North Central London
Integrated Care Board

Minutes
Meeting of NHS North Central London ICB Board of Members
7 November 2023 between 2pm and 3.30pm
Clerkenwell Room

Present:	
Mike Cooke	Chair, NCL Integrated Care Board
Frances O'Callaghan	Chief Executive Officer
Ibrahim Abubakar	Non-Executive Member
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
John Hooton	Chief Executive, Barnet Council
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
Mark Lam*	Chair, Royal Free Hospitals and NMUH
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Sarah Mansuralli*	Chief Strategy and Population Health Officer
Sarah McDonnell-Davies*	Executive Director of Place
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
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:	
Katie Coleman	Clinical Director, Primary Care
Apologies:	
Dr Alpesh Patel*	Acting Chair, GP Provider Alliance
Minutes:	
Steve Beeho	Senior Board Secretary

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	Mike Cooke welcomed attendees to the meeting. He noted that this would be the last Board meeting attended by Frances O'Callaghan prior to her going on sabbatical and he took the opportunity to wish her well and thank her for her hard work over the past 18 months, particularly in terms of steering the ICB through a number of challenges, while also setting a course for the future under her leadership through the various transformations now underway and the renewed focus on population health, as well as working closely with fellow Chief Executives to address more immediate challenges, such as waiting lists.

* Standing Participant

1.1.2	He then thanked Phill Wells for agreeing to take on the role of Interim Chief Executive in Frances's absence and thanked the other Executives who would also need to shoulder some additional responsibility over this period.
1.1.3	Apologies had been received from Dr Alpesh Patel.
1.2	**Declarations of Interest relating to the items on the Agenda**
1.2.1	Mike Cooke invited Members to declare any interests relating to items on the agenda.
1.2.2	Dr Jonathan Levy and Dr Simon Caplan declared an interest for the sake of transparency with regards to Item 2.1 as they both practice as GPs in NCL. There were no additional declarations of interests or gifts and hospitality.
1.2.3	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	**Minutes of the NCL ICB Board of Members Meeting on 25 July 2023**
1.3.1	The Board of Members **APPROVED t**he minutes as an accurate record.
1.4	**Minutes of the NCL ICB Annual General Meeting 19 September 2023**
1.4.1	The Board of Members **APPROVED t**he minutes as an accurate record.
1.5	**Matters Arising**
1.5.1	The Board of Members **NOTED** the Action Log.
1.6	**Report from the Chief Executive Officer**
1.6.1	Frances O'Callaghan provided an overview of the report, highlighting the following points: • The system is currently under considerable pressure, particularly in Emergency Departments, and she expressed her gratitude to everybody working in clinical services to address this. Although the pressure is not evenly spread at any given moment, all parts of the system have been coming together to provide mutual support. • People living with sickle cell disorder (SCD) in NCL will benefit from improved access to specialist, integrated community nursing care and timely pain relief, thanks to the development of the NCL Community sickle cell, thalassaemia, and rare anaemia service and the hyperacute service based at NMUH. This represents a massive step-forward for a group of patients who have previously been under-served • It is important for Board Members to be kept abreast of discussions at the Integrated Care Partnership (ICP) around population health and the report highlights productive conversations which took place at the recent ICP meeting on 3 October 2023 around the delivery of the Population Health and Integrated Care Strategy, special educational needs and disability (SEND), adults with SMI (serious mental illness) and early years/school readiness • The NCL Long Term Conditions model, which aims to keep people well and avoid having to return to hospital, is the epitome of the population health work which the ICB is promoting as a new statutory organisation and the scaling up of this model will be key to the ICB's success • The proposed new ICB structure has now been finalised following feedback from staff through the Organisation Change Programme, although it is recognised that there are still some outstanding issues to progress, including understanding the impact of voluntary redundancy. The focus will now move into the various implementation phases. This has been a huge piece of work which will enable the ICB to move forward as a new and different organisation with an absolute focus on population health.

1.6.2	The Board then discussed the paper, making the following comments: • Members paid tribute to Frances O'Callaghan's leadership over a critical period for the NHS and wished her well in her sabbatical • It was noted that the impact of industrial action continues to be challenging for providers. Each new strike makes it increasingly difficult for Trusts to maintain safe patient care on the day, without taking into account any longer-term consequences and this represents a significant system risk • The renewed focus on Sickle Cell and Frances O'Callaghan's role in driving this were commended • The dual focus in the report on immediate priorities, such as the impact of the industrial action, and the longer-term pro-active work was welcomed, as was the sight of planning beginning to come to fruition after the first year of the ICB's existence, as demonstrated by the Sickle Cell and SEND updates • It was confirmed that the system has a number of priorities set out through CORE20 and CORE20PLUS, as well as other national priorities. The ICP has had a particular focus on mental health and CAMHS, as well as school readiness through a partnership between the NHS, local authorities and the voluntary sector.
1.6.3	The Board of Members **NOTED** the Report.
2.	**STRATEGY AND BUSINESS**
2.1	**National Delivery Plan for Recovering Access to Primary Care – NCL approach**
2.1.1	Sarah McDonnell-Davies introduced the paper, highlighting the following points: • This is one of the three major NHS recovery plans initiated post-pandemic • The pandemic triggered rapid change over a short period to the General Practice operating model, which led to new ways of working and the implementation of technology which had been in the pipeline but had not been fully rolled out • NCL practices now offer traditional access routes as well as rapidly-scaled digital routes such as e-consult and online appointment bookings • Following a brief dip at the height of the pandemic, access and activity in general practice have recovered, surpassed and never returned to pre-pandemic levels. Despite this, patient satisfaction, particularly regarding making a GP appointment, has reduced over the same period and it is important that the Board is seen to be addressing the patient experience around access as this drives people's views of general practice which in turn drives their views of the NHS more broadly • People are still extremely satisfied with the care that is being delivered – 89% of people feel that their needs are met when they see their practice team • The ICB needs to support the 180 NCL practices to think about the shift that has taken place in the operating model and within their teams, as well as the barriers to access • The plan presented to the Board outlines the NCL approach to the national requirements which will be implemented over the next two years in a stratified way, concentrating initially on those practices which need the greatest support. Key focuses will be on technology, reducing workload, the role that partners such as community pharmacy can play, increased self-management and self-referral and wider work to support the workforce • An update on progress will be brought to the next Board meeting in March 2024.
2.1.2	The Board then discussed the paper, making the following comments: • The primary care team was commended for making the national plan more bespoke for NCL, as was the wider primary care community for its willingness to embrace the challenge. This will ultimately act as an important foundation for the wider population health work taking place

	• It was cautioned that the system needs to be realistic about the fact that although the number of avenues to access primary care have increased, there is nevertheless a limited number of medical decision-makers in primary care, which is compounded by the recruitment challenge and there is therefore a need to rationalise what is handled by primary care as there is finite capacity – this means distinguishing between demand and need. • Recovering access is the fulcrum which a number of programmes are orientated around. Alongside the focus on recovery there is a range of other work which needs to be tackled together as an integrated care system, including the focus on long term conditions (LTC) and proactive care and secondary prevention, to systemically reduce inequalities. The training involved with the locally commissioned service (LCS) has an undeniable impact on primary care capacity but the LTC LCS will enable the system to focus its capacity and capability on genuine need. However, this cannot be done by general practice alone – working with wider partnerships will enable collective focus on population health. Better proactive care (such as optimising blood pressure and cholesterol) will also make it possible to rapidly reduce some of the need in non-elective care • It was noted that the combination of a 33% increase in activity and a 4% drop in patient satisfaction needed to be kept in perspective when considering the pressure that the system is under • However, although the response to the national plan set out in the paper is very comprehensive, it is unclear if there is an understanding of what is driving the increased demand and what conditions people are presenting with in primary care and what can be done proactively to address this. Quantifying locally what constitutes this 33% increase would facilitate local tailoring of the national suggestions to enable them to be more appropriately delivered in an impactful way • In light of the fact that the population is not homogenous, it was also questioned to what extent the ICB can tailor the available options in each primary care area in order to make the offers more accessible to the various communities in NCL • The plan and the significant amount of work to date were welcomed. However, the ICB needs to be mindful that there is a risk that it could further exclude different communities where English is not the first language • It was questioned what differential support can be offered to areas with high health inequalities and the most challenged practices • It was noted that deprivation is often another common factor and therefore access to Councils' support services would potentially have a stronger benefit for somebody repeatedly seeking medical support for debt-related anxieties, for example. It would therefore be helpful for the data to be broken down to highlight which conditions are generating repeated high demand and where this is happening and in which communities. The voluntary sector has an important role to play in the solution, over and above being an amplifier of messaging from General Practice • The tension between demand and need is a challenge for the whole system, not just primary care. It was queried how the ICB proposes to communicate the scale of the problem to the local population and enable them to understand the potential solutions • It is also important to factor in the extent to which the huge demand at A&E is being driven by the perception that people cannot access primary care. More work needs to be done to disaggregate the causes of this and potentially provide alternative forms of access • It is undeniable that people find it frustrating to access general practice and the level of demand compounds this. It is important to understand what can be done to influence the way that this is handled. Technology will play a significant role in the way that general practice works, alongside telephony and face to face care, but this needs to be implemented effectively. The ICB needs to work with all practices to ensure that the systems in place are properly implemented and it is taking a supportive multi-disciplinary approach to offer a holistic package of support to practices

	• Assurance was given that the ICB recognises that demand is a challenge – work is taking place to understand the presentations and think about how we might work differently to triage some of the demand. It would be helpful for the Board to have a longer discussion at a future date about the demand/capacity challenge and potentially promoting more of a focus on pro-active care and need rather than demand • Work is underway on developing the ambitions for primary care in NCL and this piece of work is being tied into a London-wide deliberation where some of these tensions and challenges will be presented and the public will be asked to wrestle with these. The NCL work will inform what is put on the table for discussion.
2.1.3	Mike Cooke observed that the paper provided a set of actions and plans in place to deal with a specific issue. While this work is a good thing in itself, there is more which needs to be done and there is a strong appetite among the Board to deal with the wider issues that the paper touches on, including workforce, needs versus demand and working in partnership with the voluntary sector, community groups and local authorities to develop a more holistic approach. He therefore asked Usman Khan as Chair of the Primary Care Committee (PCC) to take this conversation back to the PCC for a more in-depth discussion with the support of executive colleagues before bringing something back to the Board in due course.
2.1.4	The Board of Members **NOTED** the North Central London ICB response to the National Delivery Plan for Recovering Primary Care Access.
2.1.5	Action: Usman Khan to arrange for an in-depth discussion of the issues raised to take place at a future PCC meeting before a follow-up paper is brought back to the Board in due course.
2.2	**Mental Health Update**
2.2.1	Sarah Mansuralli and Jinjer Kandola introduced the paper, highlighting the following points: • The report highlighted the successes following the Board's earlier approval of the Mental Health Core Offer, as well as the challenges against a backdrop of rising demand and significant workforce issues • There has been good progress in delivering the Core Offer, particularly in addressing issues around access and inequalities in Adult Mental Health Services and Eating Disorder Services • As part of the implementation of the Core Offer, a gap analysis was conducted to facilitate a targeted approach to where funding needed to be directed and what services needed to be improved in different parts of NCL • NCL has also delivered against a set of nationally-mandated targets as part of the Long Term Plan which both reflects population needs but also some of the wider work programmes in NCL, such as Start Well • As part of improvements in quality and timeliness of care, NCL is now meeting Core 24 Mental Health Liaison Service Standards • NCL also benefits from its Mental Health Crisis Assessment Centres, an innovative model which service ambulance conveyances, direct referrals and walk-in patients • There has been a significant increase in demand for Child and Adolescent Mental Health Services (CAMHS) where there is also a number of infrastructure challenges, including providers using different systems and having different waiting list approaches and variations in the model of care – this is complicating progress • Workforce issues are impacting on the pace of delivering service improvements, particularly around having the appropriate qualified specialist staff • There is a lot of work taking place to use the VCSE sector to deliver things such as talking therapies and providing peer support • The CAMHS Thrive model has a lot of interdependencies with some of the early intervention and prevention services that the ICB is seeking to implement in the community. In order to do this effectively, collaborative work will be required with local authorities. Constructive conversations have taken place around this at the ICP but there is still much more to be done

	• Increasing demand and unmet need in CAMHS is particularly concerning and more work is needed around this • An increased number of people have signed up for Mental Health Nurse training but it will take three-four years for them to be in post. The attrition rate for Mental Health staff is also challenging so it is clear that something different is needed. This will include a greater focus on the use of digital and AI support as the workforce cannot be grown fast enough • The North London Mental Health Partnership is also working with the ICB People Board and Capital Nursing to identify any stop-gap solutions, while also looking at bursaries and apprenticeships. The Partnership is seeking to increase the number of staff living locally as this improves retention rates and is also working on ethical overseas recruitment • The Partnership has also experienced 28 days of industrial action over the year, which has resulted in more individuals presenting at ED, more people being admitted who are acutely unwell and lengths of stays going up which is impeding patient flow, leading to increased out of area placements • The Partnership is in a significantly better position than it was two years ago, as demonstrated by some of its performance compared to other parts of London but this is not where it wants to be and there is more work to do.
2.2.2	The Board then discussed the paper, making the following comments: • It was suggested that it might be worth considering whether Mental Health access and workforce should be recorded as strategic system risks • The balance of the report is currently more on the here and now rather than population health for understandable reasons, bearing in mind the immediate pressures, but it would be helpful to understand the ambition around a prevention concordat and hear more about Tier 1 services • It was noted that although the level of adult mental health illness in the population has largely remained stable, there has been a significant increase in its prevalence among young people and this is a global issue. As the provision of service has been sub-optimal for all age groups, the work that is being undertaken is absolutely essential but without a focus on the preventive element among young people the level of illness will rise even higher and training more staff will not be sufficient to manage this. These societal changes pre-date the pandemic, although the pandemic also exacerbated them. This will require work outside the health service, particularly in schools and communities, as a more lateral approach is the only way to reduce the burden in the future • It was agreed that Mental Health access and workforce represent a systemic risk. There has been a huge increase in demand since the pandemic, particularly in CAMHS, and at a national level the system is on the verge of a 'silent' crisis which may not grab national headlines but nevertheless tends to impact the most vulnerable in society, so it is vital that it receives the correct level of attention at regional and system level • The specific interventions taking place to get even better at what is currently being done were welcomed, as were inspiring initiatives such as the one supporting rough sleepers • It was noted that as part of the shift to a more preventive approach, it would be helpful for the Board to be more sighted on the number of people waiting to access Community Mental Health Services. Given that the drivers of increased demand include the cost of living and the pandemic, it was questioned whether there is more that can be done to help at a system level, such as drop-ins to discuss anxieties about personal finances, and whether there are other collaborative approaches which might assist • The fact that the paper looks from primary care upwards was welcomed but it was suggested that it lacks an analysis of where things are across the five Boroughs and what is needed in terms of people's outcomes. It would also have been helpful to have had more illustrations of Thrive in the paper

	• It was noted that it was important to recognise what has been achieved to date. For instance, the innovative Mental Health Assessment Service (MHAS) is a pioneering service which is not currently replicated in most of the country. NCL has also rolled out core mental health teams which work collaboratively between statutory services, peer support and the third sector. However, although there is good support for acute need, the availability of support at the 'lower' level, such as waiting months for a psychology appointment, needs to be strengthened but there also needs to be an emphasis on community support to avoid people feeling isolated • In response it was noted that the system needs to recognise pockets of excellence and make them standard. The development of core teams, building on good practice in one area in Camden, was cited as a good example of this • It was acknowledged that there is now a need to focus on early intervention and prevention. A large amount of time is devoted to supporting people in crisis but people need more help with maintaining mental health in a good state. There are examples of good practice, such as the service user-led Thumb networks, which warrant further attention • In response to the challenge to think more radically it was suggested that there is a need to think differently about CAMHS, which has the highest vacancy rates across the five boroughs and growing demand. More thought is needed about the best model to help young people and their families with prompt access to diagnostics and then getting people into treatment • Mental Health Trusts are often not good at articulating their 'waits' and outcomes, so the focus on the Patient Tracking List and getting accurate data will help in this regard.
2.2.3	Mike Cooke observed that there was a clear consensus among the Board that the paper describes significant progress from where things stood two years ago but there is also a real appetite for thinking about the challenges in a much more rounded way, with partnership and preventative working at its heart. He asked Jinjer Kandola to take away these reflections for consideration at a future Board Seminar. It is important that CAMHS forms part of this discussion due to its criticality. He also observed, based on this paper and the preceding one, that it feels as if the ICB has reached a point in its development where all papers of this nature need to be considered in this more rounded way. It would therefore be helpful for Frances O'Callaghan and Phill Wells to lead a discussion among the Executive team around what this might mean for the preparation of papers so that this preventative perspective is established in the papers before the meeting.
2.2.4	The Board of Members **NOTED** the report.
2.2.5	Action: Jinjer Kandola to lead a discussion on Mental Health at a future Board Seminar, building on the discussion at today's meeting.
3.	**OVERVIEW REPORTS**
3.1	**Integrated Performance and Quality Escalation Report**
3.1.1	Chris Caldwell and Richard Dale introduced the paper, highlighting the following points: • NMUH had been officially moved out of Tier 1 oversight by NHS England since the Board last met, in recognition for reducing their 62-day Cancer pathway backlog and improving Faster Diagnosis Standard (FDS) performance • NCL is the best-performing ICB around the number of people waiting six months for diagnostic tests but further improvement is still needed • The industrial action is continuing to have a cumulative impact on the elective recovery programmes, with providers needing to recalibrate how theatres are used to ensure that cancer pathways are prioritised • NCL is slightly below trajectory to achieve its 76% target for A&E 4-hour waits by the end of the financial year. The ICB is working with sites to look at winter plans and consider whether anything needs to be brought forward to ease pressure • Work is also underway to understand the reason for the large number of patients spending more than 12 hours in ED as this was not experienced before the pandemic and is probably linked to issues around patient flow • Trusts are working to quantify the impact of the aforementioned challenges on patient outcomes

	• The ICB is beginning to triangulate staffing, safety and performance in ED to understand the impact on staff of having to frequently make difficult decisions • All NCL maternity units have undergone post-Ockenden visits by the CQC and outcome reports will be published in due course. In the meantime, maternity will continue to be a major focus as the system moves into the three-year maternity and neonatal delivery plan • NCL has been the best performing ICB in London and also one of the best in the country for the delivery of the Covid and flu vaccination programme targeting people who are housebound and in residential care.
3.1.2	The Board then discussed the paper. It was noted that some of the increased demand is caused by the inability of the system to manage pro-active care as highlighted earlier, leading to a deterioration in people's conditions and resulting pressures on acute pathways. Focusing on different ends of the pathway in the medium to longer term will help the system to intervene, especially in secondary prevention, in order to reduce some of this demand.
3.1.3	Mike Cooke noted that the paper and comments reflect good progress in some key performance areas but the overall position remains extremely challenging. It is nevertheless encouraging to see the strength of the ongoing partnership working across a complex system.
3.1.4	The Board of Members **NOTED** the key issues set out in the paper for escalation and the actions in place to support improvement.
3.2	**Finance Report**
3.2.1	Phill Wells introduced the Month 6 Finance Report, which set out the financial position for the ICS as a whole and in more detailed form for the ICB. He highlighted the following points: • At Month 6 the ICS reported a deficit of £87.6m, against a planned deficit of almost £57m • The second half of the year will be particularly important, both in terms of the phased recovery of this position and the planned non-recurrent support • The industrial action is continuing to have a financial and operation impact on the ICS. If the direct costs of the industrial action were stripped out, as well as the resulting 'lost' Elective Recovery Fund (ERF), NCL would actually be ahead of the challenging plan it set itself at the start of the year • The ICS is continuing to forecast a break-even position at the end of the financial year. However, this is dependent on three important assumptions: there will be a national remedy for the impact of the cost of the industrial action; providers and the ICB will continue to deliver their efficiency programmes; and the planned non-recurrent support is delivered by providers and the ICB • The report also highlights the underlying impact of prescribing costs being higher than expected due to inflation. Complex healthcare packages post-discharge are also proving more expensive than anticipated. The national team is aware of this cost pressure • The expected system risks are now starting to crystalise, as a number of organisations have begun to report emerging issues which they had not taken account of. These risks will need to be managed in line with provider plans as there is no scope for movement against the financial positions that were originally set • The ICB is still on target to deliver its £10.6m surplus – this will be used to support the ICS to deliver a break-even position. The organisation's design work will provide a structure to help the ICB to meet its running cost allowance for 2024/25 and also help in the tail-end of 2023/24 • A constructive discussion was held recently with the Finance Committee about the overall level of financial risk and a number of these risks will be carried into the planning for 2024/25. .
3.2.2	The Board of Members discussed the paper, making the following comments: • The Finance Committee has welcomed the assurance from the increased ability to track the figures presented and the system is now better able to model and predict, which helps with medium term strategic financial planning

	• The second half of the financial year will be particularly challenging, so it is important to avoid complacency.
3.2.3	The Board of Members **NOTED** the Finance Report.
3.3	**Board Assurance Framework (BAF)**
3.3.1	Ian Porter introduced the paper, noting that a refresh had been undertaken with Executives and Board Committees since the previous meeting, and he thanked all concerned for their input. He then highlighted the following points: • Four risk scores had been reduced since the previous meeting and two risks had been closed • Three new risks have been opened relating to the delivery of the financial plan, meeting the running cost allowance in future years and the costs of Continuing Healthcare/Complex Individualised Commissioning packages of care • Further thought will be given to the opening of a mental health risk in the context of the risk deep dives, building on the comments earlier in the meeting • The support of the Audit Committee, as the ICB's approach to risk management continues to evolve, was welcomed. PWC have recently undertaken a national benchmarking exercise of BAFs and overall the ICB's approach compared extremely well.
3.3.2	The Board of Members discussed the paper, making the following comments: • The huge amount of work by Executives and Committees on the refresh was acknowledged. This will provide a strong platform for the planned risk deep dives • The risk around mental health could potentially be framed as the risk around people not being able to access the treatment they need in a timely way or the fact that there is an increasing number of young people with mental health conditions which, if not helped, will lead to a deterioration in population health.
3.3.3	The Board of Members **NOTED** the Board Assurance Framework.
4.	**GOVERNANCE**
4.1	**Update to Governance Arrangements**
4.1.1	Ian Porter highlighted that the proposed changes to the Primary Care Committee Terms of Reference will provide the Committee with increased capacity to undertake more strategic work and undertake deep dives. The changes to the Procurement Oversight Group Terms of Reference will provide extra strength in governance to oversee the new Provider Selection Regime arrangements. The Board will receive a briefing on this in due course.
4.1.2	The Board of Members then discussed the paper. It was questioned how the ICB uses its procurement leverage to promote social value, such as supporting local businesses, good employment practice and the green agenda, as this was not explicitly referenced in the Procurement Oversight Group (POG) Terms of Reference. It was clarified in response that the Procurement Policy sets out some of these principles. The ICB has developed a pre-procurement checklist and the POG ensures that procurements are enacted in line with the policy. The policy is currently being refreshed to incorporate recent internal audit recommendations and also to align it with the Commissioning Handbook. It was agreed that Sarah Mansuralli would circulate to Board Members a summary of the policy and the ICB approach to procurement
4.1.3	The Board of Members: • **APPROVED** the Primary Care Committee Terms of Reference; • **APPROVED** the Procurement Oversight Group Terms of Reference; • **APPROVED** the Quality and Safety Committee Terms of Reference; • **APPROVED** the Integrated Medicines Optimisation Committee Terms of Reference; • **APPROVED** the amendments to the Standing Financial Instructions; • **APPROVED** the amendments to the Functions and Decisions Map and to other governance documentation.

4.1.4	Action: Sarah Mansuralli to circulate to Board Members a summary of the ICB Procurement Policy and its approach to procurement.
5.	**ITEMS FOR INFORMATION AND ASSURANCE**
5.1	**Update on the Delegation of Commissioning of Specialised Services**
5.1.1	The Board of Members **NOTED** the update on the Delegation of Commissioning of Specialised Services.
5.2	**Minutes of the Audit Committee Meeting on 6 June 2023**
5.2.1	The Board of Members **NOTED** the minutes of the Audit Committee.
5.3	**Minutes of the Finance Committee Meetings on 13 June and 5 September 2023**
5.3.1	The Board of Members **NOTED** the minutes of the Finance Committee.
5.4	**Minutes of the Integrated Medicines Optimisation Committee Meeting on 6 June 2023**
5.4.1	The Board of Members **NOTED** the minutes of the Integrated Medicines Optimisation Committee.
5.5	**Minutes of the People Board Meeting on 15 May 2023**
5.5.1	The Board of Members **NOTED** the minutes of the People Board.
5.6	**Minutes of the Procurement Oversight Group Meetings on 21 March and 19 July 2023**
5.6.1	The Board of Members **NOTED** the minutes of the Procurement Oversight Group**.**
5.7	**Minutes of the Quality and Safety Committee Meeting on 23 May 2023**
5.7.1	The Board of Members **NOTED** the minutes of the Quality and Safety Committee.
5.8	**Minutes of the Strategy and Development Committee Meeting on 5 July 2023**
5.8.1	The Board of Members **NOTED** the minutes of the Strategy and Development Committee.
6.	**ANY OTHER BUSINESS**
6.1	There was no other business.
7.	**DATE OF NEXT MEETING**
7.1	The Chair noted that the date of the next formal Board Meeting was 26 March 2024. However, Executive colleagues had informed him of the need to make a small segment of the Board Seminar on 7 December 2023 a Board Meeting in public.
8.	**PART 2 MEETING**
8.1	The Board of Members **RESOLVED** that as publicity on items contained in Part 2 of the agenda would be prejudicial to public interest by reason of their confidential nature, representatives of the press and members of the public should be excluded from the remainder of the meeting.