefit, recognising that quality requirements need to be addressed and this would therefore, require ICB Board decision. The importance of monitoring the benefits and risks associated with the proposed hybrid approach, in comparison with the original model, was also highlighted.</p> <p>Members expressed their thanks to the team for the report, which was acknowledged as being of high quality.</p> <p>RESOLVED: That the committee:</p> <ul style="list-style-type: none"> - Endorse the strengthened quality and clinical assurance framework, including the revised governance and validation processes - Mandate the calibration controls (no double-counting, duplication, savings-to-date validation, and enactment tracking) - Note that opportunities within IPA cohorts are to support the in-year delivery plan, not to create additional savings - Agreed that a hybrid delivery model would require ICB Board approval; the committee support the financial element, however, it was recognised that this was multi-faceted with quality to be addressed aswell - Agree that High-Cost Package reviews remain paused while outstanding disputes from previous Supplier 1 reviews are resolved, and until the local authority reset Memorandum of Understanding and joint governance arrangements are confirmed, to ensure any recommissioned activity proceeds on a jointly agreed basis - Support continued work between internal and external teams to ensure quality, consistency, and strengthened governance across all AACC review activity - Reinstate supplier oversight through contract management through the AACC Turnaround Board, with escalation of non-delivery or performance concerns through the Chief Finance Officer/Chief Executive Officer chaired supplier control meeting, to hold external partners and internal teams accountable for outcomes and delivery. <p><i>C Harris, N Park and S Sadiq left the meeting.</i></p> | |
| <p>122 25/26</p> | <p><u>Prescribing Update</u></p> <p>A White presented a report outlining the current pressures affecting the prescribing budget, along with actions completed and plans to mitigate growth and reduce spend through active clinical review, noting the volatility of prescribing data.</p> <p>He emphasised that prescribing was not solely a financial issue but also related to quality, safety and patient outcomes.</p> <p>He encouraged members to consider medicines as an enabler of better care and an investment, advocating for an economic basis as well as financial variance perspective.</p> | |

The report highlighted that much of the work undertaken by the medicines management team contributed to improving population health, with examples provided to illustrate the consequential nature of prescribing. Whilst prescribing aimed to prevent adverse health outcomes, it also carried inherent risks. The report identified areas where medicines were contributing to problems and outlined ongoing work to address these.

It was noted that prescribing activity was extensive, with growth particularly evident in long term conditions, such as diabetes, although prevalence was slightly lower than expected. This linked to work around the long-term conditions Local Enhanced Service (LES); an update would be provided later in this meeting.

Members were reminded that Lancashire and South Cumbria had the lowest cost per head and the lowest number of items per population in the North of England, however, it was acknowledged that prescribing levels may have previously been too low, and whilst increasing them may not be financially advantageous, it could be necessary to ensure patient safety through preventative prescribing.

The importance of clinical engagement within practices was highlighted, alongside the availability of digital support. Planned team efforts were focused on areas of growth and safety concerns, with further detail provided in the Medicines Optimisation LES. A key priority was to ensure that basic systems and processes were functioning effectively, as poor practice systems could lead to waste. Improvement action plans had been developed for practices where such issues had been identified.

A White continued that cost / item growth areas were primarily linked to long-term conditions. A recent change in national asthma guidance had led to a 13% reduction in one type of medication, with a corresponding increase in preventative treatments. This shift had enabled better condition management and reduced reliance on emergency medicines.

It was noted that members of the ICB medicines management team do not have prescribing authority, instead, they work to influence practitioners and support implementation and change.

The impact of the use of weight loss medications was reported as a significant increase in spend, placing considerable pressure on practices and members noted that eligibility criteria for these medications had also led to a substantial number of complaints.

Members discussion included:

- That the report was commended for presenting complexity in clear manner
- The team were thanked for undertaking excellent work
- Health prevention initiatives, particularly around hypertension, were welcomed as positive developments
- The introduction of weight reduction medication was seen as a positive step, with the potential to reduce NHS costs in the future, despite the current high upfront expenditure
- The reduction in opioid prescribing was acknowledged as having a significant and life-saving impact
- From a financial perspective, clarity was requested on the overall mitigation and delivery model, whether by community or group. It was questioned whether there was a view below regional level that could define an ideal prescribing profile for specific communities and whether support was in place to help teams move towards such profiles
- There was triangulation in terms of what was seen in population health and drug cost growth with the 4 long term conditions
- Cost per capita was not necessarily a measure of value outcome; if the right drugs

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| | <p>were not prescribed, this could lead to higher long-term costs</p> <ul style="list-style-type: none"> - There was significant variation in drug costs across different areas and it was suggested that identifying specific areas for targeted intervention could yield the greatest impact. <p>In response, A White noted that prescribing data was one of the most effective indicators of good care and was often reflective of practice quality. He added:</p> <ul style="list-style-type: none"> - That whilst prescribing could be analysed at any level, the challenge lay in the capacity to focus efforts - Priorities should centre on addressing variability, quality and efficiencies particularly in relation to prescribing cascades - A holistic approach, supported by high-quality clinicians was essential and clinicians must be empowered to lead this work - Teams had made 15,000 interventions to date this year, resulting in significant savings - An aim of the LES is for 25% of messages to be actioned, with an estimated £2m in savings, alongside quality improvements. It was emphasised that this was multi-factorial and if the savings required were achieved through the LES, the return on investment would be higher than the ICB's expenditure - Consideration must given on how this work could be sustained in the long term to continue improving care. <p>M Bakewell welcomed the positive developments and acknowledged the ongoing challenges. He noted that discussion had taken place around exploring further opportunities and the team was currently looking at areas where barriers exist. It was hoped that longer term planning would enable the development of a more integrated narrative, connecting primary care, secondary care and practices to better understand and optimise medication use. Over time, this approach was expected to deliver meaningful improvements.</p> <p>The Chair concluded that the report was well received by the committee, prompting valuable discussion and debate. It was acknowledged that the key challenge would be maintaining commitment to long-term strategies that deliver delayed but significant benefits.</p> <p>RESOLVED: That the Finance and Contracting Committee:</p> <ul style="list-style-type: none"> - Note the progress of the prescribing waste reduction programme to deliver £14m year to date with a projected full year effect of £32m on the current trajectory. This is likely an underestimate of year end savings as not all activity is recorded, nor carried out yet. - Note an unexpected patent expiry (Dapagliflozin) has occurred in September 2025, further opportunities may present later in the year depending on where the price settles and any switching which may occur. This will mostly ensure the £32m WRP is achieved and may help towards the £42m stretch. - Note that the medicines optimisation LES has been in place since May 2025 and is still embedding. Practices wish to fulfil the scheme in full and delivery will not be linear throughout the year. | |
| <p>123 25/26</p> | <p><u>Waste Reduction and Financial Mitigations Oversight Update</u></p> <p>Discussion had been held as part of item 118 25/26, month 6 finance report. The Chair highlighted the importance of the scale of the financial challenge, noting that £92m in mitigations were being sought and this remained a key issue for the committee's</p> | |

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| | <p>consideration.</p> <p>RESOLVED: That the ICB Finance and Contracting Committee note the current waste reduction programme position and the ongoing efforts to drive delivery of the £142.66m target and the wider actions to support achievement of the overall financial plan.</p> | |
| <p>124 25/26</p> | <p><u>Digital and Data Strategy Update</u></p> <p>A Patel presented an update on the digital strategy, referencing the presentation to the committee in May 2025 which outlined ongoing reforms and evolving components. Today's presentation proposed a realistic and affordable plan for the remainder of the year. Many areas were already progressing, and the system-wide plan largely reflected contributions from OneLSC colleagues and the ICB's role had been primarily as a convener and facilitator.</p> <p>He continued that the strategy approved 18 months ago was designed to support convergence rather than transformation. It focused on establishing infrastructure, recognising that transformation required a refreshed clinical strategy. It was acknowledged that global digital programmes often fail due to a lack of clear vision, and this report aimed to demonstrate how digital could support strategic goals.</p> <p>To date, minimal internal funding had been allocated to digital initiatives, with most resources secured through external bids, hindering long-term planning. However, significant gains were anticipated, particularly as the organisation undergoes major change, with approximately 1,000 digital staff now within OneLSC, providing a delivery partner for future initiatives. The ICB blueprint clarifies that digital delivery would be overseen regionally and transferred to providers. Data capabilities remained strong, though affected by capacity constraints.</p> <p>He explained that looking ahead to next year, planning would focus on responding to the clinical strategy, supporting neighbourhoods, and from an ICB perspective exploring how AI could enhance productivity and simplify plans. Members were asked to be mindful of limited capacity and consider how partners could support assurance processes.</p> <p>M Bakewell welcomed the paper and had discussed with A Patel how this area of work could be integrated into broader planning, emphasising digital as a key enabler for the system and advocating for financial investment from the ICB.</p> <p>Andy White stressed the importance of integration between digital and data functions to avoid siloed working. He highlighted inefficiencies in digital between primary care and the hospitals, calling for intelligent systems to inform commissioning, which would benefit the population.</p> <p>J Birrell expressed concern that in recent years digital funding had not been spent in this area. He requested visibility of milestones and suggested the committee receive an update in 6 months. He raised issues around cyber security and the need for future coordination.</p> <p>In response, A Patel confirmed coordination remained possible and emphasised the need to distinguish between digital and data. He explained financial flows with capital funding going direct to acute trusts, while revenue was managed by the ICB. Last year, a number of digital and data schemes were deferred to support the underlying position, this year, funding would be released where robust business cases exist. S Downs assured the committee that processes were in place to ensure funding was used</p> | |

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| | <p>appropriately, with checks and balances to release funds only when costs were incurred.</p> <p>The Chair reflected that the paper prompted valuable discussion and acknowledged financial challenges. The committee supported continued engagement in moving forward in this area of work. It was recognised that strategic resource and funding with technologies needs to be built in, with clarity on leadership responsibilities. The committee asked for quarterly or 6 monthly updates on progress against milestones.</p> <p>RESOLVED: That the committee note the content of the digital and data strategy update report.</p> | <p>SL (planner)</p> |
| <p>125 25/26</p> | <p><u>ISFE2 Update</u></p> <p>M Bakewell reminded members that a new national ledger system for ICB's had been launched with implementation having commenced on 1 October 2025. Significant issues had been experienced across the country particularly around user access and process readiness. It was noted that the absence of adequate test environments and on-system training contributed to the challenges experienced, which remained ongoing concerns.</p> <p>Since the launch, some improvements had been seen, largely due to the dedicated efforts of the local team. Shared Business Services had introduced a 'hyper care' support module, enabling users to log issues and receive assistance. Collaboration across regions had also helped users navigate the new system more effectively.</p> <p>The finance team was now entering its first month-end reporting cycle; cut-off work had been completed to provide assurance, and outputs were expected by the end of next week. Payments and invoice processing remained a concern, and work was ongoing to resolve these.</p> <p>From a governance and audit perspective, it was acknowledged that adherence to the Best Payment Practice Code may be impacted and also cash management were highlighted as particular challenges from a system-wide perspective.</p> <p>He continued that NHS England were meeting with ICBs today to work through outstanding issues and preparation for month 7 reporting was underway. Continued support for the team managing both the implementation and their regular duties was emphasised.</p> <p>The Chair reflected concern with the system, expressing his gratitude to the team for their efforts.</p> <p>RESOLVED: That the Finance and Contracting Committee note the verbal update provided on the implementation of the ISFE2 ledger system.</p> | |
| <p>126 25/26</p> | <p><u>2025/26 Contract and Contract Monitoring Update</u></p> <p>The Committee received a report outlining the current position, with a few outstanding issues noted.</p> <p>The report included a summary table of contracting issues / positions and linked to the finance report.</p> <p>M Bakewell reported that the contract issue, as included within the report, with regards</p> | |

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| | <p>to University Hospitals of Morecambe Bay had progressed in recent days.</p> <p>A number of updates were highlighted in relation to the 2025/26 contracting position, including information around the independent sector, which had been discussed earlier at this meeting. NHS provider positions included within the report were being explored through contracting conversations and informal discussions with Directors of Finance to ensure appropriate information flow.</p> <p>As per earlier discussion, the need for volumetric data to be linked into the planning process was raised.</p> <p>In relation to mental health and wider cost pressures, M Bakewell reported that efforts were underway to reduce out of area placements and also that ADHD would be monitored. Future planning was required to align with modelling projections.</p> <p>Information was shared regarding the deconstruction of block contracts national programme of work.</p> <p><i>J Scattergood and N Greaves left the meeting.</i></p> <p>The committee thanked the team for the information within the report and the ongoing work.</p> <p>The committee asked that the contract report continues to be developed and focused on areas that can provide committee assurance. M Bakewell would work with the team on continuing to develop the report in order to provide greater assurance to the committee.</p> <p>RESOLVED: That the Finance and Contracting Committee is asked to note the content of the 2025/26 Contract and Contract Monitoring update report and agree next steps.</p> | <p>MB (Action)</p> |
| <p>127 25/26</p> | <p><u>Local Enhanced Service 2025/26 Update</u></p> <p>P Tinson updated the committee on the commissioning and delivery of Local Enhanced Services (LES) for the current year, which was introduced in two phases, and highlighted the following:</p> <ul style="list-style-type: none"> - The commencement of the routine LES from 1 May, and the Long-Term Conditions LES from 1 April 2025 - 95.5% of practices had signed up to the Long-Term Conditions LES, with only one practice yet to engage - There had been significant uptake of the routine LES, and the paper outlined alternative arrangements where practices had not signed up - Delivery modelling had been reviewed from multiple perspectives, comparing traditional activity terms against planned expectations. While early, there was an evolving assessment of the impact on health inclusion. Routine monitoring data was expected by the end of the month, with current delivery ranging between 60–80% of planned levels. No consistent theme had emerged, with variation across Places and enhanced services. Some differences were attributed to the ramping up of delivery and the introduction of new enhanced services to practices - A steady increase in delivery had been seen over the first 3 months of the year, with expectations that this trend would continue - For the Long-Term Conditions LES, the key focus was on holistic health | |

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| | <p>assessments</p> <ul style="list-style-type: none"> - A session had been planned to conduct a deeper dive into LES delivery held with Local Medical Committee colleagues. This would include identifying practices with below-plan delivery and implementing further support measures for the remainder of the year - Several services within the LES were linked to the “left shift” agenda. These were detailed in commissioning intention letters sent to providers last week, following initial correspondence in March 2025 - Initial assessments indicated a 3% reduction in non-elective admissions - There was positive impact on social inclusion and health needs, with nearly 30,000 holistic health assessments completed to date. Without LES commissioning, these assessments would not have occurred - Approximately 3.4% of patients assessed had been referred to social prescribing and voluntary support services, a rate that exceeded national benchmarking. <p>Members welcomed the report. D Corcoran emphasised the importance of the emerging metrics that demonstrate how LES underpins the “left shift” agenda. She encouraged continued development of a clear framework by year-end to evidence investment impact and support future planning. J Birrell expressed support for the programme’s success and congratulated P Tinson and the team for the work undertaken. He noted that this represents the first phase of a longer-term rollout and queried the next steps.</p> <p>In response, P Tinson reported that in terms of a 3-year initial plan, planning was underway to refine the approach for next year, moving beyond LES-specific delivery towards a broader framework that strengthens integration between primary and community services. The ambition was to incentivise a more integrated working framework between common outputs.</p> <p>A White shared that there was a separate LES for medicines, highlighting the importance to work together to ensure plans were complimentary. He stressed the need to build capacity and capability in primary care, particularly as workforce development responsibilities were expected to transfer to regional level. Workforce development was fundamental to LES success.</p> <p>S Downs raised concern around Community Diagnostic Centres (CDCs) across the system as some providers planned to expand some diagnostics within CDCs. Although this was not directly linked to the LES, he highlighted that this may reduce activity routed through CDCs. He emphasised the need to align capacity and these need to be brought together.</p> <p>P Tinson acknowledged this issue and referred to the principle in the 10-year plan of delivering care closer to home. He shared that next year, it was planned to go further around elective transfer. There was a shift in attitude among some secondary care partners who were now more supportive of enabling referral-to-treatment delivery through community-based models.</p> <p>The committee thanked the team for the well-prepared and insightful report.</p> <p>RESOLVED: That the committee note the Local Enhanced Service 2025/26 update report and provide feedback to shape future reports.</p> | |
| <p>128 25/26</p> | <p><u>System Finance Group</u></p> <p>The approved minutes of the System Finance Group had been circulated to members</p> | |

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| | <p>in advance of the meeting, for information.</p> <p>J Birrell raised the need for a deeper dive into sickness absence levels and their impact on productivity and financial performance across the ICB and wider system. It was noted that the acute providers had been addressing this issue for several years, with significant investment in workforce mechanisms. Long-term sickness in acute settings was a persistent challenge and the scale of the issue was not insignificant given the size of the workforce. A Patel confirmed that the topic was being aired at the ICB People and Culture Committee.</p> <p>RESOLVED: That the Finance and Contracting Committee note the System Finance Group minutes of the meeting held on 27 June 2025.</p> | |
| 129 25/26 | <p><u>Committee Escalation and Assurance Report to the Board</u></p> <p>Members noted the items which would be included in the committee escalation and assurance report to the ICB Board.</p> <p>RESOLVED: That the Finance and Contracting Committee note that a report will be taken to ICB Board.</p> | |
| 130 25/26 | <p><u>Items Referred to Other Committees</u></p> <p>RESOLVED: Finance and Contracting Committee to refer the request for a deeper dive into staff sickness absence levels and its impact on productivity and financial performance across the ICB and wider system, to the People and Culture Committee.</p> | SL (action) |
| 131 25/26 | <p><u>Any Other Business</u></p> <p>No other business was raised.</p> | |
| 132 25/26 | <p><u>Items for the Risk Register</u></p> <p>There were no new items.</p> | |
| 133 25/26 | <p><u>Reflections from the meeting</u></p> <p>Good discussion had been held at this meeting and the Chair thanked members for their contributions and time. He shared that this was S Down's final meeting and on behalf of the committee, appreciation was expressed for his support to the committee. Thanks was also shared to M Bakewell for his input at this meeting.</p> | |
| 134 25/26 | <p><u>Date, time and venue of next meeting</u></p> <p>21 November 2025, 2 pm – 4 pm, by MS Teams.</p> | |