

Approved 20 April 2026

Minutes of the ICB Finance and Contracting Committee Held on Thursday 26 March 2026 at 10 am by MS Teams

Members		
Steve Igoe	Chair/Non-Executive Member	L&SC ICB
Debbie Corcoran (up to item 215)	Non-Executive Member	L&SC ICB
Mark Bakewell	Chief Finance Officer	L&SC ICB
Asim Patel	Chief Digital Officer	L&SC ICB
Craig Harris	Chief Commissioning Officer	L&SC ICB
Andy Knox (from item 212)	Acting Medical Director	L&SC ICB
Regular Participants		
Alistair Rose	Director of Strategic Estates, Infrastructure and Sustainability	L&SC ICB
Sarah Mattocks (attending for Debra Atkinson)	Head of Governance	L&SC ICB
Attendees		
Rakhee Jethwa (up to item 212)	Associate Director AACC and IPA	L&SC ICB
Nancy Park (from item 210 to item 212)	AACC Turnaround Director	PwC
Calum Pallister (from item 212 to 214)	Director of Workforce and Transformation	L&SC ICB
Sandra Lishman (minutes)	Committee and Governance Officer	L&SC ICB

No	Item	Action
205 25/26	<p><u>Welcome, Introductions and Chair's Remarks</u></p> <p>The Chair welcomed everyone to the meeting. Members noted that:</p> <ul style="list-style-type: none"> - S Mattocks, Head of Governance, had joined in place of Debra Atkinson, and would present the quarterly risk management report and support the committee effectiveness discussion - R Jethwa, Associate Director AACC and Individual Patient Activity, had joined the meeting and would present item 7, AACC month 11 financial and operational performance - C Pallister, Director of Workforce and Transformation, would join for item 9a, system capital planning update. <p>Members were made aware that Copilot transcription would be used throughout the meeting to aid in the production of the meeting minutes.</p>	
206 25/26	<p><u>Apologies for Absence/Quoracy of Meeting</u></p> <p>Apologies had been received from Steve Spill, Jane Scattergood, Peter Tinson, Debra Atkinson, Neil Greaves and Elaine Collier.</p> <p>A Knox was expected to join the meeting from 11 am.</p> <p>The meeting was quorate up to item 215 25/26. No decisions were required after item 215 25/26.</p>	

<p>207 25/26</p>	<p><u>Declarations of Interest</u></p> <p>(a) Finance and Performance Committee Register of Interests – Noted.</p> <p>RESOLVED: That there were no further declarations of interest raised. Should any other conflicts arise during the meeting, the Chair should be advised accordingly.</p>	
<p>208 25/26</p>	<p>(a) <u>Minutes of the Meeting held on 20 February 2026 and Matters Arising</u></p> <p>Members confirmed their agreement that the minutes of the 20 February 2026 meeting was a true and accurate record.</p> <p>RESOLVED: That the committee approve the minutes of the meeting held on 20 February 2026 as a true and accurate record.</p> <p>(b) <u>Action Log</u></p> <p>Ref 36 – Profiling and mitigations for 2026/27 - Profiling would be reported within a finance report at a future meeting. Not yet due.</p>	
<p>209 25/26</p>	<p><u>Month 11 System Financial Position</u></p> <p>Mark Bakewell presented the month 11 system financial update, highlighting that the ICB continued to forecast a breakeven position year-to-date and a revised forecast outturn of £10.1m surplus at year end, which would offset the provider sector deficit and enable the system to achieve the agreed combined control total.</p> <p>He outlined that the month 11 position reflected a continuation of trends discussed in previous months, with pressures remaining concentrated to four main areas: acute contracts, mental health and learning disability services, continuing healthcare, and prescribing. Acute independent sector spend was reported as reducing in line with expectations, reflecting improved activity management and constructive engagement with providers, including the independent sector. Mental health and learning disability pressures had increased since month 10, largely due to the resolution of long-standing issues, including historic contributions to pooled arrangements, which had been anticipated within the likely case. Further progress was expected within the next few months.</p> <p>M Bakewell highlighted continuing operational pressures in ADHD and other areas, which had been discussed by the ICB Board. In relation to continuing healthcare (CHC), he noted that the underlying drivers remained consistent with previous reports, with mitigating actions ongoing and a separate substantive agenda item scheduled later in the meeting. Prescribing performance had deteriorated between months 10 and month 11.</p> <p>He reported that waste reduction programme (WRP) delivery remained behind the original plan, with a significant element of stretch built into the initial target and reflected that lessons learned had been addressed within the 2026/27 budget setting process.</p> <p>In relation to forecast outturn, M Bakewell explained that the £10m surplus position was underpinned by a number of assumptions, including the receipt of additional system funding at month 10, which had been used in part to mitigate system risks and in part to support the funding of voluntary redundancy costs. He acknowledged that several adjustments remained to be finalised at month 12, confirming that the organisation remained on track to deliver the required financial position.</p>	

	<p>From a system perspective, M Bakewell reported that the month 11 system deficit stood at circa £71m compared to a planned deficit of just over £8m. He explained that this position largely reflected the earlier withholding of deficit support funding, which had since been released. He advised that, notwithstanding changes to planned mitigations in recent weeks, alternative mitigations had been identified and the system continued to forecast delivery of the combined £164m control total.</p> <p>D Corcoran welcomed the clarity of the report and acknowledged the significant work undertaken to date. She asked for assurance that the conditions attached to the additional NHS funding were being met and sought confidence regarding the delivery of the £16m WRP requirement in month 12. M Bakewell confirmed that based on current information, the organisation remained confident that all conditions would be met and that the funding would not be repayable, subject to audit. He acknowledged the sharp increase in WRP delivery required in month 12, explaining that many of the required transactions related to timing rather than fundamental delivery failure. He provided assurance regarding prescribing and CHC delivery, noting ongoing monitoring and engagement with responsible leads.</p> <p>The Chair commended the achievement of reaching the £164m position, highlighting the scale of late financial support received, including the release of deficit support funding and additional NHS England allocations. He questioned the sustainability of WRP delivery into 2026/27. M Bakewell responded by outlining the significant improvements in planning maturity, early scheme identification, strengthened governance arrangements, enhanced reporting and triangulation, and the introduction of improved profiling and run-rate analysis. He acknowledged the organisational change and voluntary redundancy impacts and expressed confidence that the organisation was better placed than in previous years. He highlighted that not all WRP schemes would be enacted on 1 April 2026.</p> <p>M Bakewell continued that a new group (Transformation and Financial Improvement Group) had been established to focus on 3 key savings areas, including delivery of the WRP, and reductions in the cost of commissioning and any other required mitigations. This would replace the existing Incident Management Teams (IMT) meeting which had previously focused on predominantly the WRP component and highlighted that the run rate analysis would continue and be further strengthened. More detailed profiling was being developed, including clear expectations on a weekly basis, to provide improved oversight and assurance over delivery.</p> <p>The Chair highlighted the relative size and scale of challenge for 2026/27.</p> <p>RESOLVED: That the ICB Finance and Contracting Committee note the content of the report.</p> <p><i>N Park joined the meeting.</i></p>	
<p>210 25/26</p>	<p><u>Quarterly Risk Management Report</u></p> <p>S Mattocks presented the quarterly risk update, reporting that 2 risks remained on the Board Assurance Framework (BAF) within the committee's remit: BAF4 relating to the delivery of the financial plan and BAF7 relating to all-age continuing care. BAF4 remained scored at 20 pending confirmation of year end delivery. BAF7 scored at 16 and would be discussed as a separate agenda item at this meeting. She also highlighted one operational risk around the implementation of the finance system ISFE2, which was scored at 16. A full summary of activity and actions taken against risks were set out at appendix 2 of the meeting report.</p>	

	<p>D Corcoran commented that it would be positive to see the financial risk reduce following year-end and emphasised the importance of ensuring that mitigating actions translated into sustained grip and control going forward. The Chair reflected on the subjective nature of risk scoring and stressed the importance of demonstrating delivery before reducing scores. M Bakewell agreed, noting that while the recent internal audit report had provided limited assurance overall due to one 'high' risk and resulting recommendation, it had also recognised a number of areas of improvement in financial governance and control.</p> <p>The committee agreed that risk scores should only reduce once sustained delivery and assurance were evidenced.</p> <p>RESOLVED: That the Finance and Contracting Committee:</p> <ul style="list-style-type: none"> - Note the contents of the report. - Note the risk management activity undertaken during the reporting period for those risks held on the BAF and ORR which relate to the business of the committee (as summarised in sections 2.2 and 3.2 and attached in full at Appendices 1 and 2. - Note the high-level summary dashboard of all risks currently held on the BAF and ORR, which is attached at Appendix 3 for information - Agreed that risk scores should only reduce once sustained delivery and assurance were evidenced. 	
<p>211 25/26</p>	<p><u>All Age Continuing Care: Month 11 Financial and Operational Performance</u></p> <p>R Jethwa presented the all age continuing care update, noting that 2025/26 had been a particularly challenging year for All Age Continuing Care (AACC), with sickness absence levels of between 25% and 28% across the service. Despite this, teams had performed strongly against a backdrop of a challenging budget-setting process and the most significant waste reduction programme (WRP) requirement across the ICB and the North West. She highlighted positive headlines for the service, including strong focus on run-rate and a reduction in packages of care volumes over the year. Month 11 reporting position was a year-to-date overspend of £54.4m, of which £16.3m related to prior-year costs where packages of care had exceeded accruals. Additional cost pressures were attributed to increased complexity, higher acuity, longer package durations and prevailing market conditions, with material overspends identified within learning disability services and some within continuing healthcare (CHC).</p> <p>The remaining variance was attributed to underachievement against the WRP, with a shortfall of £19.3m against the year-to-date plan. By month 11, £34.9m of WRP had been delivered against a plan of £54.2m, with £2.8m achieved in month 11. Compared to month 10, adverse movement had been largely due to learning disability invoices that were part of likely forecast outturn case with continued progress on resolving a number of historic local authority matters.</p> <p>R Jethwa continued that the year-end forecast for AACC was around £552m against a budget of £510m, indicating an overspend of approximately £40 - 42m. She confirmed that teams would continue to focus on mitigations in month 12, including delivery across four priority workstreams - joint funding agreements, local authority reset, provider pricing, market engagement and brokerage, alongside continued high-cost package reviews, agency controls, commissioning activity to manage demand, addressing gaps in core services and undertaking contract reviews where appropriate.</p>	

These priorities would continue into 2026/27.

Looking ahead to 2026/27, R Jethwa reported a WRP target of £29.6m, of which £22m had been identified through fully developed schemes with completed PIDs, alongside a number of pipeline opportunities under development. In relation to operational performance, she highlighted a slight increase in CHC overdue and fast-track reviews, largely attributable to sickness absence, and confirmed that eligibility remained above the national average, albeit lower than the previous financial year. Performance against the quality premium remained strong, with 89% of assessments completed within 28 days, exceeding the benchmark, and reflecting strong performance by in-house teams. Overall packages of care had reduced by 1.4%, with CHC eligibility per 50,000 population at 56 compared to a national average of 33, and a reduction from 63.7 earlier in the year. She explained that this reflected proactive caseload management by in-house teams, supported by external providers, and a reduction of 235 packages of care in under a year.

D Corcoran acknowledged the significant improvement in timeliness performance and sought assurance on the sustainability of this position given the recent increase in overdue reviews, as well as clarity on why overall spend continued to rise despite reductions in package volumes. R Jethwa explained that the increase in overdue reviews was predominantly driven by sickness absence, which remained at around 28%, limiting capacity to complete reviews. She outlined mitigating actions planned for 2026/27, including the use of external provider support through WRP schemes, a focus by internal teams on assessments and fast tracks, and the use of NHS Professionals agency to support delivery of statutory duties. It was hoped that sickness absence would reduce following organisational development support and stability of the organisational restructure. N Park added that an improvement plan had been developed for AACC as part of the ICB's strategic priorities, including a pilot focused on understanding activity and time spent on reviews to improve productivity, share best practice, and explore opportunities for digital and technological support, including AI, drawing on learning across the North West and nationally.

Addressing the issue of rising costs despite reduced volumes, R Jethwa advised that an ICB framework had been developed in 2025/26, however, this had been paused due to local authority reset discussions and ambitions for joint frameworks with local authority partners. She confirmed that local authorities were at varying stages of developing their own frameworks and that the ICB had expressed interest in joining these over the past three years, already being associates to two frameworks. A paper had been prepared to agree a way forward and reintroduce the ICB framework in the new financial year. She confirmed that current cost pressures were largely driven by spot purchasing and prevailing market conditions. In response to further questions from the Chair regarding budget history and outlook, it was noted that the £510m budget was understood to be after the application of stretch, with the original budget being approximately £570m.

R Jethwa advised that the indicative 2026/27 CHC budget was circa £370m, noting that non-CHC individual patient activity would shortly transfer into the commissioning portfolio. She acknowledged concerns regarding confidence in delivering a significantly lower outturn in 2026/27 and explained that the introduction of fixed-rate ICB frameworks, alongside continued reductions in package volumes, tightened front-door controls including dual ratification, and strengthened governance arrangements, were expected to reduce variability and overall expenditure.

The Chair highlighted the importance of collaboration with other North West ICBs to improve efficiency and effectiveness at scale. R Jethwa and N Park confirmed this was already underway, with CHC identified as a priority area for regional "do once"

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	<p>approaches, including digital solutions, led at executive level; feedback would be provided within future committee reports.</p> <p><i>C Pallister joined the meeting.</i></p> <p>In closing, the Chair thanked N Park on behalf of the committee and the ICB for her leadership and the significant improvement in reporting and performance over the past 12 months, and extended best wishes for her future endeavours.</p> <p>RESOLVED: That the Finance and Contracting Committee:</p> <ul style="list-style-type: none"> - Note the AACC M11 financial and operational position, including the £54.4m YTD overspend - Note the WRP delivery position and £19.3m YTD shortfall - Note the most likely forecast outturn risk of £42.8m overspend - Support continued focus on recovery actions across the four AACC priority workstreams - Support strengthened financial validation, operational grip and WRP recovery oversight - Endorse continued development of the 26/27 WRP programme <p><i>N Park and R Jethwa left the meeting.</i></p>	
<p>212 25/26</p>	<p><u>ICB Operational Plan Update</u></p> <p>M Bakewell presented an update on the ICB's operational and financial plan, highlighting that the ICB remained compliant from a finance perspective against the submitted plan, notwithstanding the significant level of risk within the system. He reported that the assessed financial risk totalled £214m, comprising risks associated with delivery of the waste reduction programme (WRP), cost of commissioning adjustments, and other mitigations required to close the remaining gap. He advised that if these were successfully mitigated and other risks appropriately managed, this would result in the ICB meeting its control total deficit of £34.9m for 2026/27, contributing to the overall system deficit. He confirmed that the plan had been resubmitted on 18 March with no fundamental changes, other than updated WRP plans and profiles and minor technical corrections, and that no further feedback had yet been received from NHS England on the finance submission.</p> <p>M Bakewell emphasised that the operational plan extended beyond finance to include activity, performance and workforce, noting that most ICB-level metrics were compliant. He highlighted a small number of outstanding issues within the plan, and these had been set out within the report. In relation to referral to treatment (RTT), the ICB had submitted a compliant plan across the 3-year period, although NHS England was currently addressing a trust-level phasing issue at University Hospitals Morecambe Bay NHS Foundation Trust (UHMB). The ICB plan was non-compliant for diagnostics due to a challenging starting position, despite a significantly improved trajectory over the planning period. As providers were assessed individually, there was no overall ICB-level performance measure for urgent and emergency care, however, a non-compliance issue remained at UHMB, again linked to starting position, with improvement trajectories in place. He noted that other areas, including community waiting lists and mental health reliable recovery, were not flagged as compliant but related primarily to year 1 of the plan rather than later years.</p> <p>M Bakewell reported that on a 'do nothing' basis, the ICB was forecasting expenditure of approximately £214m above allocation. He outlined the 3 key workstreams and mitigations that would be overseen through the newly established Transformation and Financial Improvement Group, with updates to be reported back to the Finance and</p>	

Contracting Committee once the group's terms of reference had been agreed. He advised that strong progress had been made on the WRP, with further gains achieved since the report had been written, and confirmed that all schemes were expected to be identified by the end of March. He highlighted that schemes were not only being identified but increasingly being categorised as fully developed, enabling the organisation to commence the financial year with a significant proportion of plans ready for implementation, whilst acknowledging that not all schemes would necessarily be implemented from 1 April 2026. He explained that the cost of commissioning element included savings from the voluntary redundancy scheme, which accounted for around one third of the required savings and was nearing completion. He further advised that transition to the new operating model was expected to deliver a further significant proportion of savings, subject to NHS England approval and consultation in early quarter 1 with implementation from quarter 2. Additional changes, including commissioning support unit contracts, OPIC and 'do once' arrangements, were expected to contribute further savings, leaving a residual gap to be managed.

He outlined other mitigation actions, including demand management, decommissioning, and review of acute contract assumptions, noting concerns about provider capacity to deliver increased activity alongside workforce reductions. A zero-based/deep dive budgeting exercise was due to commence shortly, with each line of expenditure reviewed for alignment with objectives, alongside controls on new and existing expenditure in quarter 1. Benchmarking work continued, including in areas such as continuing healthcare (CHC) and learning disabilities. Non-recurrent savings would form part of the overall approach, with an emphasis on ensuring the majority of savings were recurrent.

He briefly recapped the performance RAG ratings previously discussed at Board and noted that capital would be discussed later in this meeting. He highlighted risks associated with acute contracts, prescribing pressures, CHC, transforming care and learning disability pooled budgets, stressing the importance of stabilising the current year to enable future investment in prevention and 'shift left' approaches.

M Bakewell provided an update on contract resolution, confirming all contracts must be agreed by the end of March. He advised that negotiations with Lancashire and South Cumbria NHS Foundation Trust had been resolved, and discussions continued with UHMB regarding the related issues of local price modification, segment zero funding and sparsity funding. He noted ongoing issues with some inter-ICB contracts, particularly Mersey West Lancashire, which were expected to be resolved, albeit with some residual risk. He explained that unresolved contracts would enter arbitration via NHS England if necessary. The importance of moving into a new contract management model was emphasised, with greater clarity on activity plans for the new financial year allowing greater management of contracts but requiring appropriate resourcing across finance, contracting and business intelligence. He concluded by stressing that demand management and deconstruction of block contracts, including mental health and community contracts, were critical to ensuring transparency, value for money and clarity on what the ICB was purchasing, acknowledging that this work could generate short-term challenge but was necessary for longer-term stability.

In discussion, D Corcoran thanked M Bakewell for the comprehensive update. She welcomed the progress on the WRP, noting that over £73m of the £127m target was fully developed, and requested future reporting on the profiling and timing of delivery to provide assurance on risk and phasing. She also asked for clarity on the risks associated with the UHMB contract, given non-compliance issues in the plan and the absence of a signed contract, and sought assurance on mitigations. In response, M Bakewell explained the historic context of local price modifications, segment zero

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	<p>funding, sparsity payments, and current negotiations, including potential arbitration if agreement could not be reached.</p> <p><i>A Knox joined the meeting.</i></p> <p>The Chair reflected on the significant level of risk entering 2026/27 and noted that change was also a risk as all the work currently being undertaking around the plan was from everything changing – model, blueprint, demand management, commissioning, etc. All current risks would have to be addressed during a period of considerable change within the ICB.</p> <p>RESOLVED: That the Finance and Contracting Committee is asked to:</p> <ul style="list-style-type: none"> - Note the updated plan submission made on 18 March 2026 - Note the risk/issues as described within the meeting report. 	
<p>213 25/26</p>	<p><u>Estates and Capital Update</u></p> <p>a) <u>System Capital Planning Update 2026-2030</u></p> <p>C Pallister presented the system capital planning update, highlighting that the meeting report covered four key areas - changes in roles and responsibilities for capital across the system and NHS England, the complexity of the various capital funding pots and associated arrangements, an update on the current financial year position, and progress against the system capital strategy including work on optimising estate, space utilisation and net zero.</p> <p>He explained that the capital funding arrangements were complex, comprising multiple funding streams, and noted positively that the system now had a four-year capital settlement to work to. He advised that aligning plans against this settlement remained work in progress, largely due to very constrained timelines and the late release of detailed funding information. As a result, the ICB had been working with system partners and NHS England to allocate plans against available funding; this process was ongoing. In relation to the current year, he highlighted the principal risk as underspend against NHS England Public Dividend Capital (PDC) schemes, which had been released very late in the year. He also confirmed that the paper set out progress against the wider system capital strategy, including work on optimising space, supporting net zero ambitions and related priorities.</p> <p>C Pallister emphasised the importance of ensuring that capital plans and proposed investments were fully aligned with system strategy, including commissioning intentions, the 3 shifts within the 10-year plan, workforce plans and the affordability of revenue consequences arising from capital investment. He stressed the need for agreement on revenue impacts prior to schemes proceeding and highlighted the importance of alignment with major schemes. He highlighted the need for robust management arrangements and oversight, noting significant change both within the ICB and the regional capital function in NHS England. Capital oversight now involved multiple bodies, including provider collaboratives, NHS Property Services and other independent organisations, and it was critical to ensure these arrangements aligned and provided sufficient assurance, particularly given the scale of change underway.</p> <p>C Pallister outlined the key management priorities for the next 6 months, advising that further work was required to firm up the detail of capital plans. He reported that there had been recent feedback indicating that the proposed front-loading of capital funding was being reviewed, which was welcomed given the risks associated with placing significant funding into the first year of a programme</p>	

where capital schemes, particularly large schemes, had long lead times. He also highlighted the need to strengthen demonstration of return on investment, noting that the total value of schemes submitted by the three North West ICBs exceeded the current indicative allocation by over £50m. Regional teams would prioritise schemes based on return on investment, making it essential that the ICB's schemes were well described and supported by robust evidence. The system was moving from an initial long list of schemes to a more robust prioritised list capable of supporting full business case development. He stressed the need for the system to remain responsive to change, including potential future capital funding releases, such as neighbourhood investment, and confirmed that an active reserve list was being developed to support this.

D Corcoran welcomed the paper and update and reflected on the significant risk of fragmentation arising from the new capital arrangements. She highlighted concerns about how oversight and governance would operate in practice, given the multiple funding routes and organisations involved, and questioned how the system would ensure best use of public funding, both for capital directly controlled by the ICB and for provider-led investment, in a way that aligned with commissioning priorities. She acknowledged that the complexity and lack of clarity reflected that arrangements were still evolving.

In response, C Pallister agreed that governance and oversight arrangements were still in progress. There was recognition of the need to improve alignment and there was momentum to put appropriate arrangements in place. He confirmed that the ICB retained responsibility for oversight, noting in particular that any capital scheme over £1m required ICB sign-off, and stressed the importance of collaborative working across the system to discharge this responsibility effectively.

The Chair welcomed the move to 4-year capital allocations, and queried how longer-term capital planning could be aligned with 3-year financial planning horizons. He also raised questions around benefit realisation, observing that historically some major capital schemes had been approved on the basis of promised revenue savings that had not subsequently materialised. C Pallister agreed that a more robust programme management and assurance function was required, including the ability to track delivery and benefits across multiple funding streams and schemes, acknowledging that the necessary infrastructure was not yet fully in place.

The Chair further reflected on the opportunity to use capital investment to reduce revenue costs, citing backlog maintenance as an example where demolition and rebuild could offer better long-term value than ongoing maintenance. In response, A Rose advised that NHS England was increasingly requiring large business cases to demonstrate reductions in backlog and revenue costs. He acknowledged the risk of inadvertently rewarding historic under-investment or poor estate management and emphasised the need for stronger collaborative oversight and longer-term planning across the system, particularly in the context of shifting activity out of hospital settings and reducing estate footprint where appropriate.

The committee noted the complexity and long-term nature of capital decision-making within the context of wider service transformation and thanked C Pallister for a comprehensive update.

RESOLVED: That the Finance and Contracting Committee note the meeting report.

b) ICB Infrastructure Strategy

A Rose presented an update on the infrastructure strategy explaining that the refresh was being driven by significant changes in national policy and priorities, particularly the NHS 10-Year Plan, the neighbourhood health agenda, and the deferment of the two new hospitals programme. Consideration also needed to be taken of forthcoming changes to local government arrangements and the potential implications for local authority estate decisions and joint approaches to usership across the system. A Rose reported that an announcement on neighbourhood health investment was due to be released that day, with Lancashire and South Cumbria cited as a case study, including exemplar sites, representing a positive development for the system.

It was confirmed that the ICB Board would be required to endorse the refreshed infrastructure strategy once finalised, following several cycles of engagement with system partners. A Rose advised that early discussions had taken place with NHS England, who were considering the development of a regional infrastructure strategy, of which the Lancashire and South Cumbria strategy would form part. He explained that infrastructure strategies were increasingly being used to support the strategic case for major business cases, as alignment at system level strengthened the justification for investment, making it easier to demonstrate strategic support. He advised that the meeting report also set out the proposed next steps.

The Chair sought clarification on the ICB's role in local authority planning processes and confirmed that the ICB was a statutory consultee on local plans. A Rose confirmed this position and advised that engagement with local planning processes supported the ICB's ability to secure Section 106 contributions, although success varied between local authorities and remained an ongoing area of focus. The Chair also asked whether the infrastructure strategy would address divestment of estate surplus to requirements, as well as investment. A Rose explained that disposals were managed by the asset owner in line with the Estate Code, with proposals being discussed with partners prior to marketing. He outlined that disposals were considered through 4 Strategic Infrastructure Groups (SIGs) covering the main conurbations, ensuring that partner organisations, including local authorities, had the opportunity to comment prior to assets being placed on the market. He noted that there was a national push for disposals and that the SIG arrangements provided a mechanism for coordinated discussion across the system.

The Chair further explored how emerging Integrated Health Organisations (IHOs) would engage with system-level capital planning, given the wider policy direction towards devolving activity to local systems. A Rose advised that, at this stage, engagement would continue to be routed through the SIGs, which considered infrastructure investment across whole places using a usership approach rather than focusing solely on NHS assets. He acknowledged that IHOs continued to emerge, however, highlighted that the SIGs already brought together the organisations most likely to form part of those arrangements, providing a practical mechanism for local-level planning within the wider ICB framework. The Chair reflected that this reinforced the complexity highlighted earlier in the meeting and the challenges this created for delivery.

A Rose acknowledged the complexity arising from multiple funding streams and governance routes.

RESOLVED: The committee noted the Infrastructure Strategy update and

report.

c) ICB Green Plan; month 6 update

A Rose presented an update on the net zero and green agenda, noting the continued national focus on sustainability and the NHS commitment to achieving net zero by 2040, with a later deadline of 2045 applying to contractors. He clarified that primary care was included within the 2040 target, notwithstanding its status as a contracted service.

A Rose advised that governance and reporting arrangements for net zero activity had been periodically overseen through an ICB group, now transitioning into a senior leaders forum, with draft terms of reference currently in development. He confirmed that this group would remain the primary recipient of updates and oversight on net zero delivery. A Rose highlighted that a number of non-delivery issues had been escalated nationally, particularly in light of the deferral of the two new hospital programmes. This meant sites such as Preston and Lancaster would remain operational beyond the 2040 deadline, raising questions around the value of investing significant capital to bring estates up to net zero standards where demolition was anticipated in future years. He confirmed that these implications had been formally escalated to national level, recognising that the deferral of new hospital funding had directly influenced the system's ability to meet net zero targets.

It was noted that responsibility for achieving net zero across estates remained with individual providers, while the ICB's role was to support, influence, identify opportunities and provide appropriate challenge. A Rose confirmed that there was no specific national funding stream dedicated to net zero upgrades, although there was a clear expectation that all capital upgrades and new builds would meet net zero standards. He also reiterated that any capital business case over £1m required ICB approval and that one of the formal checks within that process was explicit consideration of how proposals contributed to net zero objectives. The net zero Board Assurance Framework (BAF) risk was currently incorporated within the wider infrastructure strategy delivery risk. A Rose invited reflection on whether the Board would wish to see a discrete net zero BAF risk, noting that delivery of net zero extended beyond estates alone and included commissioning impacts such as prescribing, pharmacy and other system-wide factors. He confirmed that the meeting report also set out the planned programme of work for the next 6 months.

The Chair welcomed the update and reflected on the importance of addressing both large-scale capital schemes and smaller, lower-cost opportunities. He queried how lower-cost initiatives were being identified and progressed at scale across the system. A Rose advised that this was an ongoing focus through regular engagement with Trust estates directors. He acknowledged that higher-risk backlog maintenance issues often took priority but confirmed that trusts continued to progress energy efficiency schemes where feasible due to their clear financial and environmental benefits.

A Patel reflected on the implications of the emerging ICB blueprint and organisational change, noting that the Green Plan was clearly defined as an ICB responsibility, to be discharged through partnership working. He highlighted the importance of ensuring that future organisational structures retained sufficient capability and leadership to deliver this responsibility effectively, particularly during reorganisation and consultation processes. The Chair agreed, observing that net zero delivery added to the overall complexity of the system and raised broader questions about where accountability and operational leverage ultimately

sat. He suggested that this issue be captured as an outstanding action for future consideration in due course.

RESOLVED: The committee is asked to:

- **Note the meeting report**
- **Consider the development of a specific net zero risk**
- **Receive a further update in Q3 2026/27.**

d) LIFT estate end of concession planning / Securing the Future Programme

A Rose presented a paper outlining the LIFT (Local Improvement Finance Trust) estate, explaining its purpose, structure and ongoing relevance to the ICB. He advised that LIFT was established as a public-private partnership model during the Primary Care Trust era and remained important to the ICB. The ICB underwrote the cost of the estate, meaning it was financially liable whether space was occupied or vacant. As a result, there was a continued imperative to maximise utilisation, align commissioning decisions to specific locations where possible, and avoid the creation of void space, which would otherwise generate additional cost pressures for the system. A Rose confirmed that the ICB operated a space utilisation programme and that opportunities relating to the LIFT estate were routinely discussed through the four Strategic Infrastructure Groups (SIGs), involving partner organisations across the system.

It was noted that the LIFT estate formed part of the Department of Health property company portfolio through Community Health Partnerships (CHP), and that there had been some recent success in securing investment into the estate. A Rose highlighted that the estate was moving towards the end of its concession period, with a number of fixed and immovable milestones approaching. These end-of-concession dates required ongoing engagement with both national and regional teams within CHP to ensure the system was prepared and positioned to respond effectively. He advised that there were near-term opportunities to secure additional investment through Department of Health capital programmes, with funding flowing from multiple sources. The ICB continued to influence and encourage the Department of Health to invest in the estate to support service delivery locally, reduce voids and mitigate revenue costs, recognising the inherent complexity of the funding and ownership arrangements.

A Rose explained that the ICB was also seeking to influence the national 'Securing the Future' programme, which addressed Department of Health intentions at the end of LIFT concessions. He outlined that a number of options were beginning to crystallise, some of which could deliver local benefit. The contractual structure allowed assets to be purchased at end of concession at a discount to market value; should the ICB, a Trust or a future integrated health organisation choose to acquire these assets, this could generate an immediate capital departmental limit (CDL) benefit for the system. A Rose also highlighted that some services within LIFT buildings were historically subsidised, reflecting legacy arrangements from the Primary Care Trust. At end of concession, once the original debt used to construct the buildings was repaid, re-leasing could take place at reduced cost. He advised that detailed work would be required on a building-by-building and floor-by-floor basis to identify and unwind subsidy arrangements, representing an ongoing recurrent revenue cost to the ICB and therefore a potential source of future savings.

The committee was advised that the future use of public-private partnership (PPP) models for neighbourhood health centres was being actively considered by government and was likely to resemble a LIFT-type structure or similar models used elsewhere. A Rose emphasised the importance of the ICB maintaining a strong understanding of how such contractual structures operated, particularly

	<p>given the anticipated need for at least two new buildings, in Preston and Lancaster, where suitable estate options were currently limited. He confirmed that the ICB engaged periodically with colleagues in HM Treasury and the Department of Health who were shaping future PPP models, to ensure that the system was well positioned to benefit from emerging national policy.</p> <p>To support committee oversight, A Rose drew attention to the appendix within the meeting report, which provided a high-level summary of the full LIFT estate, including costs, assets and utilisation. He confirmed that more detailed building-level information was also available and was used to inform the work of the Space Utilisation Board and the SIGs. He concluded that the paper was intended to address questions raised by the committee previously regarding what the LIFT estate was, why it mattered, and what actions and opportunities lay ahead.</p> <p>In discussion, the Chair welcomed the paper and sought clarification on whether lease repairing obligations created contingent liabilities for the ICB should leases conclude simultaneously. A Rose confirmed that this did not represent a liability for the ICB, as ownership rested with the Department of Health and private funders through the LIFT boards, rather than with the ICB. He advised that the ICB's primary focus within LIFT governance was on securing ongoing investment, reducing voids, supporting neighbourhood health priorities and ensuring that buildings were at or near net zero standard ahead of any future ownership changes. This was intended to avoid the need for significant additional capital investment at the point of transfer.</p> <p>The Chair also queried potential tax and VAT implications arising from asset transfers. A Rose advised that while these matters were live considerations at individual LIFT boards, NHS Trusts and ICBs did not incur stamp duty land tax, and it was therefore important to ensure that any future purchaser or transferee of assets fell within those categories to avoid additional cost. The Chair reflected on the inherent complexity of the arrangements and thanked A Rose and C Pallister for the comprehensive suite of papers, noting that they had significantly improved the committee's understanding of the issues and challenges associated with estates, infrastructure and capital across the system.</p> <p>RESOLVED: That the committee note the contents of the report and agreed timescales for future committee updates as half yearly.</p> <p><i>C Pallister left the meeting</i></p>	
<p>214 25/26</p>	<p><u>Review of Committee Effectiveness</u></p> <p>This item provided members with an opportunity to feedback against prompt questions on the committee's effectiveness to discharge its duties. S Mattocks reminded the committee that 5 key prompt questions had been circulated in advance of the meeting to support reflection and allow members time to consider feedback. These questions were intended to inform discussion on areas where the committee had operated effectively during the last financial year, as well as identifying aspects that may require further development as the committee moved into the next financial year's programme of meetings.</p> <p>During discussion, the committee reflected that it had reported to the Board in a balanced and insightful manner, focusing on key risks and areas of financial underperformance rather than duplicating committee level discussion. There was strong emphasis on the need for sharp reporting and oversight of risk in the coming year, informed by the principal risks within the BAF and the ICB's evolving financial</p>	

	<p>position. Members noted improvements in the quality and maturity of reporting during the year, particularly in relation to All Age Continuing Care and the waste reduction programme (WRP), with greater focus on key issues supported by underpinning data, placing the committee in a stronger position to manage significant risks going forward.</p> <p>The committee considered that it had generally received the level of assurance required under its Terms of Reference, with a strengthened focus on financial governance, although some areas, including digital, data, and environmental, had initially provided lighter assurance which had improved over time. The importance of clear committee remits and effective interplay with other committees, particularly the Commissioning Committee and Quality and Outcomes Committee, was highlighted, alongside the need for greater clarity on oversight responsibilities and strengthened contract monitoring.</p> <p>Members agreed that the committee had received appropriate granularity and transparency of information, particularly in relation to system financial oversight, while recognising the need for deeper understanding of WRP profiling.</p> <p>It was confirmed that members felt confident in asking challenging questions, with robust recording and follow-up of actions.</p> <p>While the committee was at times reassured rather than fully assured, it had appropriately sought further evidence where required, recognising assurance as an iterative process within a fluid organisational context.</p> <p>Feedback was noted and would be taken forward accordingly.</p> <p>RESOLVED: That the committee note the discussion.</p> <p><i>D Corcoran left the meeting. From this point the meeting was not quorate.</i></p>	
<p>215 25/26</p>	<p><u>Commissioning for Success 2026/27</u></p> <p>The Chair invited comments following discussion at the 20 February committee meeting. C Harris advised that matters had already been covered through ICB Board discussions and earlier items on the agenda, confirming that there were no additional issues to raise.</p> <p>In response to a members question regarding whether a 6 month review of the effectiveness of commissioning decisions would form part of the ongoing commissioning development process, C Harris confirmed that he routinely provided a formal update to the Board in October, setting out progress to date alongside forward-looking considerations. He explained that this update also provided an opportunity to review and, where necessary, adjust commissioning intentions for the following year, including reinforcing expectations with providers where sufficient progress had not been achieved. He confirmed that this mid-year review would be presented to the ICB Board in a public session. In addition, he advised that progress against the commissioning delivery dashboard would in future be reported quarterly to the ICB Commissioning Committee rather than the Executive Committee, thereby strengthening the regularity of oversight of delivery.</p> <p>RESOLVED: That the committee note the meeting report for information.</p>	
<p>216</p>	<p><u>UEC Capacity Investment Funding 2025/26 and 2026/27 / UEC Financial Update</u></p>	

25/26	RESOLVED: That the committee note the content of the report and associated risks.	
217 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>	
218 25/26	<p><u>Items Referred to Other Committees</u></p> <p>There were no items referred to other committees.</p>	
219 25/26	<p><u>Any Other Business</u></p> <p>No other business was raised.</p>	
220 25/26	<p><u>Items for the Risk Register</u></p> <p>There were no new items.</p>	
221 25/26	<p><u>Reflections from the meeting</u></p> <p>Members reflected that they felt comfortable to raise issues within the meeting.</p> <p>The Chair thanked members for their contributions and their dedicated time given to the meeting.</p>	
222 25/26	<p><u>Date, time and venue of next meeting</u></p> <p>20 April 2026, 10 am – 12 noon, by MS Teams.</p>	