NHS
North Central London
Integrated Care Board

Minutes
Meeting of NHS North Central London ICB Board of Members
26 March 2024 between 2pm and 3.30pm
Clerkenwell Room

Present:	
Mike Cooke	Chair, NCL Integrated Care Board
Phill Wells	Interim 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
Richard Dale*	Executive Director of Performance and Transformation
Usman Khan	Non-Executive Member
Sarah Mansuralli*	Chief Strategy and Population Health Officer
Sarah McDonnell-Davies*	Executive Director of Place
Sarah Morgan*	Chief People Officer
Bimal Patel	Chief Finance Officer
Ian Porter*	Executive Director of Corporate Affairs
David Probert	Chief Executive, UCLH NHS Foundation Trust
Dr Jo Sauvage	Chief Medical Officer
Liz Sayce	Non-Executive Member
In Attendance:	
Paul Allen	Assistant Director of Strategy, Communities and Inequalities
Sarah D'Souza	Director of Strategy, Communities and Inequalities
Rebecca Kingsnorth	Assistant Director for Primary Care Programmes and Transformation
Apologies:	
Cllr Kaya Comer-Schwartz	Leader, Islington Council
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
Mark Lam*	Chair, Royal Free Hospitals and NMUH
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
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.

* Standing Participant

1.1.2	Apologies had been received from Cllr Kaya Comer-Schwartz, John Hooton, Jinjer Kandola, Mark Lam, Dr Jonathan Levy, Baroness Julia Neuberger and Dr Alpesh Patel. David Probert was attending on behalf of Baroness Neuberger.
1.2	**Declarations of Interest relating to the items on the Agenda**
1.2.1 1.2.2	Mike Cooke invited Members to declare any interests relating to items on the agenda. There were no additional declarations. 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 Meetings on 7 November and 5 December 2023**
1.3.1	The Board of Members **APPROVED t**he minutes as accurate records.
1.4	**Matters Arising**
1.4.1	The Board of Members **NOTED** the Action Log.
1.5	**Report from the Chief Executive Officer**
1.5.1	Phill Wells provided an overview of the report. He began by thanking everybody involved in responding to the system pressures over recent months and then highlighted the following points: • The Urgent and Emergency Care pathway has been a particular focus, particularly because of the imperative to achieve 76% four-hour wait performance across England. This work is starting to have an impact and over the last few days all sites have achieved 70% at least once. There is a strong system focus on supporting NMUH, which is one of NCL's most challenged sites, as well as recent work with LAS and colleagues at other Trusts around the 'postcode flow' for that hospital • Barnet Hospital has declared two business critical incidents in recent weeks, mainly because of discharge capacity and this has therefore also been a strong focus for the system • Cancer performance in NCL has improved significantly since the previous Board meeting and the 62 day backlog has been reduced to below 500 (the lowest figure since June 2021), although it is acknowledged that this number is still too high • NCL remains on track to deliver a break-even financial position at year-end. This is a testament to the hard work across the system on achieving financial outcomes alongside the performance metrics. The financial outlook for 2024/25 for London and across England is extremely challenging and work on setting the financial plan for 2024/25 remains ongoing. The ICB's financial performance in 2023/24 means that NCL CCG's historic debt will be written off. This will be a significant boost to both the ICB and the system going forward • The Start Well public consultation has now concluded. Hundreds of stakeholder and community events have been held across NCL over recent months and the responses to the proposals are now being analysed before a final decision is taken • The new Population Health Outcomes Framework, which has been published on the ICB website, starts to show transparently the metrics that the ICB is seeking to improve. This Framework will be regularly referenced in the future as the ICB makes progress • The Change Programme is now in its final stages as the ICB stands up the new organisation on 1 April 2024 and meets its financial obligation regarding the reduced Running Cost Allowance.

	• The significant focus will now be on how colleagues work with each other and external partners in the new structure, the leadership capacity required to make this successful, the development of high-performing teams and continuing to deliver efficiency and efficacy through the work of the ICB • The ICB has received a change of control notification from AT Medics, who hold eight GP contracts in NCL. Contract holders are required to obtain the consent of the commissioner as part of the change of control process. The ICB is working with London colleagues to understand what this will involve and have also shared this request with the public via multiple channels to give people the opportunity to ask questions and inform the due diligence process. A final decision on the change of control request will be taken in due course at a meeting of the Primary Care Committee.
1.5.2	The Board then discussed the paper, making the following comments: • In response to a query about the impact of the fertility clinic at the Homerton Hospital having its licence suspended, it was noted that issues had been experienced for some time around access to Homerton services and alternative arrangements have been put in place to ensure that NCL can offer choice to local residents. The new ICB Fertility Policy will also serve to address this by mitigating some of the risks associated with provision at the Homerton not being available • The progress made in the past 12 months since Dental Services were delegated to the ICB and the plans to embed transformational changes was commended • The impact of the Wood Green Community Diagnostic Centre and its continuing expansion since its opening in 2022 was also praised.
1.5.3	The Board of Members **NOTED** the Report.
2.	**STRATEGY AND BUSINESS**
2.1	**Population Health and Integrated Care Strategy – NCL Joint Forward Plan**
2.1.1 2.1.2	Mike Cooke highlighted that the Board was being asked to approve the paper, rather than note it. Sarah Mansuralli then provided an overview of the report, highlighting the following points: • The document follows on from the discussion at the Board Seminar in February where it was agreed to bring together the Joint Forward Plan that had been produced for NHS England and the Delivery Plan that had been developed to underpin the Population Health and Integrated Cate Strategy • The document therefore sets out the progress and key achievements over the past 12 months and looks at how NCL will build on this going forward to maintain momentum and continuity over the next 18 months • As the Joint Forward Plan needs to be published on the ICB website, this presents an opportunity to communicate to residents the work taking place around Population Health • The slide deck contains place holders for design content and pictures to be added, subject to the Board approving the content • The content of the Delivery Plan reflects much of the work undertaken since the Population Health and Integrated Care Strategy was approved in April 2023 and sets out the critical path which NCL needs to follow in terms of focusing on outcomes. The Plan will be refreshed annually while still working to the 18 month horizons which have been drawn up and will evolve in terms of the clarity of the deliverables and how they are measured, supplemented by an Annual Outcomes Report • A cycle has been built into the delivery planning for monitoring and oversight, giving the system the ability to track progress and understand where it is making a difference as well as identifying where corrections might need to be made. The Outcomes Framework dashboard will be integral to this

	• A large amount of engagement work has taken place with different parts of the system around how the dashboard can be used to provide insight into the work that is taking place. As part of the next phase the Borough Partnerships and system transformation programmes will apply the Outcomes Framework to look at the current position in different areas and consider future aspirations within the 18 month cycle • The Outcomes Framework will enable the Delivery Plans to become more granular in terms of year on year goals • This work will remain in a state of evolution and will be brought back to the Board at regular intervals with regards to both an annual report and a refresh of the Plan, as well as a separate Outcomes Framework annual report.
2.1.3	The Board then discussed the paper, making the following comments: • The collation of the achievements to date was welcomed. • Assurance was given that the different priorities for various parts of the system are all aligned to the Population Health and Integrated Care Strategy and often overlap as enablers for work to be delivered effectively in other parts of the system. • The Delivery Plan recognises that there has been a large amount of mapping of the work of the Borough Partnerships which has identified that although much excellent work is taking place in each partnership, there is an opportunity to refine and hone this to focus on the key Population Heath risks at Borough Partnership level • The Integrated Care Partnership (ICP) recognises that through their endorsement and support, as well as their collective focus and resources, system changes can be more impactful. The 'supercharged' improvement in vaccinations and immunisations is a prime example of this. Heart health is another example of an area where the ICP is seeking to supercharge change • It was noted with regards to the opportunities afforded around greater use of digital and greater personalisation that activation levels are important in terms of self-care and health improvement but activated patients tend to be from the less deprived local population, so it important to apply an inequalities lens when promoting self-care to avoid entrenching wider disparities. • It was agreed that it would be helpful to use any engagement around the Delivery Plan as an opportunity to impart messages around self-care and lifestyle choices to develop a shared approach with residents around managing their health • It was noted that although the Long Term Conditions which are not currently treated to target tend to be fairly universal across the local population, the approach will need be tailored for different communities to gain people's trust and encourage them to come forward, as that is currently one of the largest barriers to equitable access • It was highlighted that a piece work was carried out on personalisation and self-activation a few years ago, culminating in a paper published by the Health Foundation, which measured the activity of Islington residents across all practices and then triangulated levels of activation with long-term conditions and outcomes. That retrospective information can be applied to the current population in the context of managing and optimising the treatment of hypertension. • New modelling which was recently reviewed by the ICB Executive Management Team can look at the level of additional intervention and support that people may need to improve their activation. Calculations can be undertaken on the return on investment by looking at the population and different levels of risk, the cost of various interventions and how that then translates into return on investment by optimising care proactively • It was clarified that patient activation signifies a person's health literacy based on a questionnaire which provides an understanding of the sort of barriers that an individual might encounter when engaging with an intervention, as well as their confidence, motivation and ability to change • It was noted that a large amount of the local population overlaps in different priority cohorts in the individual priorities and it would therefore be beneficial for different treatments to be provided under one roof, rather than having people treated in isolation

	• In response it was noted that the Integrated Neighbourhood Teams are beginning to develop a team around the individual patient but this team must not detract from the fact that patients wants to see a health professional, so it is important not to seek to replace that. Some of the more complex patients may well benefit from a more integrated and rapid response team. Work is taking place with the Provider Alliance to consider how the Alliance might do some very specific work, utilising some of the capacity and capability of specialists in the system to provide some of that rapid 'wraparound' assessment treatment. However, this will need to be closely integrated with primary care and the voluntary sector so that is fully embedded • The coherency of the multiple actions and the plans sitting beneath them was welcomed. It was suggested that it would be helpful for individual actions to be brought together for the Population Health Committee to assess whether they are making a difference to Population Health at scale and whether inequalities are being addressed. It was also suggested that there is scope to improve some of the measurements – for instance, a 3.5% increase in immunisation coverage may not be a meaningful metric in the context of the threshold needed to prevent outbreaks • It was acknowledged that some of the entries need to be more robust and the offer for the Population Health Committee to follow this up and carry out further work was welcomed • The references to health equity were welcomed as a particularly positive way of framing the need to avoid increasing health inequalities. It was suggested that that the emphasis on this point could perhaps be strengthened in the document • The achievement in distilling so much complex information into one document was applauded. However, it was suggested that the document would benefit from greater clarity around what is meant by an input and an outcome, as well as some of the timeframes before any wider engagement. Greater clarity around the priorities would also strengthen its Impact • It was recommended that the Plan should be published in its current form for the time being, prior to Jane Simmonds (Director of Communications and Engagement) and her team producing a resident-friendly version • It was noted that although the cover sheet refers to getting the Delivery Plan designed under the next steps, the key next step will actually be to deliver the priorities • In response to a query about what area had exceeded expectations this year and which one has proved particularly challenging, it was noted that progress has been easiest when plans have already been in place to deliver early on, with attached resources and clear understanding of responsibility for delivery. The work on speech and language therapy, where investment has gone into more deprived areas with a clear focus on addressing inequalities is a prime example of this and its impact is already visible through things like the SEND inspections. By contrast, achieving progress is more challenging when trying to deal with something more amorphous across the system where it is unclear where responsibility lies and resourcing is more complex. This is an area where the system will need to improve if it is to achieve its Population Health ambitions.
2.1.4	Mike Cooke welcomed the discussion and recommended that it should be developed further at the next meeting of the Strategy and Development Committee.
2.1.5	The Board of Members: • **APPROVED** the NCL Delivery Plan • **NOTED** the development of other resident-friendly products to support the communication of work the ICB and partners are doing to improve population health • **SUPPORTED** the prioritisation of the work set out in the NCL Delivery Plan through 2024/25.
2.2	**Sustainable Healthcare: Green Plan Annual Report**
2.2.1	Jo Sauvage and Sarah D'Souza provided an overview of the Annual Report, highlighting the following points:

	• It is recognised that some of the datasets are being collated at a national level, which means that NCL Is potentially seeking to deliver in an environment where there is a time lag in how some of the aggregate data is captured • Since the discussion at the Board Seminar in February the ICB has met two inhaler emissions targets in Quarter 3 and has also stopped the use of desflurane • NCL carbon admissions data for 2021/22 has now been received from NHS England and will provide a helpful baseline to measure future progress across the 10 local Trusts. As the 2022/23 data is unlikely to be available until February 2025, the ICB is working with NHS England (London) in the meantime to understand its position comparative to other London ICBs. The latest pack of benchmarking data shows that NCL is performing well around inhalers and anaesthetic gases but further progress is needed to catch up with other London ICBs around procurement, supply chain, travel and transport. This information will be used to refine and iterate the NCL plan to ensure focus on areas of greatest impact • To date the ICB has cut its cloth to meet its resource and expertise but there has not been any additional national funding for structural changes which might be required around particular estates to make them more energy efficient. This accounts for 75% of the emissions in NCL. • Although strong collaborative relationships have been developed there are some tough challenges ahead. The first is around dedicated capacity, particularly around programme management and clinical support. Active discussions are currently taking place with Trusts about how this is done collaboratively • To partially address the funding challenge, the ICB will investigate Green Investment Bonds as it believes that there is a potentially 'easy win' around investment and demonstrable savings going forward. Community Infrastructure Levies will also be looked into • The report highlights that support will be required from the regional and national teams in order that better use is made of system levers to incorporate this work into planning processes going forward.
2.2.2	The Board then discussed the paper, making the following comments: • The challenge to the Board to commit to actions was welcomed. However, with regards to the specific recommendation that the Board should commit to supporting the decisions that can be made as an ICS to speed up the pace of change, it would be helpful for the Board to have visibility of these decisions and hard choices, as well as where and when they are going to be made within the governance structure • Since the ICB knows the relative contribution and footprint of the things that have been done and has baseline data, it was queried whether it would be possible to project where NCL is in the trajectory to meet the target for 2040 while awaiting data that will only be available in 2025 • In response it was confirmed that the ICB will be looking in more detail at the material available from NHS England and the extent to which it can forecast forward based on its activity. This information is now available at a granular level by Trust as well as differential outputs, so this will also help the ICB to focus on its biggest areas of opportunity • The key contribution played by the Primary Care Network pharmacists in the achievement of the inhaler emissions targets was highlighted • It was noted that UCLH had declared a climate emergency in 2021. The main driver behind this was the fact that this is an issue which the workforce cares passionately about. This level of engagement and best practice has been shared more widely over time as staff move around the system • It was suggested that the ICB should set aspirations for hospitals and GP practices that all organisations can meet and which do not require capital investment • A key contribution that can be made through the model of care is to reduce where possible the need for patients come into hospital, building on the shift to more online consultations that occurred during the pandemic

	• Tackling the climate crisis will require systemic engagement because this will impact the disease profile and the ability to tackle it. The system needs to create a culture where people feel energised to do something positive while also helping to allay some of the climate anxiety that is prevalent • Maintaining the prominence of this piece of work is therefore vital. The ICB will be meeting Hannah Whitty, Regional Finance Director and convening a round table session to facilitate a system conversation about how some of the financial levers might be aligned slightly differently • Assurance was given that work is taking place with the Estates Board and the Local Care Infrastructure Delivery Board to ensure that green issues are embedded, as well as with the Digital Board around digital-related emissions • It was agreed that it would be helpful to take a paper on the work taking place around social value to a future meeting of the Population Health Committee. The ICB is demonstrating strong leadership in this area, particularly around its own social value procurement.
2.2.3	Mike Cooke thanked Members for their observations which would be absorbed and followed up. He commented that it would be helpful if the Estates Board could be asked to confirm its approach to building improvements/new builds through a green lens, while acknowledging issues around affordability.
2.2.4	The Board of Members: • **NOTED** the progress made to deliver the Green Plan in 2023/24 and the work planned for 2024/25 and the further support required to deliver the ICB's ambitions • **NOTED** the challenges identified to making greater progress in 2024/25, the scaling back of plans in line with resource/capacity and the raised risk to achieving net zero targets • **COMMITTED** to actions identified to champion sustainability as Board members and system partners.
2.2.5	Action: Sarah Mansuralli to bring a paper on the ICB work around social value and anchor for discussion at a future Board Seminar.
2.2.6	Action: Bimal Patel to arrange for the Estates Board to review its programmes/projects of work, ensuring appropriate attention is paid to the 'Green' agenda.
2.3	**Primary Care Access Recovery Plan**
2.3.1	Sarah McDonnell-Davies provided an overview of the report which summarises progress since the previous presentation to the Board in November 2023 and marks the end of the first year of a two year programme of work. She highlighted the following points: • There has been significant work at practice level since November on systems and processes, ways of working and interfaces such as GP websites. The practice-level change support offer has been mobilised. This is a mixture of clinical leadership operational expertise and digital change facilitators, reflecting the focus on embedding digital tools and ways of working • Supplementary communications and engagement activity has been commissioned • Additional enhancements have been made over and above what is required with regards to digital inclusion, including funding pilots in each Borough which connect practice teams to the voluntary sector, as well as developing an impact monitoring approach • As the programme moves into its second year it is anticipated that demand will continue to outstrip capacity and resources in general practice so there will be a need to think about the multiplicity of approaches that can help practices and the system address that challenge. This will include things such as self-service, greater self-activation and the role of technology • The role of Community Pharmacy will be expanded, including a commissioned Pharmacy First scheme that will enable over the counter medications to be provided free of charge to patients who cannot afford them, to ensure that pharmacy pathways can be effectively used by all residents

	• The strategic estates planning work has also been brought into this programme to consider what the modern general practice access model means for the estate in order to align capital to primary care in NCL and to convert and modernise the estate, particularly to enable clinical intervention and face to face care • Going forward, discussions will need to take place with Trust colleagues about the interface between primary and secondary care as this will need co-production with acute colleagues because this is the aspect of recovery planning that areas are finding most challenging.
2.3.2	The Board then discussed the paper, making the following comments: • It was acknowledged that almost half of the NCL general practice estate was built before 1948 and the vast majority was built before 1990, so far more progress is needed to create a primary care infrastructure which is truly fit for purpose. That said, discussions are more mature in NCL than most other areas, to the extent that NCL is the only ICB to have allocated 5% recurrently of its capital funding to general practice. Nevertheless, it will take decades for the general practice estate to reach the state that it is needed, so the ICB will need to continue to talk to the Estates Board and system colleagues about how this might be addressed • The need to have a system in place to monitor prescribing through ARRS (Additional Roles Reimbursement Scheme) and Pharmacy First was highlighted. In recent years the ICB has provided practices with excellent education around prescribing but these groups will not be part of that envelope, so it is important to ensure that they are prescribing appropriately and cost-effectively while also operating within their remit • In response it was noted that the ARRS workforce has been crucial in recent years but this scheme is drawing to a close so there is a question about how the workforce challenge will be met if demand continues to grow. The role of the GP will be critical to this. • Assurance was then given that the Integrated Medicines Optimisation Committee (IMOC) has discussed Pharmacy First prescribing previously. It was recognised that there will be a need to closely monitor quality, prescribing patterns in terms of appropriateness and cost, as well as potential conflicts of interest • Although the focus in the paper on digital was welcomed, concern was expressed about practices often lacking laptops and PCs. It was suggested that extra funding from the ICB is required to address this • In response it was noted that there had been a revolution in the general practice operating model during the pandemic, centred significantly around digital and IT, but sustaining this, let alone developing it, will be challenging • It was further clarified that the GPIT funding allocation covers hardware in practices, rather than laptops for remote usage, although ICBs were allowed to purchase laptops non-recurrently during the pandemic. It would be helpful to have discussions with practices about the optimum 'mix' going forward as part of the Digital Strategy which is currently being refreshed • The strong rationale for the decision taken to support practices with 5% of the capital allocation which has traditionally gone to secondary care providers was highlighted. Practices occupying the worst of the NCL estate have fewer GPs per head of population and therefore more conveyances to A&E as a result and also offer fewer training places than those in higher quality estate, so there is a clear argument for investment in primary care estate. • The system needs to continue to make the case collectively to NHS England and the Treasury to invest in this part of the health system as the capital regime does not support it well enough and as a result there is a reliance on organisations seeking support through the Community Infrastructure Levy/Section 106 and other funding sources to fund the kind of development that is needed. NCL's ambitions exceed the amount of money available and it is the capital regime which is the constraint. The ICB may need to be more creative about sources of finance to support the rebuild of the primary care estate over the next decade • It was suggested that it would be helpful if some metrics could be included in future reports about what this work means for the primary care workforce, including their satisfaction levels

	• Recognising the need for capital and revenue, it would be helpful to review the Primary Care infrastructure position (estates and digital) at a future Board Seminar • The level of engagement from practice teams, despite them often being under intense pressure, was acknowledged • Assurance was given that the ICB has worked with the voluntary sector and primary care in multiple ways over recent years, including call and re-call and work on high intensity users. However, the prevention agenda is a huge untapped opportunity for integrated working between primary care and the voluntary sector. There are significant gaps which the voluntary sector can help to fill in terms of access based on need rather than demand.
2.3.3	The Board of Members **APPROVED** the Primary Care Access Recovery Plan.
2.3.4	Sarah McDonnell-Davies to arrange for the Board to review the Primary Care infrastructure position (estates and digital) at a future Board Seminar.
3.	**OVERVIEW REPORTS**
3.1	**Integrated Performance and Quality Escalation Report**
3.1.1	Richard Dale and Chris Caldwell introduced the paper, highlighting key points and providing further updates since the paper was published: • NCL continues to be one of the highest performing ICBs in the country in respect of access to diagnostics – this is a credit to the system working across the Diagnostic Network • Excellent progress has been made on reducing the number of mental health out of area placements which have decreased by almost 50% compared to the previous quarter. However, there has recently been a slight increase so there is a system focus to understand the cause of this • At an aggregate level, practices are consistently meeting the national expectation that 90% of primary care appointments are booked within 2 weeks • There are continuing challenges around access to CAMHS in the community – this is an area that will require particular attention as part of the planning for 2024/25 • There is a still a number of patients who have been waiting longer than 104 weeks for treatment, the majority of whom are paediatric dentistry patients being treated by GOSH. Work is taking place with other providers and the national team to address this • The recent industrial action has had a negative impact on the ambition to eliminate the 78 week waiters. The ICB is leading a collaborative system approach to clearing the backlog through mutual aid and demand management initiatives • The ICB needs to maintain a strong focus on three Urgent and Emergency Care metrics: A&E performance, ambulance handovers and 12 hour breaches. Although improvements are being made in all three areas, there is nevertheless day to day volatility. The consistent application of clinical practice will be key to overcoming this • All sites are continuing to experience significant numbers of medically optimised patients. This is posing operational challenges as most sites are operating at or above 100% basic capacity. These numbers are being reviewed daily by pathway so that patients can be escalated as quickly as possible. A concerted plan will be needed to ensure that the system has moved to a different position by the summer • Over the next 12 months future iterations of the report will include more horizon-thinking, using the Outcomes Framework to take a broader view of the health and care system • The ICB has been supporting organisations' applications to the Maternity Incentive Scheme which supports the delivery of safer maternity care. Although the Royal Free, UCLH and Whittington Health were fully compliant with the 10 safety actions, NMUH did not meet two of them, so the ICB will be working with the Trust over the next year through the Maternity and Neo-Natal system as part of their wider improvement programme • The ICB is in the final stages of completing a dashboard for maternity performance which will also help to demonstrate that it has leadership and oversight of maternity services in the same way that it does for Urgent and Emergency Care

- A future report will include more information about the support being given to people with learning difficulties, particularly with regards to annual health checks and how they are then acted on, as well as the learning from the deaths of people with learning difficulties.

3.1.2 The Board then discussed the paper, making the following comments:

- It is important to note that considerable progress has been made outside the periods of industrial action. Unfortunately there is now the possibility of further industrial action which could have an even greater impact than it has to date
- The excellent work of the Cancer Network, which brings together colleagues from providers and primary care, is a key factor in the progress on cancer targets.
- Although the progress on reducing diagnostic waiting times was welcomed, the figures remained concerning and it is imperative to avoid them becoming normalised

3.1.3 Mike Cooke concurred with this comment and reflected that although it is important to focus on where things have gone well and the excellent work taking place, this is in the context of also highlighting the downsides which need to be addressed.

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 Bimal Patel introduced the Month 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:

- NCL ICS is reporting a £71.1m deficit at Month 10 (£56.2m excluding the impact of industrial action). This is adverse to plan by £35.7m. The forecast out-turn at Month 10 is a deficit of £15.5m. However, during Month 11 the system has received funding for the direct cost impact of the industrial action. Via the ICB and providers the ICS has been able to consume the pressures relating to the indirect costs on a non-recurrent basis. Costs include lost activity and lost efficiencies. The system is therefore still forecasting a break-even position at year-end.
- As stated earlier, the ICB's financial position will enable NCL CCG's historic debt to be written off. This achievement will also result in a capital incentive for the ICB for 2024/25. This is likely to be in the region of £4-6m depending on the final NHS financial position.
- Provider efficiency within the ICS shows a shortfall, which is partly, but not entirely, due to the industrial action. The impact of this will be carried over into next year as part of underlying deficits
- The capital position is slightly over plan but this will be mitigated in Month 12
- The ICB is reporting a £0.1m adverse position against plan at Month 10 which will be mitigated in Month 11. Non-acute is overspent by £24m, mainly around Continuing Healthcare, prescribing and primary care co-commissioning. These forecast overspends are largely off-set by the ARRS (Additional Roles Reimbursement Scheme) allocation which has been subsequently received in Month 11 and the dental underspend.

3.2.2 The Board of Members **NOTED** the Finance Report.

3.3 Board Assurance Framework (BAF)

3.3.1 Ian Porter introduced the paper, highlighting the following points:

- Two new risks have been added to the BAF regarding the capital programme and the St Pancras Hospital Transformation Programme
- The risk concerning patient flow at peak times has been closed on two grounds: a set of 24/7 operating procedures is now in place to support the system at all times and secondly, spikes are a recurring phenomenon, so that risk has been combined with PERF29 which concerns urgent and emergency care at all times
- Good progress has been made on the risk relating to Deprivation of Liberty assessments and as a result the score has been reduced from 16 to 12

	• A new risk management system is being implemented which will make risk reporting and analysis much easier • Positive discussions continue to take place with the Audit Committee about the ICB approach to risk management. As a result, it has been agreed that the Target Risk Score column on the Risk Register will be supplemented with a Target Date.
3.3.2	The Board of Members discussed the paper. It was highlighted that a large amount of work is taking place, particularly in terms of distinguishing between system risks, provider-led risks and ICB-only risks, as well as considering which risks warrant deep dives and which ones need to be reported to the Board. Setting target dates will help to identify instances where the ICB has to tolerate a certain level of risk.
3.3.3	The Board of Members **NOTED** the Board Assurance Framework.
4	**ITEMS FOR INFORMATION AND ASSURANCE**
4.1	**Minutes of the Audit Committee Meeting on 19 September, 14 November 2023 and 16 January 2024**
4.1.1	The Board of Members **NOTED** the minutes of the Audit Committee.
4.2	**Minutes of the Finance Committee Meetings on 10 October and 12 December 2023**
4.2.1	The Board of Members **NOTED** the minutes of the Finance Committee.
4.3	**Minutes of the Integrated Medicines Optimisation Committee Meeting on 26 September and 28 November 2023**
4.3.1	The Board of Members **NOTED** the minutes of the Integrated Medicines Optimisation Committee.
4.4	**Minutes of the People Board Meeting on 20 November 2023**
4.4.1	The Board of Members **NOTED** the minutes of the People Board.
4.5	**Minutes of the Procurement Oversight Group Meetings on 20 September, 8 November and 13 December 2023**
4.5.1	The Board of Members **NOTED** the minutes of the Procurement Oversight Group.
4.6	**Minutes of the Quality and Safety Committee Meeting on 18 July and 24 October 2023**
4.6.1	The Board of Members **NOTED** the minutes of the Quality and Safety Committee.
4.7	**Minutes of the Strategy and Development Committee Meeting on 27 September and 6 December 2023**
4.7.1	The Board of Members **NOTED** the minutes of the Strategy and Development Committee.
5.	**ANY OTHER BUSINESS**
5.1	There was no other business.
6.	**DATE OF NEXT MEETING**
6.1	7 May 2024.
7.	**PART 2 MEETING**
7.1	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.