North Central London
Integrated Care Board

Minutes
Meeting of NHS North Central London ICB Board of Members

23 July 2024 between 2pm and 4pm
Clerkenwell Room

Present:	
Mike Cooke	Chair, NCL Integrated Care Board
Frances O'Callaghan	Chief Executive Officer
Phill Wells	Chief Finance Officer (Substantive)
Ibrahim Abubakar	Non-Executive Member
Kay Boycott	Non-Executive Member
Dr Simon Caplan	GP - Provider of Primary Medical Services
Richard Dale*	Executive Director of Performance and Transformation
Usman Khan	Non-Executive Member
Mark Lam*	Chair, Royal Free Hospitals and NMUH
Victoria Lawson*	Chief Executive, Islington Council
Sarah Mansuralli*	Chief Strategy and Population Health Officer
Sarah Morgan*	Chief People Officer
Bimal Patel	Chief Finance Officer (Interim)
David Probert	Chief Executive, UCLH NHS Foundation Trust
Dr Jo Sauvage	Chief Medical Officer
Liz Sayce	Non-Executive Member
In Attendance:	
Jane Clegg	Regional Chief Nurse, NHS England (Item 2.1)
Will Huxter	Regional Director of Commissioning, NHS England (Item 2.1)
Alice O'Brien	Head of Programmes (Item 2.1)
Owen Sloman	Assistant Director, Estates Strategy (Item 2.5)
Andrew Spicer	Assistant Director of Governance, Risk and Legal Services (Item 3.3)
Anna Stewart	Director of Service Development: CYP, CAMHS, Maternity and Neonates (Item 2.1)
Nicola Theron	Director of Estates (Item 2.5)
Apologies:	
Dr Chris Caldwell	Chief Nursing Officer
Jinjer Kandola	Chief Executive Officer, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Sarah McDonnell-Davies*	Executive Director of Place
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
Dr Alpesh Patel*	Acting Chair, GP Provider Alliance
Ian Porter*	Executive Director of Corporate Affairs
Minutes:	
Steve Beeho	Senior Board Secretary

* Standing Participant

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	Mike Cooke welcomed attendees to the meeting. Apologies had been received from Chris Caldwell, Dr Jonathan Levy, Sarah McDonnell-Davies, Baroness Julia Neuberger, Dr Alpesh Patel and Ian Porter. David Probert was attending on behalf of Baroness Neuberger.
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. 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	**Minutes of the NCL ICB Board of Members Meeting on 7 May 2024**
1.3.1	It was highlighted that the Long Term Workforce Plan should be described in the seventh bullet point of paragraph 2.3.2 as NHS-centric and the NCL People Strategy should be referred to as a 'one workforce' approach, rather than vice-versa.
1.3.2	The Board of Members **APPROVED** the minutes as an accurate record, subject to the above amendment.
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, which had been written while he was still Acting Chief Executive Officer. He began by welcoming Frances O'Callaghan back to the ICB after her career break and thanked the Executive Management Team for their support while he was covering Frances, in particular Sarah Mansuralli, who was Deputy Chief Executive Officer during the period and Bimal Patel, who took on the role of Interim Chief Finance Officer. He also thanked the wider ICB for its outstanding work over the eight months in question. He then highlighted the following points: • Urgent Emergency Care (UEC) continues to be an operational pressure in NCL. There has been a strong focus on supporting NMUH through internal flow actions and there are now signs of improvement, particularly with regards to ambulance handover delays and Emergency Department waits. There has been tremendous support from across the system, although there is still more which needs to be done, especially around Category 2 response times. NCL performance in this area is the worst in London and this needs to be addressed • The NCL system experienced significant disruption as a result of the global IT outage on 19 July. The internal response to support secondary care and primary care was outstanding • The Month 3 outturn figures show a marginal deterioration in the adverse variance. The ICB will work closely with providers on what is driving this and remains committed to keeping as close to the financial plan as possible before recovering the position later in the year • Good progress has been made on the processes in train within the system on organisational alignments. The Royal Free and NMUH Boards have both approved the business case for the merger of the two Trusts and it is hoped that this will take place in early 2025. The planned merger of BEHMHT and Camden and Islington NHS Foundation Trust is also well advanced • Highgate East, a brand new purpose-built 78 bed mental health facility, has now been opened

	• The BMA is balloting GP contractor and partner members in England over industrial action. It is expected that this will result in some service disruption in NCL. Placing limits on the daily contact of clinicians is one of the nine potential action areas listed on the BMA website. This will clearly impact on the service offering if it comes to pass. A series of planning exercises has been held across NCL to mitigate the consequences of any industrial action and the ICB has also participated in scenario planning work • The ICB has been unable to reach agreement with the five NCL local authorities over the National Discharge Fund, part of the Better Care Fund (BCF) which supports discharge activity. The ICB and the local authorities therefore entered a mediation process with an independent arbiter and agreement has now been reached. Under this settlement the ICB will contribute just over £4.5m to support discharge processes undertaken by the five Councils. The ICB will also contribute approximately £3m to cover the consequences of the Section 22 Policy which the Councils introduced in April, and will honour a commitment for £3.4m worth of funding for 2023/24, which was conditional on a piece of work that was never concluded. In total £10.4m will transition to the Councils, over £7m of which will be recurrent. • Through this process the organisations have collectively maintained the support for homelessness individuals and discharge from hospital, protected a sum of money which supports weekend and 24/7 social work (effectively protecting 1500 discharges at weekends) and protected the cohort of patients who require Checklist. Work is underway for the ICB to mitigate these newly-created cost pressures. The process has also put an element of strain on relationships and there is a collective determination to move on from this challenging episode and refocus efforts on driving improvements in Population Health and ensuring that the money which has been committed improves performance and patient outcomes.
1.5.2	The Board then discussed the paper, making the following comments: • It was noted that there is a perception that the BCF discussions have strained relationships and the commitment to a re-set was welcomed • Formal approval is now awaited from the Secretary of State for the merger between Royal Free London and NMUH, following the approval of the respective Boards. It was highlighted that a fresh set of clinical opportunities has emerged from the merger process as a result of the clinical engagement that took place across both organisations • It was suggested that it might be helpful for the ICB to share with NCL Chief Executives and Chief Medical Officers the clinical case for both mergers referred to in Phill Wells's overview and the importance of this for patients and staff. It was also suggested that it would be helpful for Frances O'Callaghan to co-ordinate with Mark Lam briefings for the new intake of MPs and new Council Leaders and Chief Executives, as well as the ICB Board, on the two mergers and the structural changes for the NHS • It was noted that although there had been a disagreement on one part of the BCF, there has been an appetite to look at the BCF in its totality, as much of the funding has been allocated recurrently, and the Partnership has been planning a wider review of the efficiency and efficacy of the investments which have been made. Now that these issues have been resolved this wider review which can take place and potentially help to address some of the funding challenges • The introduction of a free prescription scheme for care leavers was welcomed.
1.5.3	Mike Cooke highlighted to members of the public that the Board had previously commended Phill Wells' achievements as Interim Chief Executive Officer at the recent Board Seminar.
1.5.4	The Board of Members **NOTED** the Report.
2.	**STRATEGY AND BUSINESS**
2.1	**Start Well**
2.1.1	Mike Cooke welcomed the opportunity for the Board to receive an update on the progress of the Start Well programme.

2.1.2	He also welcomed Jane Clegg and Will Huxter from NHS England (London) Specialised Commissioning to participate in the discussion as the responsible commissioner for some of the services within the scope of the consultation, and the body jointly responsible for the consultation.
2.1.3	Sarah Mansuralli introduced the item, highlighting the following points: • The report provided updates on three aspects of the programme: the breadth of the engagement, the high level themes which have emerged from the consultation and how these inform the next steps which have been brought for approval • An extensive consultation was run from 11 December 2023 to 17 March 2024. Considerable engagement took place over this 14 week period, generating extensive feedback. In addition to the Programme Team, Trust colleagues also played an important role in supporting the engagement with staff and specific patient groups. The fact that a full Outcome Report is not yet available is a testament to the sheer wealth of feedback • The consultation methodology and activity report highlights how the consultation sought a range of views from a variety of communities. Thanks to the work that had been done on the interim Integrated Equalities Impact Assessment it was possible to hone in on some of the communities who would be most impacted by the proposed changes • Over 3,100 completed questionnaires were submitted, over 2,000 of which were from members of the public. Approximately 1,000 were received from NHS staff, as well as 21 organisations. The team also carried out just under 200 engagement events with community groups in different settings • The breadth of responses and nature of the comments indicate that the consultation material conveyed the case for change and the rationale underpinning the proposed changes. There was a recognition of the challenges that services are facing and the need for changes to address them. There was broad support for all NCL neonatal units offering a minimum of Level 2 provision and closure of the birthing suites at the Edgware Birthing Centre, as well as very strong support for the paediatric surgery proposals from patients and the public • However, there was less support for consolidating maternity and neonatal care from five units to four, although there was broad support for all units delivering a minimum of Level 2 neonatal provision, even though the case for change was very clear about needing to do one in order to achieve the other • Concerns were raised around pressures on remaining services, specialist pathways, travel times and travel costs • Although there was a large amount of support from patients and the public for the proposed paediatric surgery changes, it is also important to take into account feedback from staff who would need to deliver them. GOSH clinicians and the GOSH executive team provided feedback on potentially needing to reconsider the feasibility of delivering the proposed inpatient and emergency surgical pathway. In discussion with UCLH colleagues it has been concluded that it is entirely feasible for the day case proposal to proceed without the inpatient and emergency proposals being taken forward. However, the workforce implications would need to be thought through, as well as the interdependencies that may exist with the inpatient and emergency proposal, so there is further work to be done on this • The feedback received has been instrumental in informing the suggested next steps for this programme of work. There are three key areas where the feedback has highlighted that there is more work to do: o Thinking through the maternity pathways relating to maternal medicine, Interventional radiology and postnatal and antenatal care, and how some of them interlink with local authority services and how integration can be facilitated, potentially with out-of-NCL services and other local authorities

	○ The day case pathway at UCLH will need further work. Further thought also needs to be given to the paediatric surgical inpatient and emergency pathway, probably involving short-term and longer-term options which will need to be brought back to the Board ○ Work to develop the Decision-Making Business Case (DMBC) which will set out the ICB's approach to implementation. This will require updated modelling to respond to points that have been raised during the consultation regarding specific pathways, and to respond to the Mayor's Six Tests recommendations • The Board is being asked to approve proceeding to the next stage of the programme. This will need to be done jointly with NHS England (London) Specialised Commissioning colleagues as the responsible commissioners for some of the services, particularly neonatal care .
2.1.3	Will Huxter noted the importance of looking at these services in a joined-up way and welcomed the integrated work which is already taking place. He commended the breadth, scale and depth of the consultation and supported the proposed next steps set out in the paper.
2.1.4	Jane Clegg echoed these comments and welcomed the fact that the work looked beyond the NCL boundaries in recognition of the number of patients who come from outside NCL for treatment. It is anticipated that children and young people will become an increasingly high priority over the next few years and NHS England consider this consultation as a blueprint for how they could be run.
2.1.5	The Board then discussed the paper, making the following comments: • It was confirmed that the clinical opportunities that are emerging from the proposed merger between NMUH and the Royal Free London will be considered as part of the modelling for the next phase of work. • It was noted that the inpatient and emergency paediatric surgery proposal is a good model of care which is evidence-based. However, it is made more difficult in NCL as the tertiary paediatric centre at GOSH does not have an emergency 'front door'. In light of the feedback, it is possible that NCL was over-ambitious in its thinking and the feedback from the consultation is an opportunity to review what can be done within the timescales and within the capital affordability • The courage shown in tackling a long-standing strategic issue around maternity and neonatal provision was applauded. The view of the board was that failing to address this challenge would result in a far more difficult problem further down the line. Declining birth rates in NCL mean that the status quo, with many sites in close proximity, is not sustainable in the longer-term. The fundamental issue boils down to whether services in the future should be enhanced at the Whittington or the Royal Free, so the proposed merger between NMUH and the Royal Free London will not be central to considerations. It was noted that in the proposed new arrangements NMUH are likely to be asked to lead on paediatrics in the newly-formed Group, with Barnet retaining leadership for maternity services across the Group. • Strong representation has been made throughout the consultation process as to why services should continue to be provided at the Royal Free and assurance was sought that this would be taken into account in the next phase in the interests of transparency, despite the fact that the pre-consultation business case setting out a preference for the option in which the Whittington remained (option A) • Assurance was given that the feedback from the Royal Free will be taken on board and be a key plank of the next phase, such as quantifying what happens at different stages of the maternity pathway and the implications of removing either the Whittington or Royal Free and the specialist services which they provide. • At present the ICB is aiming to finalise the Decision Making Business Case (DMBC) by the close of the financial year. The issue of pace is central to this work as the workforce challenge and operation delivery concerns while this work is taking place is creating unhelpful uncertainty for staff. • It was emphasised that there are no service changes currently taking place in respect of the three proposals that were consulted on. The DMBC will set out the timescales and the operational practicalities of implementing changes across the three domains

	• The programme highlights the impact that an ICB can make in setting out a strong clinical case for change and working as a system to deliver it. • It was noted that the models of care are evidence-based, so the ICB was thinking about the best form of care on these pathways for people in different circumstances. The consultation has been invaluable in providing additional insights into some of the things that will need to be considered, such as possible mitigations in the event of a particular unit being closed and how best to ensure that people's feedback is factored into the final proposals. • Assurance was given that many of the points raised have already been picked up by the Start Well Clinical Reference Group and are being followed up. • Assurance was given that funding for Start Well has been allocated within the capital programme for the next 10 years. NCL has also been fortunate to receive additional funding for the current financial year as a reward for its financial performance and it is hoped that further additional funding may be available in future years, subject to NCL's financial performance. The revenue consequences of Start Well will potentially be more challenging and a mature conversation will be needed about shifts in revenue across organisations as a result of this, recognising that there may be some 'stranded' costs which will need to be managed over time. • It was confirmed that a workforce workstream will be established, including Chief People Officer representation, to ensure communications are aligned and that there is close working with the trade unions on what can be achieved.
2.1.6	The Board of Members: • **NOTED** the activity undertaken and reach achieved through the public consultation relating to proposed changes to maternity, neonatal and children's surgery care in NCL and that the programme has met with its duty to engage and involve the public and that the engagement with target groups who have protected characteristics will inform equalities considerations under the Public Sector Equalities Duty and Equality Act 2010. • **NOTED** the feedback themes identified by ORS in their interim evaluation report • **APPROVED** the actions that will be taken forward to take the consultation feedback into account and the further work proposed to develop the DMBC. • **NOTED** that a final evaluation report and JHOSC feedback will be shared with the Board in advance of any decision-making meeting • **NOTED** the proposed timeline around a decision-making meeting of late 2024/early 2025.
2.2	**NCL ICB People, Culture and Equalities Annual Report 2023-24**
2.2.1	Sarah Morgan provided an overview of the suite of equalities reports, which included for the first time an overview of the achievements of the People and Culture function, as well as the statutory reporting requirements on the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), the Gender Pay Gap and the Equalities Delivery System 2022. The requirement to produce a series of stand-alone reports meant that there was inevitably some duplication in content. She highlighted the following points: • The data pertaining to the WRES, WDES and Gender Pay Gap all related to the previous structure of the ICB up to 31 March 2024 • The full year has been taken up with the Organisational Change Programme and good progress has been made by the People and Culture team in the circumstances, bearing in mind the reorganisation and the fact that a large number of posts have been 'held' to offer opportunities through ring-fencing and offers of suitable alternative employment. At the same time, the ICB has been standing up the new organisation, which has High Performing Teams at its heart

	• The People and Culture directorate have supported the ICB to achieve the requirements set out in the Change Programme around delivering the priorities of the • Population Health and Integrated Care Strategy, ensuring that structures and processes are fit for purpose and meeting the Running Cost Allowance. The ways of working processes are currently a work in progress due to the nature of standing up an organisation • The WRES and WDES derive data from the Staff Survey which was brought to the previous meeting. As noted previously, there had been a deterioration in some of the results which has in turn led to a decline in the ratings in the WRES and WDES. However, the ICB believes that it has put some strong initiatives in place, particularly around wellbeing and working towards a more inclusive and compassionate culture • There has been an increase in the proportion of staff from a BME background, as well as larger increase in the proportion who are at Band 8a and above. There has also been a shortening of the gap in representation at 8b level and a reduction in the number of BME staff entering formal disciplinary proceedings and feeling discrimination from managers, team members or colleagues • There has been an increase in the relative likelihood of white staff being appointed from shortlisting compared to BME staff. The WRES score is only based on the external recruitment. Due to the change programme, very few posts were recruited to externally and those that were, were senior and highly specialist. • There has also been an increase in the relative likelihood of white staff accessing non-mandatory training and CPD (continuing professional development) compared to BME staff. This probably reflects the fact that much of the training available in year was around leading change, particularly for managers, and because of the nature of the profile of the ICB workforce, the majority of senior posts (8c and above) are held by people from a white background • It is evident that there is more to be done from a WRES perspective, and although the ICB believes that it has put strong building blocks in place the current plan does not go far enough. More work is planned on anti-racism and it is recommended that a dedicate equity and inclusion strategy is developed for the ICB. • A new EQIA will be produced at the end of the change process which will provide a new workforce profile • The WDES has highlighted an increase in the number of staff declaring a long term condition or disability, following the ICB enabling staff to self-declare their protected characteristics. This increased visibility has in turn shown a decline in performance against many standards and the ICB is committed to improving this. As part of this commitment, the ICB is in the process of recommissioning the Occupational Health Service and there will be a greater focus on wellbeing in the appraisal process, as well as work with the Carers, Disabilities and Long-Term Conditions network on workplace adjustments • There has been a reduction in the Gender Pay Gap compared to the previous year and further work on this is planned with the ICB's Women's Network • The ICB had two staff-related objectives under the Equality Delivery System 2022 (EDS2022) concerning improving the culture and the Change Programme. A third objective, which relates to population, would be covered under the next item. The report set out the achievements made in these areas. The focus for next year will again include improving the culture and the EDI improvement plan sets out targeted actions to address prejudice and discrimination (both direct and indirect).
2.2.2	The Board then discussed the paper, making the following comments: • It was acknowledged that the ICB needs to do further work on root cause analysis in order to identify what has caused deteriorations and also to identify the reasons for improvements. With regards to the WRES, it has been identified that the challenge lies at the point of interviewing people, rather than attracting applicants in the first place.

	• As a result, the ICB has introduced the Recruitment Advisor Role into the process but there is more to do to strengthen this, including applying the learning from other organisations. The ICB will also be participating in the NHS Employers Diversity Programme and continuing to work with the Workforce Integration Network. In addition, it will also need to explore some of the hypotheses which have emerged about different protected characteristics as part of the anecdotal feedback about the Change Programme • A piece of work will be undertaken on the disability data which cuts across the Staff Survey recruitment data similar to what the ICB has done for race data, so that this can be considered in more detail • It was highlighted that each Staff Network now has an executive sponsor and feeds into the People and Culture Oversight Group (PCOG). The PCOG meeting frequency has been increased to monthly in recognition of the importance of its work. The ICB is committed to strengthening the networks as they have been impacted by the movement of staff during the Change Programme and funding has been set aside to support this. The ICB will be relaunching a piece of work on Values and Behaviours Framework which will eventually feed into the appraisal process. This year all executives will have a diversity objective and this will filter down through the organisation • It was noted that a number of new national policies are coming down the line, including Flexible Working by Default and Disability and Ethnicity Pay Gap reporting. Assurance was given that all ICB policies will be reviewed with the Staff Networks and other staff through an intersectional lens and then overhauled where necessary, as many current policies are not fit for purpose because they do not see people 'in the round'. It is also recognised that there is a lot of informal flexible working which may not have translated across when people have changed roles and will need to be addressed, along with more work needed on the Workplace Adjustment Passport. • The amount of data provided within the report and the amount of thinking it demonstrated was welcomed, as was the intersectionality approach to reviewing ICB policies. However, it was highlighted that when there is a focus on making comparisons between ethnic minorities and the white population, there is a risk that the significance of the actual figures involved can be overlooked. For instance, the number of staff who have experienced bullying or harassment in the last 12 months is extremely high and needs to be addressed • It was acknowledged in response that these figures are stark and the ICB has sought to address this through a strong focus on high performing teams; hidden bias training and greater support for staff with disabilities through the refresh of the workplace adjustment passport. These instances have been primarily reported by corporate staff and the likelihood is that this arises from people's frustration with organisational processes, rather than being directed at specific individuals. There has also been a piece of work about supporting people with emotional burden, such as staff who handle complaints or have challenging conversations with members of the public. It is hoped that there will have been a shift in this area when the next Staff Survey results are published. • The volume of work that has gone into the Change Programme was commended. In light of the extent of the changes, it would be helpful if there is a continued focus on culture and teamworking as the ICB will need time and space to stabilise • However, it was noted that the three-year OD plan does not contain metrics around 'harder' pieces of work, such as capability development, productivity and efficiency. ICBs have been asked to deliver more with 30% reduction in running costs and the Board needs to be assured that this is happening and that it gets early sight of any emerging risks • It was noted in response that there has been a lack of investment in staff learning and development for a number of years, caused in part by the pandemic. As a result, having a 'harder' set of measures in place is problematic at this point in time because the necessary work has not yet taken place to build people's capabilities, hence the introduction of the Learning and Development programme.

	• The ICB needs to get into the position where people can embrace the new organisation and new ways of working but when the ICB feels more confident in this area it will build in more capability metrics to take this forward.
2.2.3	Mike Cooke commended the amount of work that had taken place, Board members were pleased to receive this level of information because mature organisations need to address the reality of where they are in order to move forward. The report outlines positive progress while also being candid about what else needs to be done to deliver further improvement.
2.2.4	The Board of Members: • **NOTED** the key achievements and activities of the People & Culture function between July 2023 to June 2024. • **NOTED** the progress against the 3-year OD plan (2023-26) • **NOTED** the ICB's equality, diversity and inclusion (EDI) performance against the national EDI standards (WRES, WDES, Gender Pay Gap, EDS22 and Equality Information Report) • **APPROVED** the following EDI reports for publishing publicly: o 2023/24 Workforce Race Equality Standard (WRES) report o 2023/24 Workforce Disability Equality Standard (WDES) report o 2023/24 Gender Pay Gap Report o 2023/24 EDS22 report o 2023/24 Equality Information Report • **APPROVED** the workforce priorities that have been identified for 2024/25 • **APPROVED** the approach to developing an EDI improvement plan in accordance with the national programme and with the right external expert support.
2.3	**2023/24 Health Inequalities Report**
2.3.1	Sarah Mansuralli introduced the paper, highlighting the following key points: • The report set out the excellent progress made by the ICB during 2023/24 in reducing health inequalities and strengthening its partnership approach to population health and care. It highlighted hyper-local examples of work with specific communities supported by the Inequalities Fund as well as widescale transformative programmes of work taking place in NCL, such as Start Well and the Community and Mental Health Core Offers, through which the ICB seeks to address inequalities for particular populations, as well as inequities in access, experience and outcomes for the general population • The Population Health and Integrated Care Strategy commits the ICB to a relentless focus on reducing inequalities at both community and general population level. As part of this, it has a duty to address some of the legacy historic issues it has inherited in terms of patchwork provision while also getting into some of the hyper-local work required to help communities achieve the same outcomes as the rest of the population • Despite the progress over the past year, the report highlights that there is still much more to be done to tackle the levels of inequality seen in different parts of society and some of the wider determinants driving these inequalities. • In addition to these wider determinants, the key population health risks defined in the Strategy are mental health, childhood immunisations, cancer, lung health and heart health • The ICB has done a lot to align its inequalities work to the ambitions in the Population Health and Integrated Care Strategy, focusing on NCL residents who live in the 20% most deprived areas nationally (our 'Core20') and other key child and adult communities identified in the strategy, including our NCL PLUS populations (within 'Core20PLUS5'), such as children with special educational needs and disabilities and adults from inclusion health groups. • The focus in 2024/25 will be on measurable impact so that the ICB can determine what is working well and has the potential to be scaled up and similarly what requires course correction. The Outcomes Framework will be used as the basis for this work

	• The ICB has started to make good progress in understanding the data and insights which provide rich information about the different populations. Reducing inequalities within different services for the people already using them as part of 'business as usual' activities will also be an important priority for the future. • Looking ahead, discussions are taking place about a longer term pipeline of work around how data and digital start to inform future inequalities work, particularly through targeted impact.
2.3.2	The Board then discussed the paper, making the following comments: • It was noted that there had been a constructive Population Health Committee meeting the previous day, where the importance of demonstrating where the ICB makes an impact was highlighted. Going forward, the ICB will need to identify the 'winners' and be able to show in a couple of years' time how focused impact has been translated into impact at scale across NCL for the most deprived groups. This should be the focus during the next phase and may require additional resources and bold decisions to do things differently in secondary and tertiary care to enable reinvestment in prevention, but this will also need to be backed by compelling evidence • It was noted that although the report highlighted where transformation projects have had a positive impact, it was unclear in places whether they have also had an impact on reducing inequalities • It was suggested that although the report contained helpful commentary about the ICB's achievements and reflections, it potentially sells itself short by not taking a system-wide perspective and being more data-driven, especially around providers where there is a lot of focus and progress in this area • It was noted that the ICB needs to be mindful of the fact that some traditional care models actually exacerbate inequalities for some communities. It therefore needs to consider how services might be designed or delivered slightly differently, such as the way that waiting lists are managed, as there may be particular communities where a different approach is needed to ensure that they take up their appointments. Making effective use of data will help to build inequalities monitoring into core services and starting to build this data capability into all datasets over the next year will help to identify areas where things need to be done differently • Further information will be provided in due course about the next steps for the high-performing schemes supported by the Inequalities Fund.
2.3.3	The Board of Members **APPROVED** the 2023/24 Health Inequalities Report.
2.4	**NHS Sexual Safety Charter**
2.4.1	Sarah Morgan introduced the paper, highlighting the following key points: • NHS England launched the Sexual Safety Charter in September 2023. The Charter asks all organisations to sign up to it by the end of July 2024 • In the last Staff Survey a small number of staff reported that they had experienced some form of sexual harassment at work • The ICB has been doing preparatory work, led by David Pennington, Director of Safeguarding, to ensure that it is signing up to the Charter in a meaningful way and good progress has been made • The paper has been presented previously to the Executive Management Team (EMT) and is now being commended to the Board for endorsement.
2.4.2	The Board then discussed the paper: • It was noted that data will be recorded on the Employee Relations Tracker, which is reviewed regularly by the Chief People Officer and the Chief Executive Officer, and data has begun to be presented to EMT meetings • The ICB is currently reviewing how best to signal to the organisation around employee relations cases while also preserving anonymity and confidentiality, as the relatively small number of cases makes avoiding identifiability a challenge • It is hoped that the planned awareness-raising work and demonstrating that action is being taken will serve to build up further trust among staff.

2.4.3	The Board of Members: • **NOTED** the ICB's progress against the 10 principles • **ENDORSED** the ICB making a commitment to have zero tolerance approach to unwanted, inappropriate and/or harmful sexual behaviours by signing up to the charter • **ENDORSED** the action plan to meet each of the ten principles of commitment.
2.5	**NCL Infrastructure Strategy**
2.5.1	Bimal Patel introduced the paper, highlighting the following points: • NCL ICS is required to submit its Infrastructure Strategy to NHS England by July 31. The NCL Strategy will be submitted in conjunction with the other four London ICSs' strategies as part of the London-wide Infrastructure Strategy for NHS England (London) • The Strategy builds on the work that the ICB undertook on the Estates and Infrastructure Plan in 2023 and is aligned to the Population Health and Integrated Care Strategy. It has been previously reviewed by the ICB Executive Management Team and elements have been shared with NCL providers for comment • The NCL system will receive a £178.6m capital allocation for 2024/25. The ICS has also been able to secure nearly £48m additional funding for this financial year, which equates to 26% extra funding. This is a reward for NCL's previous financial performance and submitting a break-even plan • A critical infrastructure review has been carried out across providers to prioritise which areas need to be addressed more immediately. There will need to be an increased focus on delivery, as the backlog of maintenance work has increased over time • 5% of the system allocation has been committed to primary care. This has enabled investment in health centres and the primary care estate • IT is recognised as a crucial part of the NCL infrastructure. Two important Electronic Patient Record (EPR) initiatives are underway, at Moorfields and RNOH • As part of the next iteration of the Strategy, the system will need to consider further how the productivity of the estate can be improved and also look at the contribution that the disposal of assets might make to clearing the backlog of work, alongside any future new investment • The Strategy has been underpinned by the goal of getting as close to Net Zero as possible through the application of the latest building standards.
2.5.2	The Board then discussed the paper, making the following comments: • It was agreed that there is potential to be far more collaborative with local authorities around void space. In particular, there is an opportunity for joint thinking about how hospital disposals might be used to support the ambition for more affordable housing • The presentation in the report of the implementation of the Fuller Report at Borough level was welcomed for showing the reality on the ground • NCL is now reaping the benefits of system working. Going forward it will be important to ensure that the NCL 'jigsaw piece' can fit into any new emergent jigsaws under the new government • Concern was expressed about the fact that 60% of primary care premises are still not as good as they need to be and about the length of time it will take for the primary care estate to be raised to the necessary standard. In light of the new government's policy of increased housebuilding, the ICB needs to ensure that it is working closely with local authorities to ensure that a primary care facility is built into any new developments • The analysis in the report suggesting a link between the quality of primary care estate and patient outcomes and likelihood of going to A&E was questioned on the basis that A&E attendance is determined far more by access and proximity to an A&E department • It was acknowledged in response that proximity to a hospital can influence hospital flows but there is not a definite correlation, and there are still some practices which are outliers in terms of their patients presenting at A&E.

	• The report goes further and links quality of estate with infrastructure, recruitment, retention and staff wellbeing which in turn impacts on the pressures across the system and highlights the need for investment in primary care infrastructure • Assurance was given that the Infrastructure Strategy is aligned to the Digital Strategy which is currently in development and will be the focus of a detailed discussion at a future Board Seminar in the autumn. It was noted that incorporating emerging funding streams for digital within different strategies in a joined-up way can be challenging. It was questioned whether NCL has identified areas where it might wish to go further in the event of changes in funding flows and if so, whether these potential new ways of working ought to be reflected in this strategy • It was highlighted that the extent to which NCL is geared towards specialist centres of excellence means there are potentially vast opportunities in this space as part of the government's growth ambitions. The Strategy focuses on delivering safe and effective care locally in excellent facilities, but in the event of the government putting in place a strategy for significant growth, it would be wise for NCL to have some potential schemes prepared in advance to be able to capitalise on this • There will be an increased focus on productivity and effectiveness, and digital solutions will be integral to this • It was suggested that there should be more explicit reference to research and extensive private provision and the role they will play in the Strategy • Ibrahim Abubakar declared an interest as Pro-Provost (Health) at University College London (UCL). He observed that UCL is having similar forward-looking discussions about the large levels of investment it makes in the system and it would be sensible to discuss combined approaches to maximise the impact.
2.5.3	The Board of Members **APPROVED** the Infrastructure Strategy for submission to NHS England.
3.	**OVERVIEW REPORTS**
3.1	**Integrated Performance and Quality Escalation Report**
3.1.1	Richard Dale introduced the paper, highlighting the following key points: • Ongoing work is taking place with mental health providers around short and long term planning, including the implementation of the core offer. Within this, overall access to talking therapies remains challenging in terms of both demand and capacity. Although there has been a reduction in the number of out of area placements for mental health beds, the position has deteriorated in recent months. Addressing this is a key part of the merger between BEHMHT and C&I NHS Foundation Trust. • General practice activity remains significantly higher than pre-pandemic levels • The recent publication of the national GP Experience Survey shows some deterioration across NCL and this will be followed up by the Primary Care Committee • A large elective recovery programme remains in place, focusing on reducing and eliminating the number of people waiting more than 65 weeks for treatment by the end of September. Although achieving this will be a challenge, NCL is delivering 104% of the previous year's activity. However, a number of pathways require further attention • The position around emergency care remains challenging at all sites. NMUH is the most challenged and as a result the ICS has put in a temporary change regarding the way that ambulances flow to the hospital to give it greater headroom. Although this is reducing handover delays within NCL and at NMUH, there has not yet been a corresponding improvement in Category 2 response times. This is being followed up with the London Ambulance Service.
3.1.2	Liz Sayce noted that the report had been previously reviewed by the Quality and Safety Committee. The Committee had recently conducted 'deep dives' into mental health services, as well as learning disabilities and autism, including the significant increase in diagnoses of autism, which has increased the figure for inpatient care.

3.1.3	The Board then discussed the paper, making the following comments: • It was noted that performance is always relative and contextual but there are elements of what is going on that could create a perfect storm. NCL generally performs well, albeit there are issues which it is addressing but there are a number of important things which have been discussed in the meeting which need to be borne in mind. For example, CHC performance is dependent on the relationship with local authorities and there have been some 'bumps in the road' Although there is a mutual commitment at senior level to strengthening relationships, it is inevitable that these issues flow down into teams and affect performance and joint working. The potential GP collective action may cause disruption and put pressure on services across NCL. The planned merger between the Royal Free and NMUH also has the potential to create distraction amid various ongoing challenges. On top of this, the new government has high expectations around how the NHS will deliver some of the access standards. A conversation will be needed around how the system will 'shift the dial', while recognising how hard people are already working, to ensure that NCL stays ahead • It was highlighted that the figures in the report relating to primary care access do not mean that there has been a deterioration as there have been changes to the methodology and questions in the GP Survey which make it difficult to make direct comparisons. Although there has been some overall flux, 130 of the 176 NCL practices have remained stable or improved. The Primary Care Access Recovery Programme is being targeted in particular at those practices where there has been a deterioration • It is also important to note that GP access levels have not changed significantly, alongside a large increase in the number of appointments being offered in primary care.
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 paper, highlighting the following points: • The NCL system submitted a balanced 2024/25 financial plan in June as part of the planning process. As mentioned previously, NCL received £17.9m of capital to be spent in 2024/25 • The ICB plan initially set a £10.6m surplus but following a shortfall in getting the system to a breakeven position, this was extended to a £14.6m surplus under the authority that the Board had delegated to Phill Wells and Bimal, on the basis that additional funding is usually received throughout the year and the system CFOs have agreed that this will be used to off-set this difference in the first instance • Month 2 consisted of light-touch reporting as the planning round was still underway. NCL ICS reported a £38.2m deficit, which was £11.7m higher than planned. The main areas of adverse variance were around underperformance and delivery of efficiencies • Month 3 was slightly better from a run-rate perspective but slightly worse in respect of adverse variance. This does not take into account the recent industrial action. • Recovery plans have been requested from two NCL organisations that are reporting significantly adverse to plan, Whittington Health and NMUH • NCL ICB reported a breakeven position at Month 2. £4m of the 2024/25 CIP target is currently unidentified and work is ongoing to address this. The main risk to achieving this concerns CHC delivery.
3.2.2	The Board of Members **NOTED** the Finance Report.
3.3	**Board Assurance Framework (BAF)**
3.3.1	Andrew Spicer highlighted that two new risks had been added to the BAF, the first relating to the provision of CAMHS services (Comm32) and the second regarding delayed CHC assessments (Qual64). The score for the risk concerning the financial cost of CHC and CIC packages (Qual72) had decreased below the BAF threshold.

3.3.2	The Chair observed that this was the third reference to CHC in the meeting and it was therefore fitting that a new CHC risk had been added to the BAF. He encouraged the ICB to look again at what can be done to make improvements in this area as there are things it can do which are not dependent on the wider partnership.
3.3.3	Frances O'Callaghan highlighted that the risk score for the St Pancras transformation programme on the BAF was different to the one on the Infrastructure Strategy paper, so these would need to be made consistent. She then suggested that it would be helpful for the Board to devote more time to the BAF at a point in the future to obtain a deeper understanding of what it is seeking to convey. For instance, the UEC A&E risk score continuously remains static and changing this is beyond the ICB's control.
3.3.4	In response, the Chair recommended that the best way to address this and ensure that more time is devoted to discussion of the BAF at future meetings could be to move it up the agenda so that it is part of the Strategy and Business section.
3.3.5	The Board of Members **NOTED** the Board Assurance Framework.
3.3.6	Andrew Spicer to ensure that the St Pancras transformation programme risk score on the BAF is harmonised with other documents.
4.	**ITEMS FOR INFORMATION AND ASSURANCE**
4.1	**Minutes of the Audit Committee Meeting on 19 March 2024**
4.1.1	The Board of Members **NOTED** the minutes of the Audit Committee.
4.2	**Minutes of the Integrated Medicines Optimisation Committee Meeting on 12 March 2024**
4.2.1	The Board of Members **NOTED** the minutes of the Integrated Medicines Optimisation Committee.
4.3	**Minutes of the People Board Meeting on 19 February 2024**
4.3.1	The Board of Members **NOTED** the minutes of the People Board.
4.4	**Minutes of the Procurement Oversight Group Meeting on 17 January 2024**
4.4.1	The Board of Members **NOTED** the minutes of the Procurement Oversight Group.
4.5	**Minutes of the Quality and Safety Committee Meeting on 19 March 2024**
4.5.1	The Board of Members **NOTED** the minutes of the Quality and Safety Committee.
4.6	**Minutes of the Strategy and Development Committee Meeting on 17 April 2024**
4.6.1	The Board of Members **NOTED** the minutes of the Strategy and Development Committee.
5.	**ANY OTHER BUSINESS**
5.1	Frances O'Callaghan paid tribute to the Chair, who was chairing his final Board meeting. She highlighted Mike Cooke's major contribution to NCL over his years at the ICB and ICS, as well as at Camden Council. His level-headedness, good humour and exhortations had been much appreciated, as had his invaluable constructive support for Frances in her first role as a CEO. The Board was collectively grateful for everything that he had done and Mike would be hugely missed.
5.2	The Chair thanked the Board for their warm wishes. He reflected that NCL has been on quite a journey and a fantastic partnership is now in place across the five Boroughs, full of superb institutions and people, which has made working in NCL a pleasure over the years. Today's meeting exemplified the passion in NCL to tackle profound health inequalities and he looked forward to the shared sense of public service driving the organisation forward in the future.
6.	**DATE OF NEXT MEETING**
6.1	12 November 2024.