North Central London
Integrated Care Board

Minutes
Meeting of NHS North Central London ICB Board of Members
28 March 2023 between 2pm and 3.15pm
Claremont Room

Present:	
Mike Cooke	Chair, NCL Integrated Care Board
Kay Boycott	Non-Executive Member
Dr Chris Caldwell	Chief Nursing Officer
Dr Simon Caplan	GP - Provider of Primary Medical Services
Cllr Kaya Comer-Schwartz	Leader, Islington Council
Richard Dale*	Executive Director of Performance and Transformation
Jinjer Kandola	Chief Executive Officer, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust
Usman Khan	Non-Executive Member
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Sarah Mansuralli*	Chief Development and Population Health Officer
Sarah McDonnell-Davies*	Executive Director of Places
Sarah Morgan*	Chief People Officer
Ian Porter*	Executive Director of Corporate Affairs
Dr Jo Sauvage	Chief Medical Officer
Liz Sayce	Non-Executive Member
Phill Wells	Chief Finance Officer
In attendance	
Sarah Mcilwaine	Director of Primary Care (Item 2.3)
Sarah Rothenberg	Director of Finance, Primary Care (Item 2.3)
Anna Stewart	Start Well Programme Director (Item 2.1)
Emma Whicher	Clinical Director for Transformation and Lead for Children, Young People, Neonates and Maternity (Item 2.1)
Apologies	
Frances O'Callaghan	Chief Executive Officer
John Hooton*	Chief Executive, Barnet Council
Mark Lam*	Chair, Royal Free Hospitals and Accountable Officer, NMUH
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
Dr Alpesh Patel*	Acting Chair, GP Provider Alliance
Minutes	
Steve Beeho	Board Secretary

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	The Chair welcomed attendees to the Meeting.
1.1.2	Apologies had been received from Frances O'Callaghan, John Hooton, Mark Lam, Baroness Julia Neuberger and Dr Alpesh Patel.

* Standing Participant

1.2	**Declarations of Interest relating to the items on the Agenda**
1.2.1	The Chair invited Members to declare any interests relating to items on the agenda. There were no additional declarations.
1.2.2	The Board of Members: • **NOTED** the requirement to declare any interests relating to the agenda; • **NOTED** the Declaration of Interests Register and the requirement to inspect their entry and advise the Board Secretary of any changes; • **NOTED** the requirement to record any relevant gifts and hospitality on the ICB Gifts and Hospitality Register.
1.3	**Update from the Chair**
1.3.1	The Chair noted that it had originally been intended to hold an informal Board seminar on this date but due to the need to progress a couple of key business items, the seminar had been switched to a formal Board meeting. He further noted that Dominic Dodd, Chair of the UCL Health Alliance, had recently tendered his resignation from the ICB Board of Members and from his role as Chair of RNOH due to a conflict of interest with some separate non-NHS work that his company is involved in. An update on this vacancy will be provided in due course.
1.4	**Report from the Chief Executive Officer**
1.4.1	Phill Wells provided an overview of the report, highlighting the following points: • The CQC has confirmed that the Barnsbury Practice in Islington has moved from a *Requires Improvement* position to *Good* in all domains and *Outstanding* in the 'well-led' category. This direction of travel was welcomed • Following the approval in February of the population health model for people at risk of or living with long term conditions, work is taking place prior to it being mobilised by September 2023 • The Enfield Borough Partnership has become one of only seven Core20plus5 Accelerator Sites that are being run by NHS England in partnership with the Health Foundation and Institute for Healthcare Improvement • Significant progress has been made in reducing the waiting lists for CAMHS and Children and Young People (CYP) Therapy Services • Operational pressures across the NHS remain challenging and the hard of work of everybody involved across the system in addressing these was commended. General practice is offering more appointments overall than it ever has before and there is a strong focus in Mental Health and acute Trusts on reducing occupancy rates • The impact of industrial action also continues to be challenging. Gratitude was expressed to staff involved in keeping patients safe during this time. The government recently made an Agenda for Change pay offer which is being considered by the trade unions concerned. However, further industrial action is planned for April by the junior doctors • The ICB has now received notification from NHS England that there will be a 30% real term reduction in its Running Cost Allowance (RCA) over 2024/25 and 2025/26. In response to this, the first phase of the organisational design programme is underway which will design a new model that meets the RCA reduction and also delivers on the ICB's population health and wider system objectives.
1.4.2	Sarah Mansuralli then provided a brief overview of the transfer of Enfield Community Services from Barnet, Enfield & Haringey Mental Health Trust (BEHMHT) to North Middlesex University Hospital (NMUH) which will be taking place on 1 April 2023. It is expected that this model of vertical integration will be replicated further as the system evolves. It was noted that the decision had been taken 'virtually' by the Board. Potential conflicts of interest were avoided by Jinjer Kandola and Mark Lam both not participating in the decision-making.
1.4.3	The Board of Members discussed the paper, making the following comments:

	• Assurance was given about the extensive strike mitigation work that is in place. It is recognised that the junior doctors' industrial action planned to take place after Easter will be particularly challenging and the risks around this are currently being quantified. Learning from the previous junior doctors strike, such as the higher attendance at A&E, is being taken forward • The possibility of consultants across primary care also taking industrial action over the next few months was highlighted • It was suggested it would be helpful to have a wider discussion on the elective recovery plan in the wake of the various challenges that have impacted on the system over the past few years • Assurance was given that regular discussions are taking place with partners about the impact on electives, which varies from site to site and across service areas, so the approaches to recovery will vary. The impact extends beyond the actual strike days to the aftermath as well. Plans are in place to recover the long waiters quite quickly but there is a recognised impact on people with long term conditions which forms part of the broader population health challenge • It is important that the challenges facing the ICB are used to stimulate innovation – for instance, looking at how waiting times are managed differently in order to improve outcomes • The focus on inequalities is also vital as access issues for different population groups can lead to more intensive resource utilisation. In particular, a better understanding is needed of high intensity users and the inequalities that might be driving this as part of the recovery planning • It was suggested that the learning from the system response to the industrial action and the mitigations put in place should be taken forward as part of future care models • The information and assurance that the Board receives around ICB risk management was welcomed. However, the Board will need to be mindful that there may come a time when the ICB has to acknowledge that as a result of the operational pressures confronting it, certain targets are unattainable for the time being • It was noted that the Board had previously identified, in the context of a discussion around improved access, the need to meet informally to discuss which innovations it might want to sponsor and bring to fruition. This discussion had highlighted the importance of recovery and population health work progressing in tandem, and strengthened by innovation. The Board will return to this discussion in due course.
1.4.4	The Board of Members **NOTED** the Report.
2.	**STRATEGY AND BUSINESS**
2.1	**Start Well Update**
2.1.1	Sarah Mansuralli, Emma Whicher and Anna Stewart introduced the paper, highlighting the following points: • The Board had previously approved at its November 2022 meeting the proposed future care models that would be the basis of the options appraisal to assess future service configurations and identify areas of improvement highlighted in the case for change • At that point a lot of work had taken place on the maternity, neonatal and paediatric surgical care models. However, a significant amount of clinical work has taken place since November to further refine the paediatric surgery model, including three meetings with the Clinical Reference Group (CRG) with strong engagement from organisations across NCL. This refined model will allow a wider variety of options to be considered within the options appraisal, with the aim of better outcomes • The clinical consensus is that children below the age of one should be treated in the same way as children under the age of three as the paediatric anaesthetic and surgical competencies do not differ significantly between the two age groups.

	The CRG therefore suggest that the options appraisal should consider the consolidation of emergency surgery for all children under the age of three and under the age of five for general surgery and urology • The CRG have further considered access arrangements for the centre of expertise for surgery and recommended that to improve patient pathways for children, there needs to be emergency access arrangements in place for the centre. The consensus is that this requirement could be satisfied with a paediatric emergency department, or an urgent surgical assessment unit which could act as a rapid receiving unit for transfers from other hospitals • Following consideration of workforce and potential configurations, the CRG have recommended that planned and emergency surgery should be co-located, with an option for day case surgery to potentially be on a different site.
2.1.2	The Board of Members discussed the paper, making the following comments: • Assurance was given that any potential 'front door complexity' be considered and therefore the need for very clear communications will need to be built into the care model • It was noted that the proposed model addresses feedback from parents and clinicians about the complexity of the current pathway. Assurance was also given that there is an active Patient and Public Engagement Group who have provided excellent feedback throughout the process • It was highlighted that when the outcome of the options appraisal is brought back to the Board, there will also be an accompanying integrated impact assessment (IIA). This will include a deep dive into any populations with protected characteristics, deprivation or inclusion health groups . The options appraisal will consider accessibility and then the ensuing engagement will look at mitigations for groups who may potentially be impacted by any changes • It was clarified that the risks highlighted in the cover paper relate to the current phase of the programme and there will be a greater focus on workforce challenges and risks in the event that the programme moves into an implementation phase. It was also noted that workforce and facilities are key components of the assessment in the options appraisal • It was noted that much of the transfers from one unit to another referred to in the paper are already happening – the goal is to have a far more efficient system in place so that access is improved from a patient experience perspective. Based on feedback relating to other specialist centres, patients are generally happy to travel a bit further provided that they are receiving optimum care • It is important to apply previous learning around the separation of planned and emergency surgery and ensure that the transfer times from one to the other are clinically safe.
2.1.3	The Chair thanked Members for their comments and in particular the reassuring contributions from clinicians. He also welcomed the process which had been followed and the valuable input from the CRG.
2.1.4	The Board of Members: • **NOTED** the changes to the children and young people's planned and emergency surgery care model • **DELEGATED** to the ICB Chief Medical Officer and Chair of the Start Well Programme Board, the review and endorsement of the revised children and young people's surgical care models. • **AGREED** to proceed to an options appraisal in respect to the implementation of the proposed emergency and planned surgical children and young people's care model. This recommendation replaced and superseded recommendation 3a in the November 2022 Board paper. This options appraisal would: o Set out all possible site-specific options for the creation of a centre, or centres, of expertise for the delivery of children and young people's surgery for low volume specialities and very young children.

	○ Set out the appraisal of these options, compared to the status quo against a set of criteria to be agreed by the Start Well Programme Board, but which would include at a minimum an assessment of the impact of the option on quality, access, workforce, and finances (including recurrent affordability, capital and cash availability) at both an organisational and system-level over an agreed time-horizon.
2.1.5	The Chief Medical Officer and the Chair thanked Emma Whicher for her work as clinical lead and Joint SRO on this programme. Emma will be taking up a new CMO position outside NCL but would be continuing to provide some interim leadership until the conclusion of the options appraisal process.
2.2	**Population Health and Integrated Care Strategy**
2.2.1	Sarah Mansuralli introduced the paper, noting that Will Maimaris, Director of Public Health, Haringey Council was unfortunately unable to attend to co-present. She highlighted the following points: • The draft strategy had been co-produced with the involvement of all parts of the system and had evolved from the original work with the Directors of Public Health on developing an outcomes framework • The fact that the Board is discussing the health and wellbeing outcomes it wants for to achieve for local residents, rather than just focusing on units of activity, is an extremely positive development • The strategy needs to be meaningful to all parts of the system but also reach consensus about areas of focus that will achieve the biggest population health gain and the levers for a sustainable system. • The strategy, which reflects the wide input of our ICS organisations, sets out the NCL strategic intention for improved population health outcomes based on our outcomes framework which has been developed on the basis of Start Well, Live Well, Age Well and Work Well as a framework. • The five delivery areas in the strategy have been developed through more granular understanding of key priorities of borough partnerships that are instrumental to the delivery of population health interventions. • The section on sustainable levers for change describes how the system will make the transition to a greater focus on population health outcomes by being embedded in delivery across the board and strengthened integrated care through the development of neighbourhood teams. • The strategy aims to deliver greater collaboration to address the wider determinants of health, while also aligning resources to need as part of a learning system which is evidence-driven and benefits from research and innovation • The NCL delivery plan will encapsulate key system and place deliverables to achieve population health improvements and it is therefore important to ensure that milestones underpinning digital and people plans are considered in this wider planning context. • The NCL delivery plan further provides the basis for integrated planning across system partners and will inform the approach to oversight and monitoring arrangements that will provide the Board, the Integrated Care Partnership and Borough Partnerships assurance about progress and delivery.
2.2.2	The Board of Members discussed the paper, making the following comments: • The ambition of the strategy and level of engagement with partners was welcomed, as was the emphasis on building on communities' strengths • It was questioned whether the system priorities could be sharpened further and made more specific, so that it can be made clear that significant clinical energy and resource is being put into making a real difference to people's lives, as opposed to potentially spreading resources too thinly • The 'I' statements, defining how the system should feel for residents and service users, were welcomed but it was queried how these will be used to hold up a mirror to ourselves to gauge patient experience and ensure that residents can see how the statements are making a tangible difference to their lives

	• It was clarified that 'making every contact count' in this context signifies person-centred and holistic conversations which tackle a key set of factors that drive health and wellbeing inequalities, while also being mindful of the need to counter inequalities in health literacy. In response to this latter point, it was noted that there also needs to be a stronger focus on health information and education • It was suggested that the word 'vulnerable' should be avoided where possible as it can imply that this is an inherent state as opposed to something which can be ameliorated or overcome with support • The focus on health inequalities was welcomed. However, concern was expressed about the references in the delivery areas sections to "exploration" and "mapping" data when local authorities already hold this data. It was suggested that the strategy should provide more clarity about the vision for greater integration in five years' time. There are already pockets of excellence but more is needed about the big opportunities that the strategy will need to take forward – and therefore the action needs to be more ambitious than being based on the Joint Forward Plan • It was acknowledged that one of the key challenges will be around how the ICB meaningfully holds itself to account to mobilise and deliver the Joint Forward Plan, ensuring that the tendrils of the Plan are a golden thread into the plans of every organisation in the system to ensure that there is alignment around workforce to deliver 'making every contact count' • It was noted that another key challenge will be ensuring that residents feel that the strategy is making a difference but it is unclear how the Board will drive this. It is therefore important that it receives regular reports on progress from provider bodies as they grow and develop • In response it was agreed that having tangible outcomes and deadlines will help to act as a filter, as it is impractical to implement everything in the short to medium term • It would be helpful if there was a stronger emphasis in the strategy on Parity of Esteem - in particular, it needs to be made more explicit at various points in the document that the references to health encompass physical *and* mental health • The emphasis on early intervention and diagnosis needs to be strengthened in latter parts of the document • It was queried how much influence the ICB can realistically have over 'place' when it is simultaneously becoming a leaner organisation • The commitment to hyper-local delivery was welcomed but it was highlighted that this also can also potentially create multiple risks across the infrastructure. More detail about how the system will seek to mitigate this will be welcomed • In light of the fact that the health and care system is fragile and beset with significant challenges, it was suggested that a transition principle should be formulated. If a transition takes place too quickly there can be a risk of destabilisation, so it would be helpful to have a Board discussion around how the ICB will ensure that providers and existing services/teams remain sustainable through transition while remaining very clear at the same time that transition needs to happen • It was highlighted that although having a sustainable environment is a key part of the NCL ambition, air quality is not included in the risk factors in the Population Health Outcomes Framework. It would therefore be helpful if the strategy could be more specific about the role of the ICB in promoting clean air • It was suggested that a future iteration of the strategy should also include details of the learning about overcoming barriers from the mixed experiences of previous attempts at integration • It was acknowledged that implementing the strategy will inevitably be challenging in light of the financial situation the system is facing. This will necessitate choices about which parts of the strategy are prioritised and the pace of delivery, and aspects will be delivered over a longer period. • It was noted that the efficiencies achieved by greater integration can lead to more effective delivery and that inequalities drive higher cost utilsation and care in the longer term, so the system should therefore be bold and embrace this.

2.2.3	The Chair welcomed the valuable feedback and made the following points: • Sarah Mansuralli will incorporate the comments into the next iteration of the strategy and share with the Board • The draft strategy will be shared with the Integrated Care Partnership (ICP) at its meeting on 18 April 2023. Depending on the ICP feedback, there might need to be further discussion at a future Board seminar focussed on delivery. • The key themes from today's discussion were the need for a more explicit focus on mental health, broad support for the strategy as a foundation document, with a desire for prioritisation and a move to action based on the existing rich knowledge base. The strategy provides an opportunity for efficiencies through integration as well as innovation through re-thinking current models, while also learning lessons from earlier attempts at integration • Recognising that the Joint Forward Plan is a mandated document, there will need to be a complementary action plan to enable the ICB to track the progress of the strategy and demonstrate how work will be progressed at a Borough level.
2.2.4	The Board of Members **NOTED and welcomed** the progress of the strategy.
2.3	**Delegation of Dentistry, Optometry and Pharmacy (DOP)**

2.3.1	Sarah McDonnell-Davies introduced the paper, highlighting the following points:
	• The Board has received previous reports on the delegation of DOP from NHS England to the ICB and work has been taking place over the previous nine months to prepare for this
	• It is proposed that from 1 April 2023 responsibility for the following will be delegated to the ICB:
	  ○ Dentistry (including Primary Care Dental, Community Dental and Acute Dental)
	  ○ Primary Care Optometry (Specialist Ophthalmology Services fall within the specialised commissioning delegation remit)
	  ○ Community Pharmacy
	  ○ Additional primary medical services (General Practice) responsibilities
	  ○ Complaints relating to providers within the ICB for the above.
	• This represents a significant additional responsibility for the ICB as the scope covers 777 contracts worth £153m and hundreds of providers (many small local providers)
	• There is a clear strategic fit between DOP commissioning and the work of the ICB; there are opportunities for earlier intervention and prevention, integration within pathways and quality improvement
	• There will be a focus over the next 12 months on a 'safe landing' for these services and the team supporting the commissioning and contracting who will be transferring to North East London ICB. We do expect to support transformation in the medium term and will be working with the Board and other London ICBs to identify priorities.

2.3.2	The Board of Members discussed the paper, making the following comments: • It was clarified that the delegation of these services is proposed as a permanent move from NHS England to ICBs, with NHS England retaining overall accountability • In the short term it will be important for the ICB to fully understand these contracts and the finances and what it can do within the scope and terms set. NCL will seek to influence reserved matters such as the contract (form, terms) as appropriate and as required to deliver key objectives. • It was noted that Dentistry is an area of interest to our patients and residents, but is an extremely complex landscape. It is recognised in the context of the Population Health Strategy that poor dental health is a key marker of health inequalities and an important determinant of overall health outcomes. • It was noted that the delegation of complaints also represented an opportunity to build a picture of complaints received in NCL and triangulate this with the local knowledge • Assurance was given that all appropriate due diligence has been undertaken.

	• It was recognised that transformation will need to be addressed in the medium term given resource and capacity constraints and the need for ICBs to focus in the first instance on effective processes for the management of contracts, finance, payments, quality assurance and regulation • It was noted that in the context of the People Strategy, delegation offers the opportunity to think about the people who run these services as part of the workforce in NCL. • It was agreed that the Board would receive an update in 12 months' time.
2.3.3	The Board of Members: • **NOTED** the final position on the delegation of NHS England London Region DOP Services and Complaints • **APPROVED** the signing of the Delegation Agreement and Memorandum of Understanding by the NCL Chief Executive Officer or NCL Chief Finance Officer.
2.3.4	Action: Sarah McDonnell-Davies to bring a report to the Board in 12 months' time.
3.	**ANY OTHER BUSINESS**
3.1	There was no other business.
4.	**DATE OF NEXT MEETING**
4.1	9 May 2023 between 2pm and 4pm.
5.	**PART 2 MEETINGS**
5.1	The Board **RESOLVED** to exclude the public from the Part 2 meeting.