NHS
Lancashire and South Cumbria
Integrated Care Board

Approved 27 August 2025

Minutes of the ICB Finance and Contracting Committee Held on Thursday 17 July 2025, 9.30 am – 11.30 am by MS Teams

Members		
Steve Igoe	Chair/Non-Executive Member	L&SC ICB
Jim Birrell	Non-Executive Member	L&SC ICB
Stephen Downs	Acting Chief Finance Officer	L&SC ICB
Andy Knox	Medical Director (Estates and net Zero)	L&SC ICB
Craig Harris (from item 63)	Chief Operating Officer/Chief Commissioner	L&SC ICB
Asim Patel	Chief Digital Officer	L&SC ICB
Regular Participants		
Alistair Rose	Director of Strategic Estates, Infrastructure and Sustainability	L&SC ICB
Elaine Collier	Deputy Director Operational Finance	L&SC ICB
Peter Tinson	Director of Primary Care	L&SC ICB
Debra Atkinson	Director of Corporate Governance	L&SC ICB
Attendees		
Kathryn Lord	Director of Quality Assurance and Safety	L&SC ICB
Sarah Mattocks	Head of Governance	L&SC ICB
Nancy Park	All Age Continuing Care Turnaround Director	PricewaterhouseCoopers LLP (PwC)
Sandra Lishman	Committee and Governance Officer	L&SC ICB

No	Item	Action
58 25/26	**Welcome, introductions and Chair's remarks** The Chair welcomed everyone to the meeting, reporting that an ICB Board briefing had been held earlier this week to discuss issues in terms of moving the rationalisation proramme forward, as well as issues that could potentially impact on the ability to meet the plan at the end of the year. Further discussion would be held by the ICB Board in due course.	
59 25/26	**Apologies for absence/Quoracy of meeting** Apologies had been received from Debbie Corcoran, Neil Greaves and Gareth Jones. The meeting was quorate.	
60 25/26	**Declarations of Interest** **(a) Finance and Performance Committee Register of Interests –** Noted. **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.**	

61 25/26	**(a) <u>Minutes of the meeting held on 17 June 2025 and matters arising</u>** **RESOLVED: That the committee approve the minutes as a true and accurate record of the meeting held on 17 June 2025.** **(b) <u>Action log</u>** **Ref 4 – AACC Conflicts of Interest –** Agreed to close. **Ref 9 – Business Plan – winter planning –** No further update at this time. **Ref 11 – Deficit support funding –** Agreed to close. **Ref 13 – All Age Continuing Care (AACC) –** MIAA action plan to be presented at today's meeting; a piece of work was being worked up in relation to this. Agreed to close. **Ref 14 – Joint Capital Resource Plan –** An analysis in relation to capital would be presented at today's committee meeting. Agreed to close. **15C to C – Medicine Optimisation QIPP target** – Referred from the Quality and Outcomes Committee to oversee the QIPP target. It was confirmed that ongoing oversight and monitoring of the waste reduction programme delivery would be through this committee and the Incident Management Team meeting, where regular updates were received. Agreed to close. **16 C to C – All Age Continuing Care –** Referral from the Quality and Outcomes Committee. It was confirmed that discussions between the local authority and the ICB were taking place outside of this committee, with feedback to the ICB private Board. It was acknowledged that savings identified would have an impact if not met. Agreed to close.	
62 25/26	**<u>Grip and Control (Acute and Mental Health)</u>** S Downs spoke to a previously circulated report proposing the governance process for maintaining oversight and escalation of compliance with breach of controls, as recommended in the reviews undertaken by PwC in relation to acute and mental health commissioning controls and recommendations. Reviews had been undertaken for all organisations within the system and were being tracked through the Improvement Assurance Groups (IAG). It was noted that whilst some areas would be rectified over time through the restructure, other controls would start at a point of escalation and these were being tracked. The committee were asked to note the lengthy timescale required to meet all of the recommendations. Members raised that it would be helpful for the committee to receive feedback from the IAGs in relation to financial assurance. It was noted that non-executives attend provider IAGs. The recent letter summarising key areas discussed at the recent ICB IAG meeting would be circulated to ICB Board members for information; this letter outlined the actions required to build momentum and support progress towards achieving the ICB's 2025/26 financial and operational objectives. S Downs shared that it was believed financial risk was overheating in the elective part of the acute contract and OAPs, not all contracts were brought to IAG meetings. ***N Park joined the meeting.*** For committee assurance, it was confirmed that more detailed information would be	**SD**

	provided to the committee at its next meeting where recommendations required implementation. S Downs confirmed that conversations were currently taking place around overseeing this work; a response to the document setting out the work each committee is required to undertake in respect of the grip and control process would be provided at the next committee meeting. **RESOLVED: That the Finance and Contracting Committee:** - **Note the content of the report.** - **Support the proposed approach for ongoing monitoring and assurance against the remaining relevant acute and mental health commissioning controls and recommendations from the reviews undertaken by PwC.**	**SD**
63 25/26	**<u>All Age Continuing Care (AACC) Update</u>** The previously circulated meeting report provided an update on the progress of the AACC turnaround programme, focusing on turnaround progress and plan. N Park reported the following key messages: - Based on the timing of the AACC meeting papers, these were based mainly on month 2 information. Month 3 data was now available, and high-level numbers had been circulated within the finance report at today's meeting - Overall, good progress was being made on the AACC waste reduction programme, which was a £32m target plus £30m stretch - £38.6m was currently in implementation and there were plans to progress £12.9m. Focus was on identification, and tracking implementation of schemes. Pending quality impact assessments, a large proportion of the schemes would be fully developed - The operational metrics within the meting papers showed key statistics and trends following package volumes, by package and cost on the quality premium. Both positive and downward trends had been seen and key areas, including discharge to assess fast track, would be closely monitored. ***Craig Harris joined the meeting.*** S Downs reported that a number of AACC complaints from families were being received. It was noted that the national view was that consideration could be made to withdraw continuing healthcare if someone was now considered ineligible on review; other systems had implemented this work. Members discussion included: - The information presented was helpful. The committee felt that presenting the information on a single page, simple dashboard would be beneficial - Concern was raised that schemes were being reported as implemented or delivered, however, were falling into high-risk category - The month 3 finance paper at this meeting stated a £7.7m overspend, projecting to be £6.5m by the end of the year; it was queried why this was not close to the level of savings required - In order to help the committee further, it would be beneficial if the action plan could be distilled down for clarity of the position relating to meeting the target savings. S Downs responded that in relation to the schemes being implemented but showing to be a high risk, these were areas that required a more in-depth look, eg, where a package would be reviewed by the local authority. As part of the waste reduction programme update, detail would be presented at the next private meeting of the ICB Board setting out risk at the year-end position, these would be looked at in more detail to establish if	

	the risk of delivery could be reduced. Further work and monitoring was taking place on a daily basis and the committee noted that schemes with risk relating to providers were not within the ICB's remit. In relation to the significant number of complaints being received, K Lord reported that a deep dive was being planned as some may relate to how the ICB was communicating and delivering messages to family and carers involved. C Harris reflected that where eligibility had been given inappropriately, there was reluctance to reverse an inappropriate decision already made. It was clarified that this was not about changing the needs or reducing a package but around someone who had been awarded continuing healthcare previously and on review they had not met the criteria. Fear of litigation had previously prevented organisations retracting the offer of continuing healthcare, however, it was noted that other ICBs were now reversing inappropriate decisions previously made. A corporate view was required in this area. The continuing healthcare team had undertaken clinical view. N Park reported that work was currently being undertaken by the ICB around complaints/benchmarking at the current time verses 6 months ago. Both the AACC and corporate teams were looking at all complaints in totality, undertaking analysis as to whether these were around changes, legal framework, communication and conduct, etc. It was hoped this work would be completed by the next committee meeting when it could be reported. K Lord and N Park to take forward with J Brennan outside of this meeting to bring the issue to the executive team in due course. S Downs reported that AACC is a standard item on the Improvement Assurance Group meetings where a full reporting pack is presented; this pack had been shared as part of the committee papers. Committee reporting would be considered, proposing a single report including run rate and metrics. A Patel reported that correspondence had been received from NHS England requesting an understanding of complaints received relating to AACC. This would be discussed further by the Quality and Outcomes Committee. The Chair thanked the team for the detailed report, with positive grip and control. The committee noted a positive move in driving out reductions in the stretch target, recognising that whilst schemes were in implementation there continued to be too much risk to deliver. The committee expressed concerns about complaints being received and were aware of the difference between legitimate changes in eligibility and those that are reassessed. It was confirmed that quality discussions should take place by the Quality and Outcomes Committee, with the Finance and Contracting Committee ensuring changes to finances do not have a quality impact. **RESOLVED: That the committee:** - **Note the progress on the waste reduction programme, operational performance, and turnaround delivery** - **Support continued risk mitigation and validation of remaining pipeline schemes** - **Endorse the use of the AACC Turnaround Plan as the formal recovery plan in line with MIAA audit recommendations.** ***N Park left the meeting.***	**SD**
64 25/26	**<u>Progress and Delivery of the ICB System Wide Estates and Infrastructure Strategy</u>** The meeting report briefly explained the ICB Infrastructure Strategy and its purpose.	

	A Rose provided the following highlights to members, reminding them of on time bound elements, including the end of the LIFT estate concession, and other areas that would start as part of the national Securing the Future programme. The ICB had been successful in LIFT schemes and capital funding this year, bringing in nearly £8m of additional non-revenue capital from the Department of Health. As part of the 3 strands of the 10-year plan, work on Hubs had been undertaken with NHS England and the Department of Health; a Department of Health fact-finding visit was expected next week looking at the ICB's thinking. NHS England had asked that further work be undertaken around the infrastructure Core, Flex and Tail, requesting that the Tail estate be refreshed, due to a change in classification. These would now be buildings where leases are not renewed, etc, without additional investment. Support had been received around much of the infrastructure strategy and provided to Place teams with strategic infrastructure strategy groups. An annual Autumn 10-year capital plan was being undertaken, feeding into the comprehensive spending reviews and informing the Department of Health around SR3. Reasonable progress was being made on the Net Zero agenda, which had been discussed at the July committee meeting, along with the Green Plan. Work was taking place with the Chief Finance Officer and a system infrastructure investment function would be included as part of the System Finance Group, picking up 10-year capital planning and some of the larger investments. Following the deferment of some of the new hospital work and timescales, it had been suggested that after the 10-year capital work in the autumn, work would be undertaken around a plan to refresh the infrastructure strategy. Members discussion included the appreciation of support around primary care aspects and in particular central Lancashire being an area that required focus. There was agreement of timeliness to refresh the strategy post commissioning intentions as the 10-year plan encouraged multiple levels of working in terms of the 50,000 population and the 250,000 population and what that might mean for the ICB's infrastructure strategy. The committee requested a breakdown of this year's expectations to ensure these were monitored. P Tinson confirmed that at the Primary Care Contract Sub-Committee a detailed capital report was presented, identifying individual practice schemes planned this year. A Rose confirmed a piece of work was being undertaken around creating a terrier for the primary care estate to ensure full visibility on when primary care leases end; responsibility around lease breaks, etc, for providers remain with them. Discussion had been held with providers and they are getting a common terrier. The exception being securing the future LIFT estate, which was currently being considered; there were options, plans and opportunities for purchase of the buildings as they arise, the purchaser would effectively be buying at market discount. S Downs confirmed that ICB primary care capital spend is discussed and overseen by the Primary Care Contracts Sub-Committee. The vast majority of capital is with providers which is reported to the Finance and Contracting Committee, the Primary Care Contracts Sub-Committee recently received an update report. The sub-committee were holding discussions around the use of LIFT buildings and the wider primary care estate. Consideration would be made to the route to provide committee oversight, without duplicating business. Members were reminded that in the last 3 months, the committee had received an update on digital data and net zero. A Patel highlighted that the ICB blueprint included these areas in terms of future responsibility; the committee would receive an update in these areas where the ICB blueprint stipulated changes. It was noted that the strategic estates team undertake fantastic work bringing income into the ICB, being exemplary across the country. It was highlighted that recently one of the team members had been put forward for Chartered Surveyor of the Year by the Royal Institute, this award was rarely available to the NHS. When the blueprint is discussed, A Patel would advocate how the estates team is unique to the ICB, and the benefit the team brings. J Birrell	**AR**

	expressed that this feedback was helpful and this very assuring. The Chair shared the difficulties when making commitments to buildings, to ensure the right size of infrastructure for the activity of the organisations , ensuring delivery of the strategic objectives and also to deliver to the communities supported. A Rose expressed that this work needs to be planned into commissioning intentions with plans to ensure the opportunities available for space is looked at in an opportunistic way. Work currently underway had been planned in the previous 3-5 years. **RESOLVED: That the committee note progress on the planning and delivery of the Infrastructure Strategy.**	
65 25/26	**<u>Waste Reduction Programme (WRP) Update</u>** S Downs highlighted the WRP summary position slide within the meeting papers, showing there was a programme of £183m and within that £47m of mitigations. He reported that the running cost amounts were less likely to be delivered. Continuing Care and prescribing were the 2 largest amounts, and the wrp programme focused on schemes that reduce the cost to the system, rather than pass the problem around the system. AACC had been discussed previously at this meeting. Prescribing details had been captured in today's finance report and were also challenged in the Improvement Assurance Group (IAG) meetings. Rebates were expected to be received each quarter. Recently undertaken practice visits showed the ICB where support was required. The wrp total of £182m, included £10m medium risk running costs and £47m mitigations. The full year impact of schemes was reported to be £148.8m, alongside £35m running cost. In-year, it was expected that some non-recurrent mitigations would have to be utilised to bridge the gap between the in and full year impact. Commissioning cycles would start to look at what would stop in order to deliver from 1 April 2026. In terms of delivery, in 2025/26 there would be an impact, however this would be limited. J Birrell raised concern in relation to the anticipated saving around the monthly delivery position against the planned in-year profile. It was raised that the full year effect assumed complete delivery, however, at this point in time, the position was far from that initially predicted. It was felt that as the ICB was not delivering this year, providers need to be aware that they must make contract adjustments that brings the system into balance. S Downs responded that differentiation would be made in future between the provider CIP plan and the ICB QIPP. The finance paper showed a big catch up in month 3, looking at delivering £32m against a £32m plan. A large part of that is finance which had now caught up; this would be explained in the finance report later in this meeting. Rather than reduce provider contract values, the ICB identifies services that could be stopped, and this work was underway. ICBs were being asked nationally to re-price all contracts on a PbR basis to pay what should be. J Birrell asked for volumetric data previously included in the performance report that used to come to this committee – last year activity was up on indicative numbers and concern was raised that this would effectively mean the ICB was paying much more. S Downs expressed that work was underway with providers to re-price the fixed part of the contract, on a PbR basis using the new national tariff, noting that the UEC tariff had recently increased by 15%. NHS England had requested that ICBs understand as a commissioner what they are buying in block contracts with communities, mental health, ambulance trusts and acute trusts. On modelling with acutes, it was thought the ICB would be paying much more.	

	The committee asked that they be kept appraised of this. Discussion was held as to the potential outcome of this across the country and for the Northwest ICBs. The Chair summarised in terms of numbers there was a large sum for mitigation, £10m on the rationalisation programme and running costs, and as time moves forward this is lost. There were mitigations to reduce down to £125m and discussion would be held at the next private Board meeting whether some of these mitigations are used to support the £10m in the running costs. The question was raised whether to start implementing conversations around the 2026/27 contracts with providers to ensure they are fully aware of the costs. Meetings with turnaround teams realised clarity on reductions. It was confirmed that identifying schemes was a continuing process. P Tinson reported on the Kingsgate work, a review of the smaller community contracts which were typically not NHS contracts and were seen reflected in the wrp slide pack, a rapid review of intelligence where opportunities were thought to be, a review of Better Care Fund community funded services and a workshop with community providers where community comparative metrics would be looked at. There was now analysis on differences in terms of demand, activity, capacity, clinical and non-clinical time, clinical activities undertaken and applied costs to this, which were being discussed with providers around productivity and efficiencies being seen, particularly around district nursing and treatment rooms. **RESOLVED: That the committee note the current waste reduction programme position and the ongoing efforts to drive delivery of the £142.66m target.**	
66 25/26	**<u>Month 3 ICB and Provider Finance Report</u>** S Downs spoke to the month 3 finance report showing a system deficit of £42.3m including deficit support funding, a £12.8m variance to plan, largely driven by unidentified savings which are £16.6m behind plan. The following highlights were provided in relation to the ICB: - After deploying mitigations of £8.2m year to date, the ICB was reporting on plan for both year to date and forecast outturn. Prior year pressures from All Age Continuing Care (AACC) and some unidentified efficiencies were driving this. If AACC deliver, a pressure of £67m which would be covered by mitigations - £30.6m of the waste reduction programme (wrp) was being delivered against the plan, with £13.5m financial mitigations - Within contingency of £21m was £20m given by NHS England to carry forward in the position - There was movement on spare deficit support funding, where between the April and May plan, provider positions had improved - Risk was seen in the learning disability pool, which was dependent on the agreement with the local authority on transforming care - Useable data was beginning to come through from acute trusts for months 1 to 3 and contracts must be signed on 18 July. Trusts had confirmed that they were not expecting any money from the ICB at month 3, as were on plan - Plans were being put in place to claw back income from providers outside of the area - Concern was being seen in the independent sector which had overheated in the first 3 months; activity management plans were in the process of being agreed which would enable management of activity in the next 9 months. The plan assumes the position could be held with the providers and it was planned that the position be recovered over the next 9 months - AACC was currently showing negative variance on continuing health care, positive	

	variance on mental health and learning disability. Coding for reporting to NHS England would be reviewed due to variances being seen in different directions. The overall position was £7m pressure, relating to the prior year - In-year pressure was being seen in Local Enhanced Services (LES), which could be offset in-year with dental underspend, and it was noted that a recurrent solution needed to be found for the LES. An £8m QIPP target was allocated this year to cover the implementation, and clarity was needed to find out the driver of this to prevent a recurrent pressure being carried into next year - If the trend continued for the independent sector, a pressure would be seen. The independent sector had agreed to lower activity plans for the next 9 months, to hold the position of £3m variance - AACC £7m pressure would be managed through mitigations. With the run rate for the first few months extrapolated, the financial position is £532m, £27m above the budget; highlighting a potential risk and suggesting that the savings target for AACC should be £75m. Further work was required due to figures being based on 3 data points. The £12m assumed QIPP that had been delivered in the first 3 months would be looked at around how much of this was an improved run rate from last year - Further data points were required to provide a better understanding of the QIPP being seen in prescribing. The Chair thanked colleagues for their work on the report in the short timeframe and the committee found it helpful to see the position on the independent sector, AACC and prescribing, which could potentially de-stabilise the system. Members commented their concern around finance and did not feel assured that the ICB was on track to meet the plan, due to many matters of concern. It was recognised that this was the position at month 3, raising concern around the timeframe to mitigate if required. In response, S Downs reported that this would form part of the discussion at the next ICB Board meeting. The prior year pressure was driving the overspend for AACC, and discussion would be held with the Acting ICB Chief Executive Officer around this pressure. All contingencies would be required to deliver the position required. The Chair reflected that the ICB Board would analyse all risks, and consideration would be made in relation to funding the staffing budget elements. S Downs reported the following highlights in relation to the provider position: - The system was £13m above plan - NHS England were now stepping into provider oversight - Each month, providers report on the forecast position, identifying further wrp - As NHS England were overseeing individual trusts, the ICB would continue to support providers where possible, without de-stabilising its own position - Run rates were shown to be improving. **RESOLVED: The Finance and Contracting Committee note the content of the month 3 system and provider finance report.**	
67 25/26	**<u>Provider Capital Update</u>** The previously circulated meeting report provided the committee with oversight of the provider capital spend, detailing schemes split by internally funded schemes and public dividend capital (PDC) funded schemes. S Downs highlighted that the overall position showed that the core allocation adjustment was nearly £12m and £6m of strategic capital reserve had been held back for any issues in the system that could need capital priority. NHS England had advised that the system would receive a further £3m capital allocation due to its recognition of higher leases. Providers have the ability to spend	

	capital, however, do not have the cash in order to take this forward. Phasing of the capital programme would be worked through, and this would start to change as capital started to flow. As well as internal capital, other sources of capital within the system included nearly £4m for diagnostics as a national programme. A bid had been submitted for PDC for urgent and emergency care, Lancashire and South Cumbria had targeted bids mainly around modifications within the department as trusts did not want to put in bids that would create a requirement for additional capacity. The failing estate within Lancashire and South Cumbria was recognised nationally and all trusts received a share of £16m. Capital was expected for reinforced autoclaved aerated concrete (RAAC) that needed to be replaced, as well as digital diagnostic capital. Capital allocation had also been found for systems that performed well last year, which included £2m for East Lancashire Hospitals and University Hospitals of Morecambe Bay for their emergency department performance, as well as £5m as a system for NWAS category 2 response times. On submitting bids for capital, it was ensured that a revenue pressure would not be created. J Birrell raised concern around the issue of backlog maintenance at trusts and asked if the capital received/bid for resolved building issues at Lancashire Teaching Hospitals. In response, Alistair explained that maintenance for Lancashire Teaching Hospitals and University Hospitals of Morecambe Bay (Lancaster) was an issue, and both were on the new hospitals programme. Members were reminded that the cost of fixing an old hospital was double what it would be to build a new hospital, however, the new hospitals programme had been deferred for over 5-years, and the backlog in the acute trusts had increased almost £30m in the last 3 years, even with the investments made. This issue would be highlighted to the Department of Health team, to consider areas of deprivation rather than fair shares. S Downs reported that for the £16m capital received, consideration had been given to spending in one place, however, part of the decision reflected that it had to be spent in one year and at scale. The backlog priorities at Lancaster hospital maternity, which needed replacing, would cost over £25-30m over a 2-3 year timeframe, sewage works at Preston hospital were estimated be around similar cost; these two significant issues were on the relative acute trust risk registers. K Lord confirmed that the ICB quality team were cited on the clinical risk relating to the sewage work required at Preston hospital, and this has been flagged with region in relation to infection, prevention and control. This impacts on the relative trust in relation to outcomes. **RESOLVED: That the ICB Finance and Contracting Committee note the content of the report.**	
68 25/26	**<u>2025/26 Contract and Contract Monitoring Update</u>** S Downs provided an update to the ICB position from a contract perspective. The previously circulated meeting report provided additional information on the main provider contracts. It was highlighted that although Lancashire and South Cumbria ICB had not escalated any contracts to NHS England, contracts escalated by Greater Manchester or Cheshire and Mersey ICBs would result in this ICB being unable to agree a contract with trusts within those areas. At this stage, the ICB's own internal contracts were yet to be agreed and it was noted that there had recently been a change in direction to a payment by results (PbR) basis for electives and the elective recovery fund (ERF). Provider activity management plans were yet to be agreed. Financial value for contracts had been issued, and the ICB had rejected an ask from providers for more payment advising the national direction for trusts. It was thought that signed contracts would	

	involve in-year risk. Morecambe Bay had been asked to deliver 75% referral to treatment (RTT), which was above target; the ICB were supporting, looking at alternative ways in which the target could be delivered. Work was also underway with Lancashire Teaching Hospitals around diagnostics, particularly looking at whether community diagnostic centre (CDC) underspend activity could be redirected. The committee would be updated at its next meeting around signed contracts and monitoring. Trusts had confirmed that they were assuming that there would be no overperformance and on plan. To de-risk the position for high-cost drugs, the ICB had agreed a block contract with 3 of the 4 trusts, putting in an additional £0.5m to these contracts. In turn, remedying the ICB's financial exposure and allowing trusts to work on biosimilars. Blackpool Teaching Hospitals were seeing issues with PAS implementation; the ICB had suggested whether they wished to block the entire contract for a year, being clear that if the service was decommissioned, block payment would still be required. This would result in de-risking elective overperformance. Blocking income for the year to de-risk the ICB's position would also be offered to other trusts. It was confirmed that the system was reporting to be over plan, with activity management plans in place to manage. The ICB was comfortable with the risk share position for mental health and learning disability. Good progress had been seen in out of area placements (OAPs). The challenge was to reduce spend in this area for 2025/26. Going forward, activity and costs would be reported against each main contract, highlighting particular areas of risk for the committee. To enable committee oversight of what reporting would look like, the committee requested a draft report on commissioning for outcomes, using shadow arrangements and similar base data to produce the data required. **RESOLVED: That the committee note the content of the report and agree next steps.**	**CH**
69 25/26	**<u>Lancashire and South Cumbria Provider Collaboration Board Minutes</u>** The approved minutes of the Lancashire and South Cumbria Provider Collaboration Board had been circulated to members in advance of the meeting, for information. **RESOLVED: That the Finance and Contracting Committee note the Provider Collaboration Board minutes of the meeting held on 8 May 2025.**	
70 25/26	**<u>System Finance Group Minutes</u>** The approved minutes of the System Finance Group had been circulated to members in advance of the meeting, for information. Members noted that future System Finance Group meetings would become 2 parts, the first being the System Finance Group and then the System Infrastructure and Investment Group, where estates colleagues would attend for capital discussions. The committee would receive the minutes of both meetings, for information. **RESOLVED: That the Finance and Contracting Committee note the System**	

	Finance Group minutes of the meeting held on 28 March 2025.	
71 25/26	**Committee escalation and assurance report to the Board** Members noted the items which would be included in the committee escalation and assurance report to the Board. **RESOLVED: That the Finance and Contracting Committee note that a report will be taken to ICB Board.**	
72 25/26	**Items referred to other committees** There were no items referred to other committees. The committee recognised that the Finance and Contracting Committee would ensure changes to finances did not have a quality impact and that specific quality discussions would take place by the Quality and Outcomes Committee.	
73 25/26	**Any other business** No other business was raised.	
74 25/26	**Items for the Risk Register** There were no new items.	
75 25/26	**Reflections from the meeting** The Chair thanked members for their contributions and time at this meeting. The committee acknowledged the difficulties in the most up to date finance data being available for this meeting and it was noted that circulation of papers should be more timely following the review of committee meeting dates.	
76 25/26	**Date, time and venue of next meeting** 27 August 2025, 10 am – 12 noon, by MS Teams.	