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in health and care

This ICS System Development Plan is a work-in-progress draft and we will continue to update it every quarter through engagement with stakeholders from across the system to reflect our progress.
Please email comments and feedback to: *northcentrallondonics@nhs.net*

NCL ICS System Development Plan

Refreshed Plan

DRAFT for Submission to NHSE/I
Q4 v.1
31st March 2022

Contents

Purpose of the document

- Our System Development Plan builds on the October 2021 version, with a focus on the core components of ICS development, as suggested by NHSE guidance. The document outlines our progress towards becoming a truly integrated care system (ICS) that helps tackle health inequalities and improves access to health and social care for our residents across North Central London (NCL).

- This document is responsive to ICS guidance as it is published and aligns with the *ICS Design Framework, Readiness to Operate Checklist* and other associated guidance.

- This document draws from existing engagement and planning across NCL to help establish a roadmap for our transition as a system.

- Our Principles through this transition are as below.
  - ✓ We will **work as one system to benefit the whole population of North Central London** and work together to drive health equality.
  - ✓ We will **retain the local patient, resident and clinical voice** in the commissioning and delivery of health and care, by working effectively across our system.
  - ✓ **We will value our staff, our partners and their expertise** to deliver the best health and care possible for the patients and residents of North Central London.
  - ✓ **We will work on a population health basis**, planning for population needs as a system, and through local partnerships and neighbourhoods/networks.
  - ✓ We will work to deliver joined-up care for our population, **planning around residents not organisations**.
  - ✓ **We will emphasise the value of subsidiarity**, working as locally as is feasible whilst retaining strategic, effective commissioning for North Central London.
- This System Development Plan also provides a framework to measure our progress against the 16 conditions for ICS success as described by NHS England (London).

While this is a working draft of the Plan, this submission provides specific updates and summaries of areas as outlined in the Q4 System Development Plan Guidance.

System Development Plan: Engagement to date

Relevant sections of the NCL System Development Plan have been shared with the following forums and feedback used to refresh the plan. This has been undertaken in conjunction with the preparation the Readiness to Operate Checklist.

Stakeholders	Engagement to date of SDP sections	Review schedule/ Updates included for Q4
NCL ICS Steering Committee	Shared and feedback incorporated	*Review every quarter*
NCL ICS System Management Board	Shared and feedback incorporated	*Review every quarter*
NCL Transition Board	Reviewed on 22/03/2022	*Review sections and every quarter*
Due Diligence Working Group	Reviewed on 30/03/2022	*Review sections in parallel with Readiness to Operate checklist*
Quarterly Partnership Council	Shared and feedback incorporated	*Review every quarter*
NCL People Board	Shared and feedback incorporated	*Continue engagement to further develop our People Plan and Clinical and Professional Leadership Framework. Includes update for Arrangements for establishing the ICS people function*
NCL Population Health Committee	Shared and feedback incorporated	*Continue engagement with Directors of Public Health to embed narrative and further develop plan on Population Health Management. Includes update on Population Health Outcomes*
LA CEO Forum	Shared and feedback incorporated	*Continue engagement to appraise of transition and embed system working*
Borough Teams incl. DASS and DCS	Shared and feedback incorporated	*Continue engagement to develop integrated ways of workings*
Borough HWBs and HASCs	Shared and feedback incorporated	*Continue engagement to develop integrated ways of workings*

Key areas where we are working together with partners to develop

Area	System forum	Working with…	Updates since October 2021…
The impacts and benefits of becoming an ICS	ICS Steering Committee	• ICP meetings • LA meetings • CCG Governing Body • Trust boards	• Critical path for transition and establishment of NCL ICS to July 2022 • Identifying ways the system worked together through Covid-19 response to deliver benefits for residents. Building on these strong foundations to develop working as an ICS. • Review of relevant guidance relating to ICS development and aligning with the *ICS Design Framework and Readiness to Operate Checklist* • Identifying what might work differently for organisations in becoming an ICS
NCL's Population Health & Inequalities Strategy	NCL Population Health and Inequalities Committee	• Local Care Forum • Community Partnership Forum • ICP Meetings • NCL Finance Groups	• Development of NCL Population Health Outcomes Framework • Initial plan to develop NCL Population Health Strategy and roadmap • Reviewed where most impact can be made at system level
Principles for collectively agreeing priorities at a place level	ICS Steering Committee	• NCL Population Health Committee • Local Care Forum • ICP Meetings	• Identifying priorities at borough and Place • Working with System Leaders through the Local Care Forum to create conditions for integrated care delivery • Meeting with Directors of Integration to support discussions across the local systems • Commencing Place development programme with Leadership Centre to agree priorities with system partners
Impact of system oversight framework	System Management Board	• System Recovery Executive • Trust Boards • ICP meetings • NCL Finance Groups	• Development of MOU for NCL and NHSE for 2021/22 • Agreeing a SOF approach for the remainder of the year that can be rolled-over in to 2022/23 • Development of approach for providers in SOF 3 segments
ICS Financial Framework	NCL Finance Groups	• NCL Finance Groups • NCL Population Health and Inequalities Committee • ICP Meetings	• Agreed ways of working and financial principles across NCL organisation Boards • Establishing a clearer ICS finance leadership team • System working to develop an ICS Financial Strategy and position through an NCL Finance and Oversight Committee with representation from NCL Trusts and CCG • Establishment of the NCL Inequalities Fund; top sliced from system allocation with agreement that this should be recurrent and incremental
Clinical Leadership Development	NCL People Board	• NCL People Board • NCL Clinical Advisory Group • CCG Governing Body • Trust boards	• Initial engagement on the vision for future clinical and care leadership with STP/ICS leads, NCL CCG Governing Body DASS, DPH, ICP Chairs, GP Alliance / Federation leads, Local Care Forum, NCL People Board, Training Hubs, Pharmacy leads, CCG Directors and development of key themes to inform next stage of framework development • Ongoing work towards agreeing an interim framework for NCL clinical and care leadership for 22/23 at system and place level in line with the five core design principles set out in guidance
Role of Strategic Commissioning	CCG Governing Body	• CCG Governing Body • Local Care Forum • ICP Meetings	• How strategic commissioning lead to better outcomes for our residents and patients • Identifying changes needed in the way we engage with local authorities and other system partners • Identifying additional skills and competencies should commissioners have to embed a strategic

London's 16 Conditions of Success for an ICS

London Priorities	NCL Position	Progress since Q3	Status
Strategic Direction & Measure of Success: There is a clear post-Covid narrative for health and care which partners and stakeholders support	We have made significant progress towards embedding a post-Covid narrative in our system through our recovery programme across acute, mental health, community and primary care.	• Continued work towards system-wide recovery through Silver Cells supported by the Accelerator Funds • Continued cross-system work to reduce inequalities in recovery, Covid and flu vaccination *Sections 6, 7 & 14: Arrangements for Place Based Partnerships, Provider Collaborative Arrangements and Engagement plan with system partners*	**In Place**
Strategic Direction & Measure of Success: There are appropriate measures and metrics of success with which we can measure progress and hold ourselves to account for continuous improvement	We have developed in-depth life course analysis of the residents of our 5 boroughs and established the Population Health and Inequalities Committee.	• Development of a Population Health Outcomes Framework as a key measure of our success in reducing population health inequities • Ongoing work to create a high performing intelligence function with professional leadership, that places analysis at the heart of strategic, operational and clinical/care decision making *Section 13 & 14: Data and digital transformation and Engagement plan with system partners*	**In Place and Ongoing**
Place Based Elements of the ICS: Health and care resources at a neighbourhood/LCN/ PCN level are well developed, integrated and resourced to be effective in providing high quality local care	With 32 PCNs and six established GP Federations, primary care representation in the Provider Alliance and in ICS Senior Leadership; our Primary Care Networks are well embedded in our ICS	• Reference group has met to determine form and function of a GP Provider Alliance with PCNs, 111 and LMC • Agreement on primary care priorities through wide system engagement • Continued work on interfaces with secondary care. *Section 6 & 7: Arrangements for Place Based Partnerships & Provider Collaborative Arrangements*	**In Place**
Place Based Elements of the ICS: Borough based integrated care partnerships are up and running and delivering intended benefits, community and primary care are integrated with local acute care	Five effective borough based partnerships that agree local priorities in partnership with local acute, community, mental health trusts, local authorities and primary care.	• Commenced ongoing OD programme of support in October 2022 to further develop borough partnerships. *Section 6 Arrangements for Place Based Partnerships*	**In Place**
Place Based Elements of the ICS: Provider collaboratives are up and running and delivering the benefits and outcomes we expect of them as pan borough vehicles (and not becoming additional layers or provider monopolies).	All NCL providers (acute, mental health and community trusts, primary care) have established a single provider alliance; and appointed a Managing Director to move into delivery of priority programmes.	• Provider Alliance has agreed name of UCL Health Alliance, appointed a Managing Director and agreed initial priorities • GP Provider Alliance has appointed a Managing Director *Section 7: Provider Collaborative Arrangements*	**In Place and Ongoing**
Place Based Elements of the ICS: The existing statutory institutions of health and care systems (e.g. NHS Trusts, FTs, Governors, HWBBs) are delivering positive benefit of focus on institutions without disbenefit on lack of focus across the system	We have role-modelled effective balancing of institutional and system focus via decision making through our GOLD arrangements and Covid Vaccination programme throughout the pandemic.	• Continued to stress test through ICS Steering Committee and Partnership Council, forerunners of ICS Governance • Establishment of the NCL System Management Board *Section 4: Managing the transition to statutory ICS*	**In Place**

London's 16 Conditions of Success for an ICS

London Priorities	NCL Position	Progress Since Q3	Status
Strong Partnerships: The role of local councils as critical partners in achieving long-term aims for prevention and health and wellbeing is fully recognised and reflected in the approach to strengthening health and care partnerships at all levels of the ICS	NCL Councils are critical partners in our ICS Steering Committee, NCL Population Health & Inequalities Committee, part of the exec chair of our Borough Partnerships (jointly chaired), and members of the ICS Partnership Council. They also play a key role in helping develop and embed our population health approach.	• Planned series of engagement with our local councils on embedding a shared understanding about the role of an Integrated Care System to July 2022 • NCL CEO forum meeting monthly with ICB CEO/Chair Designates *Section 4 & 14: Managing the transition to statutory ICS & Engagement plan with system partners*	**In Place and Ongoing**
Strong Partnerships: A strong set of clinical leaders and clinical networks within the ICS who are sufficiently empowered to improve system performance	The emerging ICS Leadership has well established roles for clinical leadership- such as those of a Primary and Secondary Care Chief Medical Officer and a Chief Nurse. NCL has successfully developed Clinical Networks, and our Clinical Advisory Group has provided essential oversight and scrutiny to our decision making during our Covid response. The appointment of the CNO and CMO to the ICB Executive Team will strengthen the clinical leadership and approach within NCL.	• Engagement across clinical and multi-professional leadership to begin designing a framework for clinical leadership at system, place and neighbourhood level in our ICS building from our current clinical leadership • Ongoing work to transition current clinical leadership into a more inclusive ICS clinical and care leadership at system and place level *Section 8: Arrangements for establishing and supporting clinical and care professional leadership across their ICS*	**In Place and Ongoing**
Strong Partnerships: Resident and patient engagement is strong at all levels of the local system and supports decision making quality and legitimacy	We are committed to embedding our resident voice in defining the role and purpose of our Integrated Care System. Our borough partnerships have close links with their local HealthWatch and we continue to engage with residents through multiple forums	• Establishment of the Community Partnership Forum with membership including HealthWatch, Voluntary Services and Patient Participation as a key means of overseeing and ensuring resident involvement at a system wide level • Development of the *NCL People and Communities Engagement Strategy and the NCL VCSE Strategy* *Section 10 & 14: Engagement plan with system partners & Arrangements for working with people and communities*	**In Place**
Strong Partnerships: Health and care staff are supported by workforce strategies, cultures and plans which help them to operate effectively at institution, ICS and regional levels as appropriate ((and transitions are managed well)	This can be evidenced through the NCL People Plan, and ICS level workforce mission and vision, our commitment to staff wellbeing as part of our recovery plans, and ongoing programmes of OD. The appointment of the CPO to the ICB Executive Team will strengthen the leadership and approach to workforce across NCL.	• Ongoing work to develop the NCL ICS People Function ensuring that workforce continues to be at the heart of what we do across NCL • Support workforce development and "one workforce" function across health and care • Ongoing work to support the safe transition of CCG staff in line with the ICS HR Transition Framework	**In Place and Ongoing**

London's 16 Conditions of Success for an ICS

London Priorities	NCL Position	Progress since Q3	Status:
Effective ICS Governance & Decision Making: The formal governance of the ICS is lean and fit for the purpose of it's legislative function and system leadership mission (whilst avoiding becoming a "super CCG" or SHA)	We have a well established Partnership Council, ICS Steering Committee and Community Partnership Forum as a forerunner of future ICS Governance. Shadow Boards are in place for April and June prior to transition	• Appointment of ICS Chair Designate and ICS CEO Designate recommended • Continued stress testing of governance arrangements and memberships • Recruitment commenced for all Executives and NEMs designate roles • Nominations approach for Partner Members to be launched once Bill has gained Royal Assent *Section 4: Managing the transition to statutory ICS*	**In Place and Ongoing**
Effective ICS Governance & Decision Making: There is increased freedom to move money around the health and care system to support sustainability through improving quality, reducing costs and increasing equality	We have agreed financial principles and system ways of working; piloted a financial approach to tackle health inequalities through the Health Inequalities Fund; and supported innovative ways of working across the system through the Accelerated System Recovery Fund	• System-wide response to Accelerator Recovery and Targeted Investment Fund ensuring there is a system agreement to investment in line with our ICS priorities • Ongoing work to further integrate financial planning with our emerging population health strategy *Section 12: Financial Flows and allocation of funding*	**In Place and Ongoing**
Effective ICS Governance & Decision Making: There are effective cultures, mechanisms and support for mutual aid and holding each other to account for continuous improvement in system performance and reduction in unwarranted variation	Our principles of mutual aid- role modelled through the pandemic across acute, community, mental health and primary care – have played a critical role in pandemic response and elective recovery across the system	• ICS Gold meetings and System Management Board in place • Continued work through our Operational Implementation Group to ensure a system-wide framework for elective recovery • Continued work through a "One NCL" approach to our waiting list • Continued work through system-wide procurement infrastructure to build sustainability and deal with supply chain issues *Section 15 & 16: Population Health Outcomes*	**In Place**
Effective ICS Governance & Decision Making: Decision making at all levels is supported by excellent population health data and management supporting improving health outcomes and reducing health inequalities	We have embedded population health data in programmes such as Covid vaccination through HealtheIntent (PHM system); and also established a Health Inequalities Fund as a step towards supporting a population health approach	• Continue to work with wider system partners to onboard onto HIE/HealtheIntent • Ongoing work to create a high performing intelligence function with professional leadership, that places analysis at the heart of strategic, operational and clinical/care decision making *Section 13: Roadmap for data and digital transformation*	**In Place and Ongoing**
Regional Added Value: *There is sufficient standardisation of ICS governance approaches, specifically in core structures and mandated performance metrics, which allows for London-level sharing, line of sight and accountability*		*These two conditions of success have been earmarked as those for which a "single regional approach would be necessary"* *The NCL ICS Executive Leadership and ICS Transition team continues to engage with the regional team to feed into regional thinking and respond to emerging guidance*	
Regional Added Value: *The regional role and operating model has a clear focus centred on added-value to ICSs plus holding them to account; and the respective roles for region and ICS are clear and appropriate*			

ICB Constitution- Areas of Development for Functions and Decisions Map

ICB Board Membership

The Board membership will need to be agreed including it size and composition to be effective. Factors include the number of Independent Non-Executive Directors, the number of partner members, what perspectives we need around the table and what we can gain insight into through meaningful engagement and how conflicts of interests will be managed.

Oversight and Functions and How Decisions are Made

The ICB's committee structure will need to be agreed including ensuring robust oversight of the exercise of the ICB's statutory functions, where decisions are made and whether any of the commissioning responsibilities will be delegated to any ICS statutory provider or groups of statutory providers. This includes consideration of decision making and operating at place.

Appointment Process and Terms of Office for ICB Board Members

The Chair designate has been, and Chief Executive designate is being, appointed through a national process. However, it will need to be agreed how the other Board members are appointed, the lengths of their Terms of Office, any additional qualification or disqualification criteria and how they may be removed from office.

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Refreshed timeline for Developing Functions and Decisions Map based on revised target date of ICS establishment to 1st July

Plan (Oct-Dec 2021)

Identify and plan for tasks required to prepare a comprehensive Functions and Decisions Map for NCL

Identify elements of functions and decisions map and develop plan and timetable, including dependencies, for creating final document.

Map current committees with transfer of powers to committees to be created.

Work with appointed CEO to develop in line with ICB Board membership.

Work in line with upcoming NHSE guidance on the requirements of a function and decisions map.

Review (Jan-Apr 2022)

Test and refine with system partners

Share draft with system partners for review and comments. Engagement Feb-Mar.

Work with newly appointed system executives to test the proposed structure.

Through existing committees/ working groups, test decision making process to help identify any challenges/ issues to proposed structures and identify options to resolve.

Escalate risks/ issues to executive team and/or NHSE

~~Submission of final proposed draft constitution 22~~ April

Finalise (By 20 May 2022)

As outlined in ICB Establishment Timeline

Ensure that ICB functions and decision map is prepared
- including (where applicable) place boundaries, place- based leadership, and place-based governance arrangements (e.g. with Health and Wellbeing Boards); delegations (where appropriate); and any supra-ICB governance arrangements.

Transparency of decision making and ready to share across the system and with the public.

Target date for settled constitutions 22 April

Statutory guidance and final model constitution by 13 May

Submission 20 May

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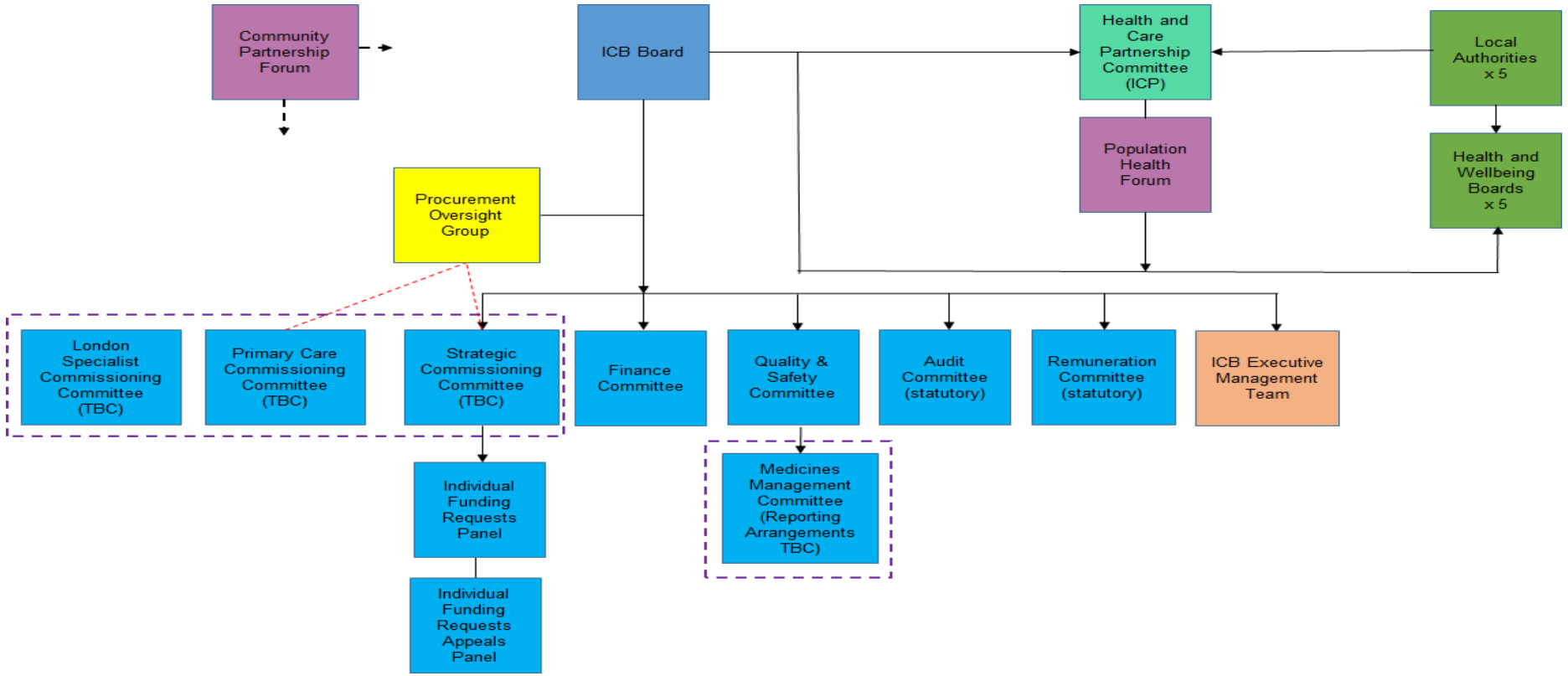
NHS North Central London Integrated Care Board Functions and Decisions Map*

ICB Governance Structure

The ICB's proposed governance structure is as follows:



*This version of the Functions and Decisions Map was used for Constitution engagement with system partners in February to March 2022. Following feedback, the structure is under development and an updated version of the structure will be shared in April.

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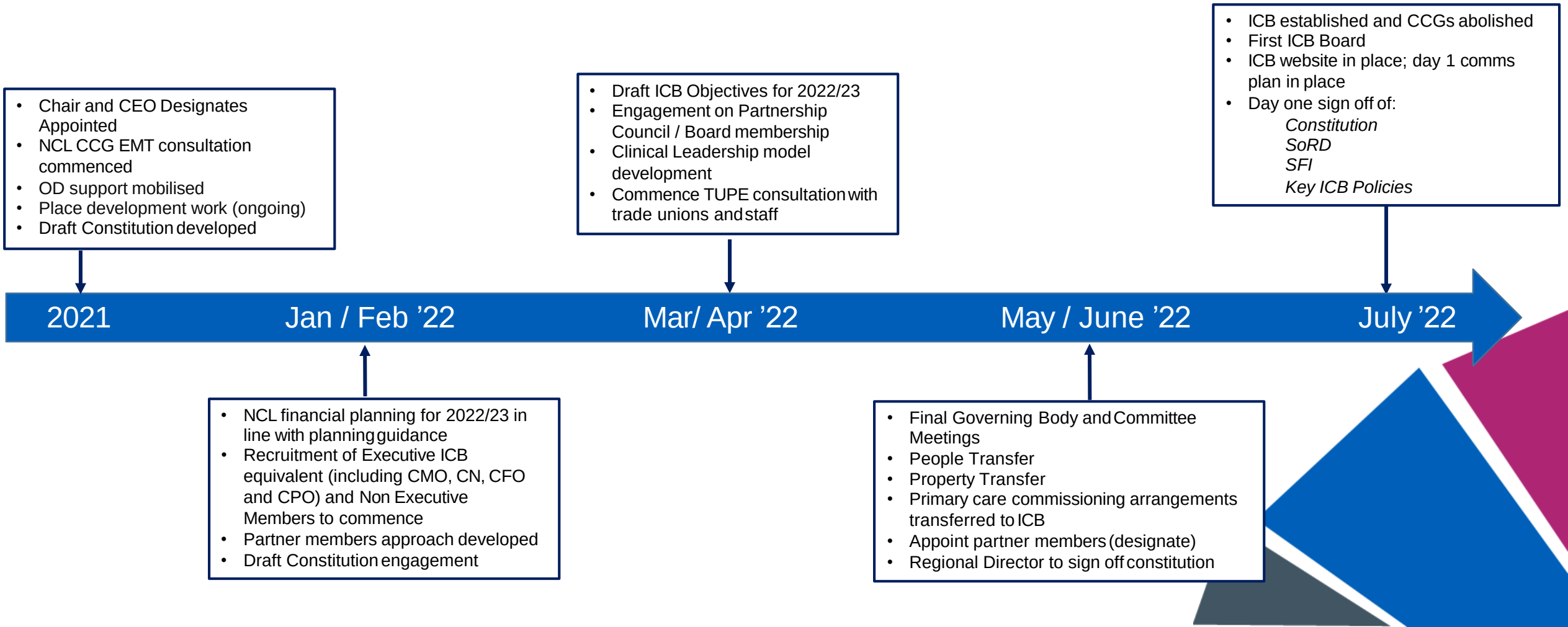
Timeline of Transition to the NCL ICB

Following the delay to the target date, the timeline for our transition has been adapted to reflect further information made available and in line with legislative changes.



ICS Transition Due Diligence Critical Path

The following slide lays out the key due diligence milestones for NCL's transition to an ICS.

This document has been developed through the bi-weekly Due Diligence meetings and the NCL ICS Transition Board

This document will ensure that each workstream and the overall transition meet the assurance requirements set by NHSEI, ICB establishment timelines and local priorities by July ’22

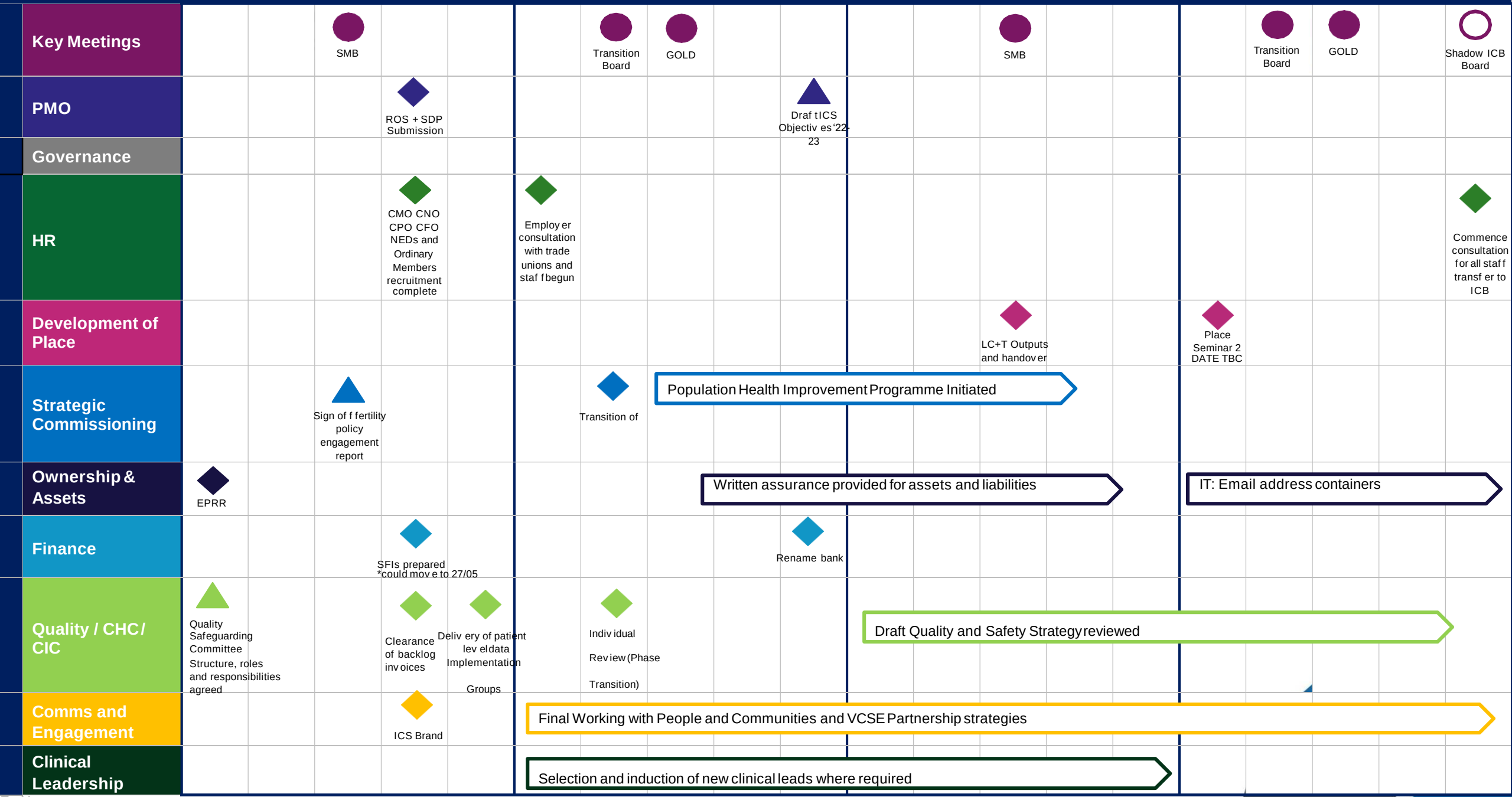
Please note that the following timelines are developing alongside due diligence and any changes in the ICB establishment timeline as laid out by NHSEI.

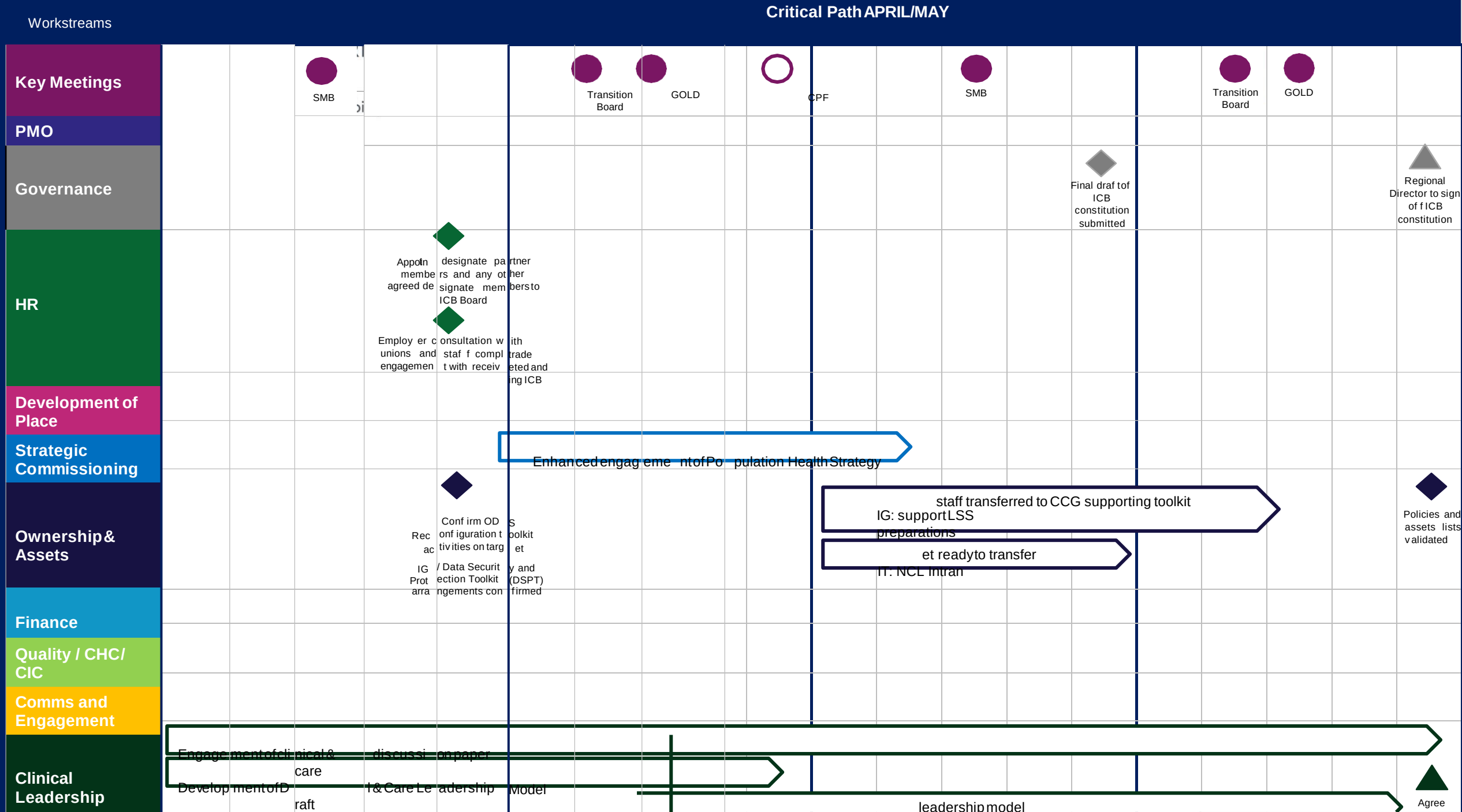
Overall Critical Path NCL ICS (Feb-July 2022)

Workstreams	28-Feb - 4-Mar	7-Mar - 11-Mar	14-Mar - 18-Mar	21-Mar - 25-Mar	28-Mar - 1-Apr	4-Apr - 8-Apr	11-Apr - 15-Apr	18-Apr - 22-Apr	25-Apr - 29-Apr	2-May - 6-May	9-May - 13-May	16-May - 20-May	23-May - 27-May	30-May - 3-Jun	6-Jun - 10-Jun	13-Jun - 17-Jun	20-Jun - 24-Jun	27-Jun - 01 Jul	4-Jul - 8-Jul
PMO					ROS + SDP Submission				ICB Board arrangements				Final ROS Submission	Assurance from CCG AOs to ICB designate CEs that due diligence processes complete		Statement of Readiness signed off by region		1st ICB Board	
Governance			Draft ICB Constitution Agreed						Constitution Development		Final draft of ICB constitution submitted	Regional Director to sign off ICB constitution	Production of the draft Risk Management Policy Production of final draft Corp gov ernance policies Final draft Committee ToR ICB Functions & Decision Map SoRD Prepared					ICB Established Sign Off: Constitution, governance handbook, key policies etc.	
HR	CNO, CMO, CPO, CFO			Complete executiv e recruitment process for ICB Board	NEMs and Ordinary Members recruitment				Appoint designate partner members and any other agreed designate members to ICB Board									Full staf ftransfer to ICB Incl. LSS	
HR	Publish consultation outcome paper and EIA					Employer consultation with trade unions and staf fbegun													
HR																			
HR																			
Strategic Commissioning																		Contracts novated to ICB	
Ownership & Assets								Confirm ODS Reconfiguration toolkit activities on target IG/ Data Security and Protection Toolkit (DSPT) arrangements confirmed		Toolkit development				Complete DSP toolkit activities & ODS toolkit activities					
Finance		Confirm bank accounts					Preparation of SFIs					VAT registration submission						New ledger go live	
Quality/ CHC/ CIC					Clearance of backlog invoices														
Comms & Engagement	People & Communities & VCSE Partnership Strategies Draft				ICS Branding													Day 1 launch comms plan	

Critical Path MARCH/APRIL

Workstreams




Workstreams
Critical Path APRIL/MAY
Key Meetings
PMO
Governance
HR
Development of Place
Strategic Commissioning
Ownership & Assets
Finance
Quality / CHC/ CIC
Comms and Engagement
Clinical Leadership
SMB
Transition Board
GOLD
CPF
SMB
Transition Board
GOLD
Final draf tof ICB constitution submitted
Regional Director to sign of f ICB constitution
designate pa rtner
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signate mem bers to
ICB Board
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trade
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Enhanced engag eme nt of Po pulation Health Strategy
staff transferred to CCG supporting toolkit
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preparations
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Model
leadership model
Agree

Critical Path MAY/JUNE

Workstreams

Key Meetings

SMB

Transition Board

GOLD

SMB

Shadow ICB Board

Transition Board

GOLD

PMO

transform

Final ROS Submission

Written assurance from CCG AOs to ICB designate CEs that due diligence processes have been completed

CCG closedown processes

Statement of Readiness sign off by region

Governance

*TBC

Production of the draft Risk Management Policy

Production of final draft Corp governance policies

Final draft Committee ToR

ICB Functions & Decision Map

SoRD Prepared

HR

Development of Place

Strategic Commissioning

Ownership & Assets

Complete DSP toolkit activities & ODS toolkit activities

IG: support LSS staff transferred to CCG supporting toolkit preparations

Finance

VAT registration submission

Who Pays guidance released

Financial Close Down Processes

Go/No Go Assessment

Quality / CHC/ CIC

Comms & Engagement

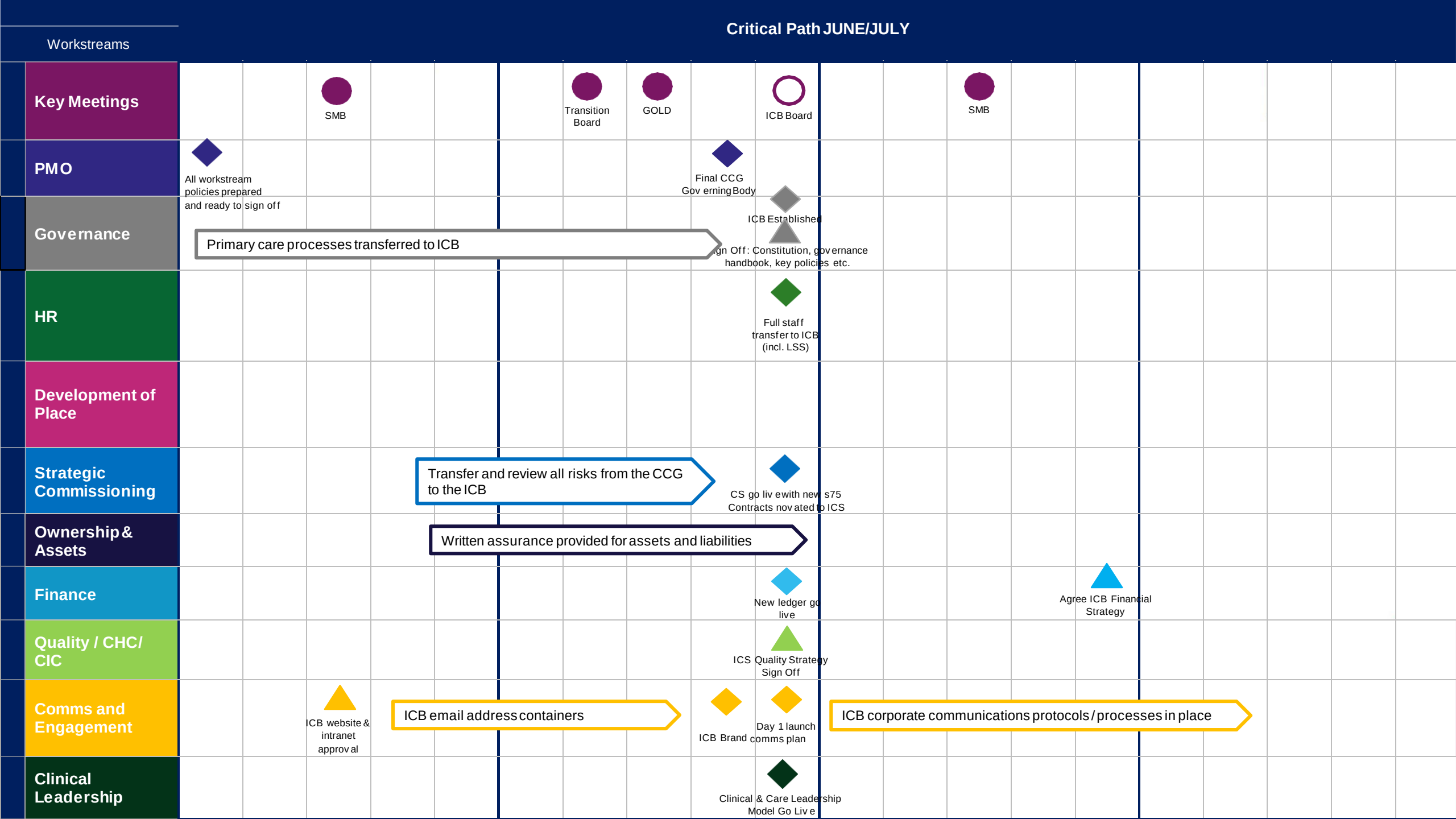
Digital engagement strategy agree

Clinical Leadership

Agree workplans and managerial support for clinical leads for 2022-2023 aligned with ICS vision and priorities

Clinical & Care Leadership Mo Signed off

Critical Path JUNE/JULY



NCL ICS Transition Priorities by month

MONTH	KEY PRIORITIES
FEB	• Constitution engagement • Recruitment • Development of committee membership
MARCH	• Draft ICB Constitution agreed • Operational planning • Non executive and partner members recruitment • New Exec team development
APRIL	• Draft ICS Objectives for '22-'23 (linked to operational planning) • SOF and approach to performance & oversight • Development of Health and Care Partnership / ICB Board Membership • Application of outputs of Leadership Centre & Traverse OD work • Shadow ICB Board in place • IT: email containers/websites • LSS onboarding • Preparation of SFIs
MAY	• Clinical Leadership model in development • Further engagement on the Population Health Strategy • ICB Constitution signed off by NHSE • Ensuring NCL Intranet is ready to transfer • Supporting staff ahead of transfer to ICB
JUNE	• Final Governing Body and Committee Meetings • Complete Due Diligence Process • Financial close down • CCG Close down • People Transfer • Property Transfer • Primary Care arrangements transferred to ICB
JULY	• ICB Board in place • Day one sign off *Constitution / SoRD / SFI / Key ICB Policies* • Final Constitution published on ICB website • Agree ICB Financial Strategy

Key Transition Risks

No.	Risk	C	L	T	Mitigation	Owner
1.	Leadership and system capacity through ongoing pandemic response stretched reducing benefits that can be delivered or impacting pandemic response	3	4	12	• Critical path planning • Early escalation of issues • Use of existing system forums • Working to align ICS development with pandemic response • Protected time for escalation and system issues with leaders through GOLD • Protected time for transformation and transition work with leaders through SMB	Richard Dale/Frances O'Callaghan
2.	Delegation of additional responsibilities for commissioning of dentistry, optometry and pharmacy services is undertaken without sufficient capacity and resource to deliver ICB and ICS objectives.	3	3	9	• NCL to seek a date effective of April 23 • Link with London ICS, Regional team and National to shape and influence the delegation agreement • Undertake formal due diligence including work to understand anytransferring liability • Review current performance and qualityinformation for services proposed for delegation to understand anykey risks • Review staffing and potential for TUPE of regional and/or national commissioning staff	Sarah McDonnell-Davis
3.	Loss of continuity, capacity and key relationships in Clinical roles as part of change	3	3	9	• All clinical leads offered an extension to 30th September 2022 • Active comms and engagement with clinical leadership ongoing • Work on clinical leadership framework extended to July 2022 • Clinical leadership to be included in system leadership development OD work • Strengthening existing clinical networks to ensure leadership is distributed	Frances O'Callaghan
4.	Delay to ICS transition to 1st July 2022 could impact pace of work within transition workstreams	3	2	6	• Critical path planning post April 2022 • Links with NHSE/I regional operations groups • Continue preparation across key transition workstreams, with options appraisals • Continued work on priority areas • Continue Transition Due Diligence at pace with unchanged timelines	Richard Dale
5	Disruption to CCG operations and transition delivery due to CCG staff anxiety related to HR transition and delay to staff consultation	2	3	6	• Active comms and engagement with CCG Staff • Established HR framework and support package • Planned OD work across CCG and broader system	Richard Dale/ Frances O' Callaghan
6.	Loss of continuity, capacity and key relationships in Executive roles as part of change	3	2	6	• Agreed deputies for key streams of work across system • Active comms and engagement of senior and clinical leadership	Frances O'Callaghan
7.	Local elections impacts public engagement	2	3	6	• Early meaningful communications and engagement through existing groups • Capacity check across system e.g. providers for comms support • Comprehensive comms and engagement plan with the public	Richard Dale
8.	Differential ambitions and expectations on place based arrangements across systems	2	2	4	• Place based design events and OD support • Early agreement on 22/23 priorities for places (COVID vaccine, Inequalities fund etc.)	Sarah McDonnell Davis
9.	Perception of lack of accountability and resident voice	2	2	4	• Formation of the Community Partnership Forum • Ongoing engagement campaign • Close working with JHOSC and HOSCs jointly with councils	Richard Dale

Corporate Transition Risk Management

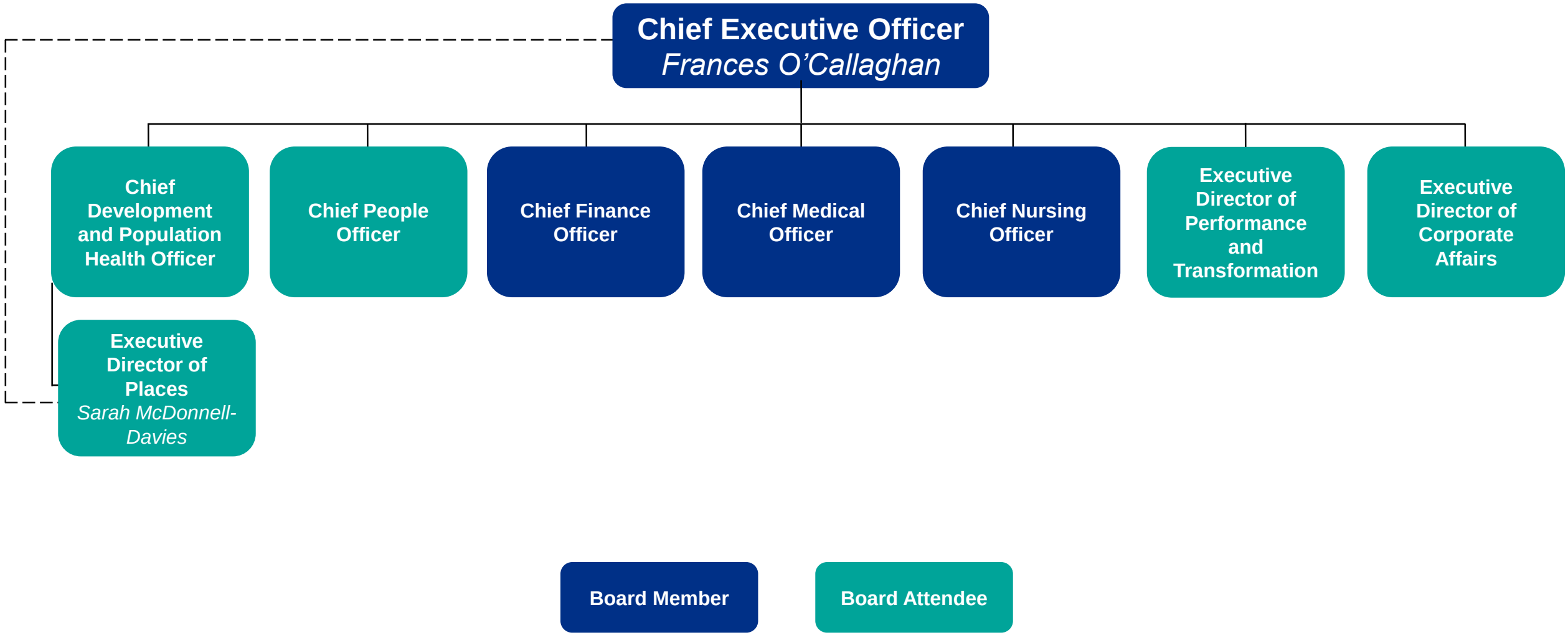
NCL ICS Corporate Transition Risks are held centrally but managed locally through the following CCG Forum and Committees:

- Primary Care Commissioning Committee
- Quality and Safety Committee
- Strategy and Commissioning Committee
- Finance Committee
- Executive Management Team Meeting
- Patient and Public Engagement and Equalities Committee

NHS North Central London Integrated Care Board Development

Work on key areas of ICS development is progressing well, with the appointment of our ICB Chair designate Mike Cooke and ICB CEO designate Frances O'Callaghan. Further appointments to our Executive posts have now been confirmed. Sarah Mansuralli has been appointed Chief Development and Population Health Officer designate, Sarah McDonnell-Davies has been appointed Executive Director of Places designate and Ian Porter has been appointed Executive Director of Corporate Affairs designate, Dr Josephine Sauvage has been appointed Chief Medical Officer designate and Richard Dale has been appointed Executive Director of Performance and Transformation designate. The executive structure can be found on the following slide.

NHS North Central London ICB Board



NORTH LONDON PARTNERS
in health and care

NHS

The North Central London health and care system

- 12 hospital trusts
- 5 local authorities
- One clinical commissioning group
- 200+ general practices
- 300+ pharmacies
- 200+ care homes
- Countless voluntary sector organisations and community groups providing essential care

[1] Index of Multiple Deprivation, 2019

Building on strong foundations in NCL

- Whilst ICSs are new statutory organisations, we have a track record of close working between partners, NHS and LA, through the STP and other collaborative programmes of work.
- In April 2020 the five Clinical Commissioning Groups in North Central London (NCL CCGs) – Barnet, Camden, Enfield, Haringey and Islington – merged to form one CCG.
- We have strong partnerships already formed in each borough to support working at a 'place' level.
- Alongside this, we have 33 thriving primary care networks across the area.
- Over the last year system partners have worked closely together, with the CCG, Councils, NHS providers, general practices, voluntary and community organisations, working to respond to the pandemic.
- There has been continued progress towards a more strategic approach to health commissioning at NCL-level, and within our borough partnerships.

Introductio
ns

This paper attempts to set out the Commissioning Cycle as it stands for the North Central London Clinical Commissioning Group (NCL CCG).

This considers the process from initial Business Case through to Mobilisation of the service and all steps in between.

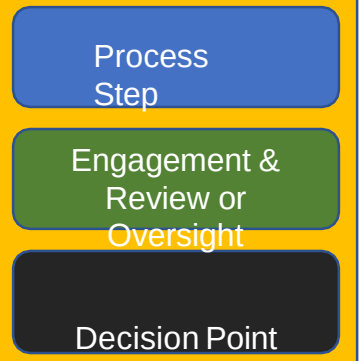
Note 1: The processes here do not cover the need to raise a Purchase Order if one is required.

Note 2: The process also applies to Non-Clinical/Healthcare Services and these decisions will be recorded in a separate register to the Clinical/Healthcare Contract Register.

Note 3: The process can be circumvented in exceptional circumstances or where other guidance is issued. This may include seeking virtual decisions or in extremis a Chairs Action or other process as agreed by

Document Key

This document uses the three colours shown here to indicate the type of step being described and is



Abbreviations Used

AO – Accountable Officer CFO – Chief Finance Officer ED – Executive Director
COO – Chief Operating Officer
ED SCD – Executive Director Strategic Commissioning Directorate FD – Finance Director
AD – Assistant Director
HoS – Head of Service

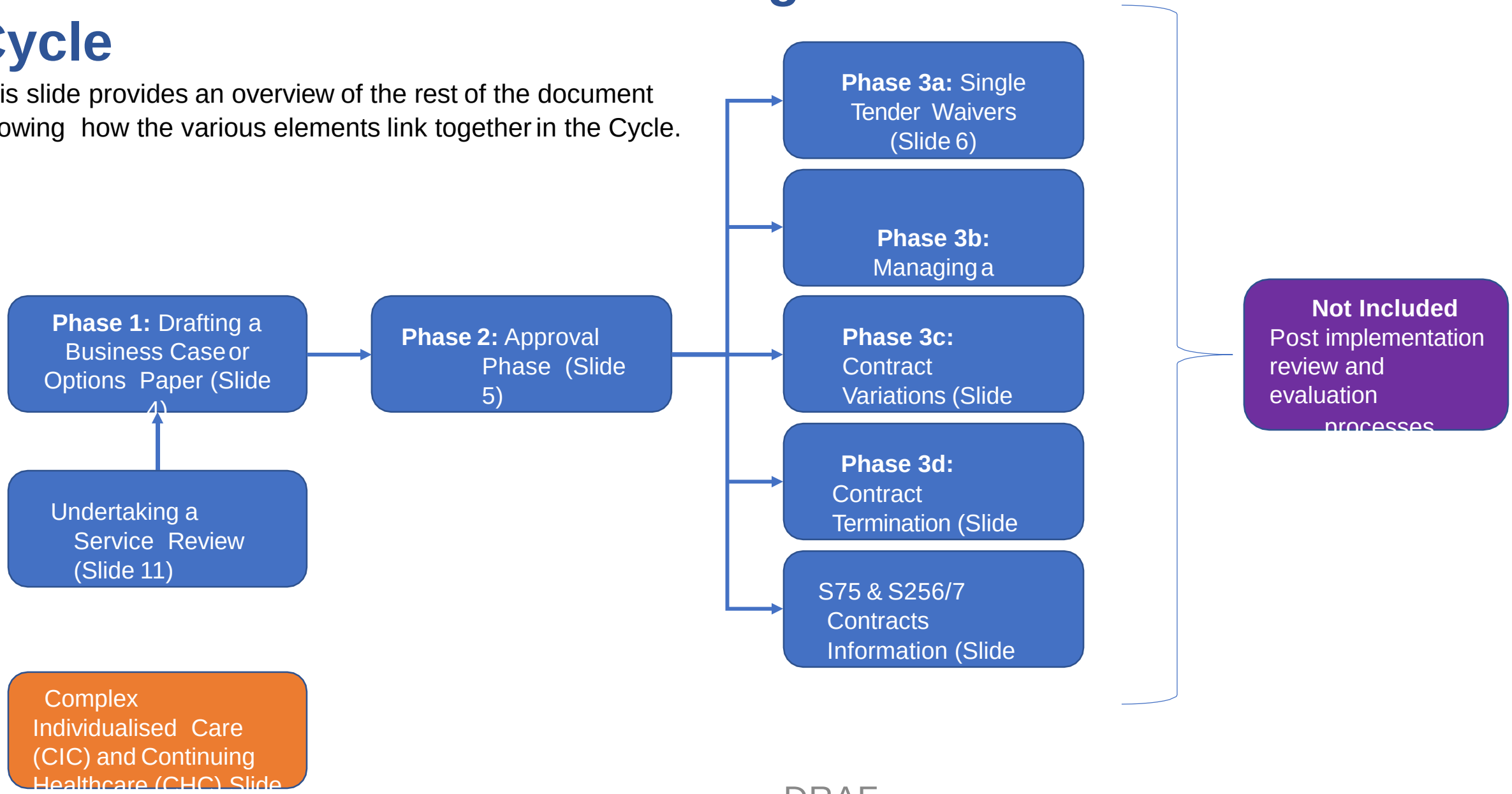
DMT – Directorate Management Team EMT – Executive Management Team
SCC – Strategy & Commissioning Committee FCWG – Finance & Contract Working Group

STW – Single Tender Waiver
PID – Project Initiation Document SEP – System Efficiency Plan
EQIA – Equality & Quality Impact Assessment
LCS – Locally Commissioned Service PCN – Primary Care Network

VCS – Voluntary & Charitable Sector PoC – Package of Care
TPuPoC – Previously Unassessed Period of Care

Overview of the Commissioning Cycle

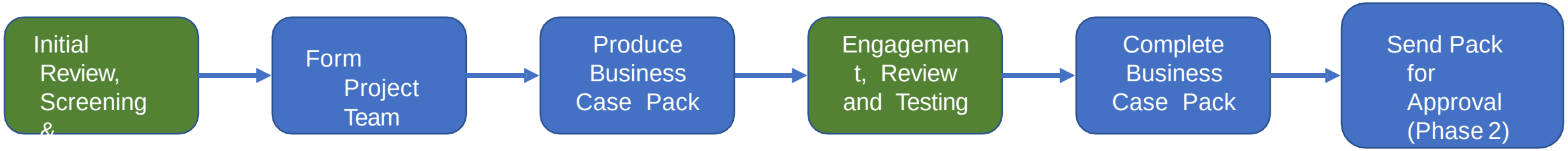
This slide provides an overview of the rest of the document showing how the various elements link together in the Cycle.



Phase 1: Drafting a Business Case (including for an LCS)

This process concerns the steps that should be taken prior to the formal approval process. Prior to commencing a Full (or Sim plified) Business Case you should produce a 'Project Initiation Document' (PID) or an Options Paper to have the concept you are seeking support for tested before investing time in a Business Case. The PID may also avoid the need for a Business Case for smaller proposals.

Total Lifetime Value is calculated by multiplying the total annual value by the number of years of the contract. <u>For recurrent investments</u> <u>you should assume the contract length is equivalent to 5 Years.</u>



Produce an initial scoping paper (or Project Initiation Document) of no more than 2-3 pages to set out the following:

- Overview of the problem to be solved (ie Needs Analysis)
- The possible approaches that will be taken to address the problem
- Any risks or inequalities that need to be addressed in the work up
- The potential financial impact including scale of potential efficiencies and how these will be realised

This scoping paper should be reviewed by the Business and FD Case who will determine if it should also be seen at EMT.

Form a Core Team

- Commissioner
- Clinical Lead
- Finance
- Quality
- Engagement/Comms
- Contracts
- Business Intelligence
- Procurement (if required)
- HR (if required)

Also identify an Executive Director

Note 1
For <£500k Total Lifetime Value: Use a Simplified Business Case Template.
For >£500k Total Lifetime Value: Use a Full Business Case Template.

Business Pack consisting of:

1. Business Case (see Note 1)

- Background & Clinical Case
- Options Considered
- Preferred Option
- Financial Analysis
- Efficiencies & Social Value
- Outcomes/Outputs
- Capital/Estates/Digital Requirements
- Engagement/Comms Plan
- Risks & Issues
- Procurement Route
- Timeline to Mobilisation

2. Equality & Quality Impact Assessment (EQIA)

3. Any relevant evidence of guidance

Before approving the Business Case Pack it will need to be reviewed first and there may be a requirement to undertake engagement activities as appropriate and as advised. Examples of places to consider reviewing the pack are:

- Provider, ICS and/or ICP Meetings
- PPE Committee
- PH&I Committee
- Local Authorities (for S75/256/257)
- Clinical Network (if one exists)
- LMC/LOC or other similar Bodies
- Healthwatch or other similar Bodies
- Primary Care Committee/PCNs
- Directorate Management Teams
- Strategic Commissioning
- Finance & Contracts Working Group

All Business Case Packs must go to:

The Business Case will need to have the following signoffs before progressing to the formal approval phase:

- Clinical
- Commissioning
- Finance
- Quality
- Engagement/Communications

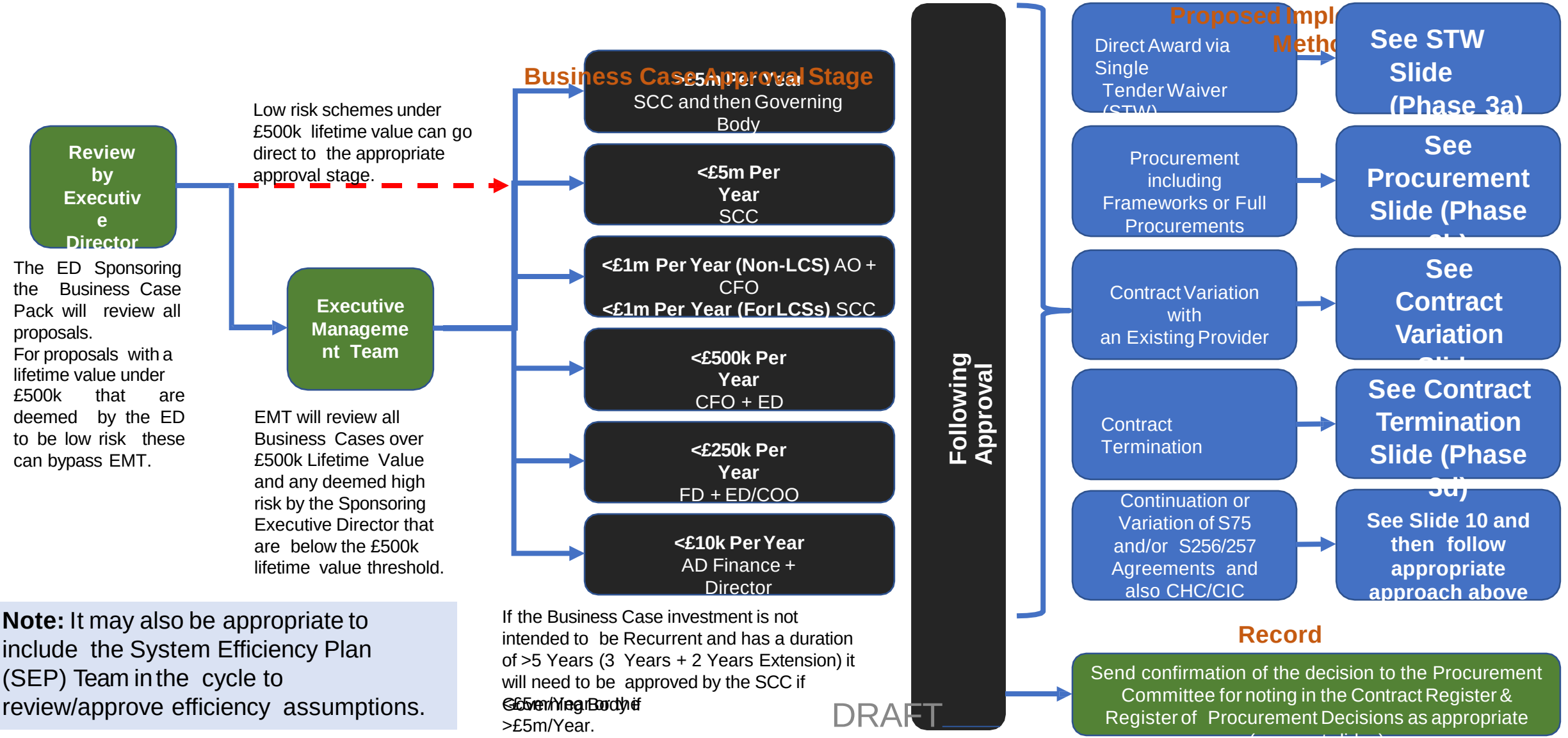
A Business Case Review & Signoff Sheet should be attached to the Business Case with the relevant signatures attached and details of the Groups/Committees that have reviewed the Business Case.

The pack should also include a completed Equality & Quality Impact Assessment.

Note 2
This process may need to be flexed for renewals and urgent actions as well as for any programmes where there is guidance suggesting alternative routes for work up.

Phase 2: Approval Phase

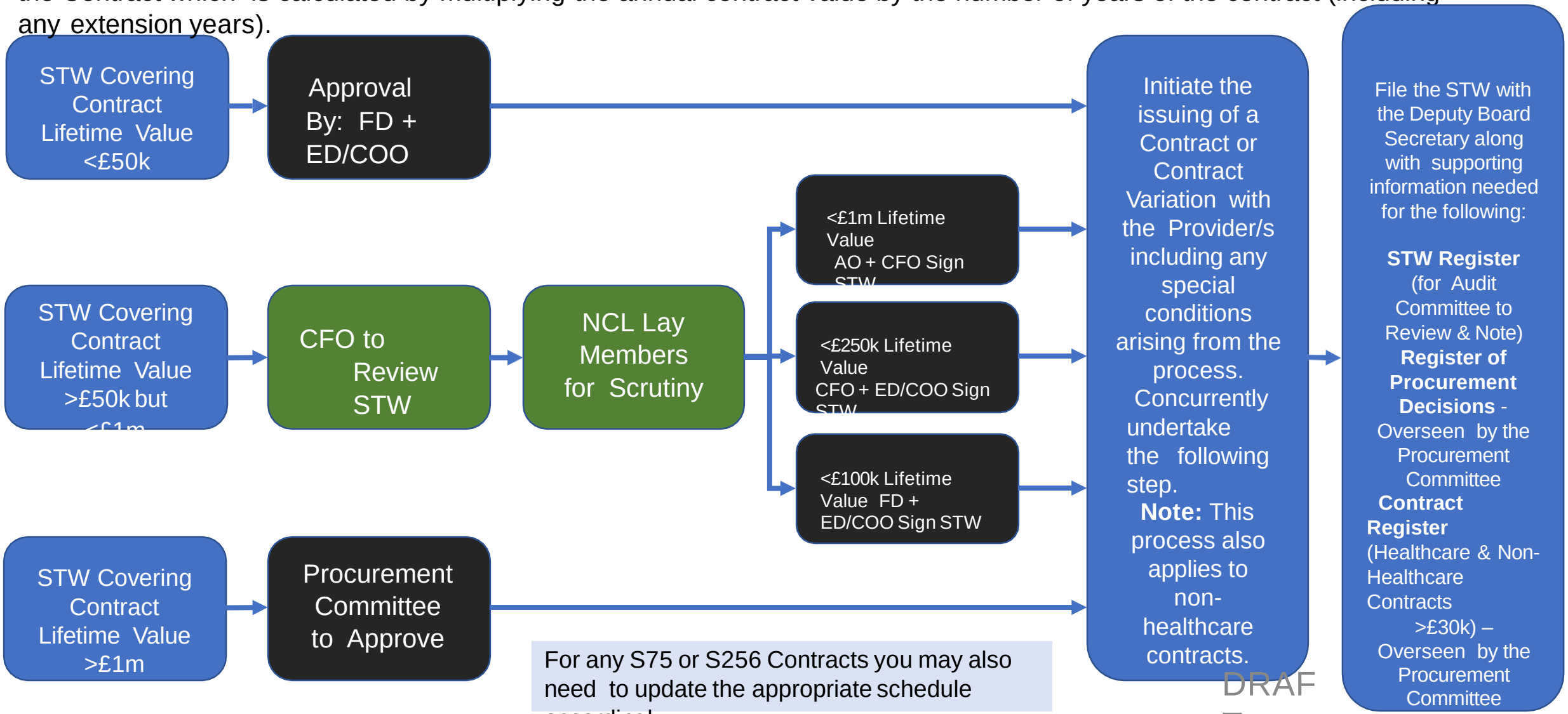
This phase deals with approving the Business Case or Options Paper and is aligned to the latest SFIs (Standing Financial Inst ructions).



Note: It may also be appropriate to include the System Efficiency Plan (SEP) Team in the cycle to review/approve efficiency assumptions.

Phase 3a: Single Tender Waivers

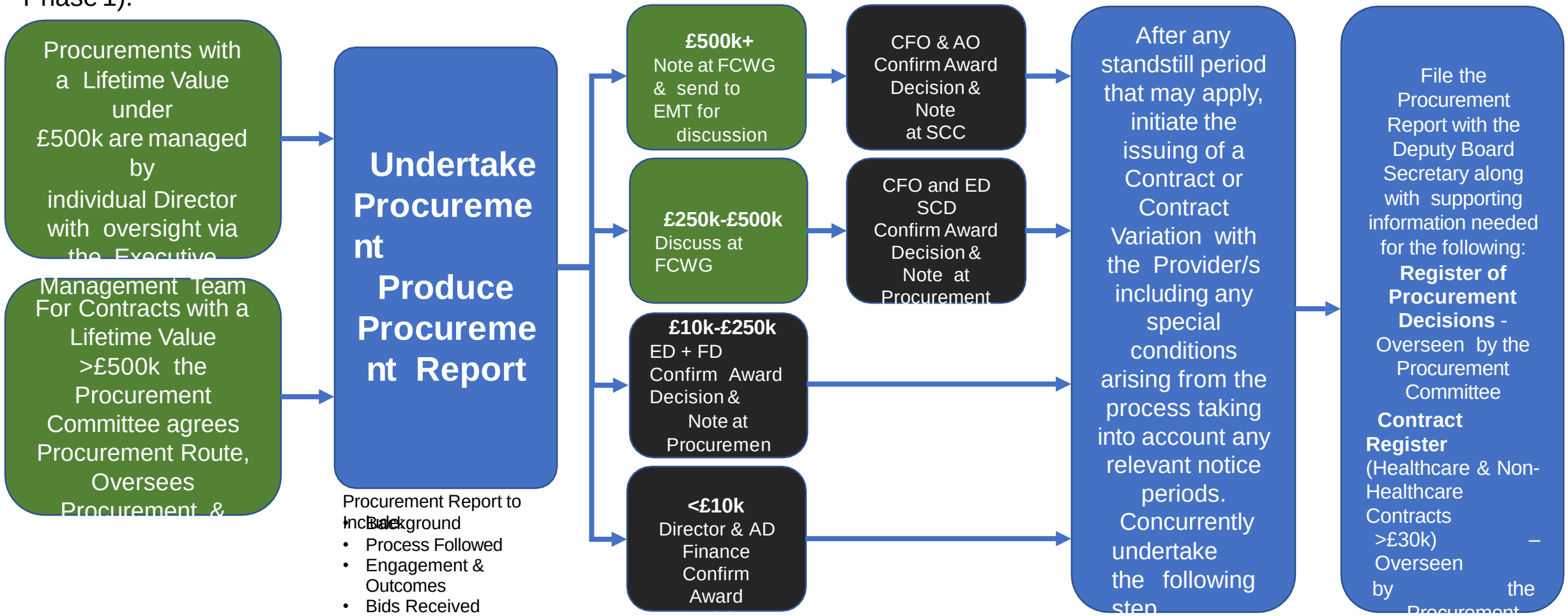
This slide covers the first of three implementation slides for Business Cases following approval of the Business Case itself. Single Tender Waivers (STWs) should be used sparingly. The process to be followed will depend on the Lifetime Value of the Contract which is calculated by multiplying the annual contract value by the number of years of the contract (including any extension years).



For any S75 or S256 Contracts you may also need to update the appropriate schedule accordingly.

Phase 3b: Managing a Procurement

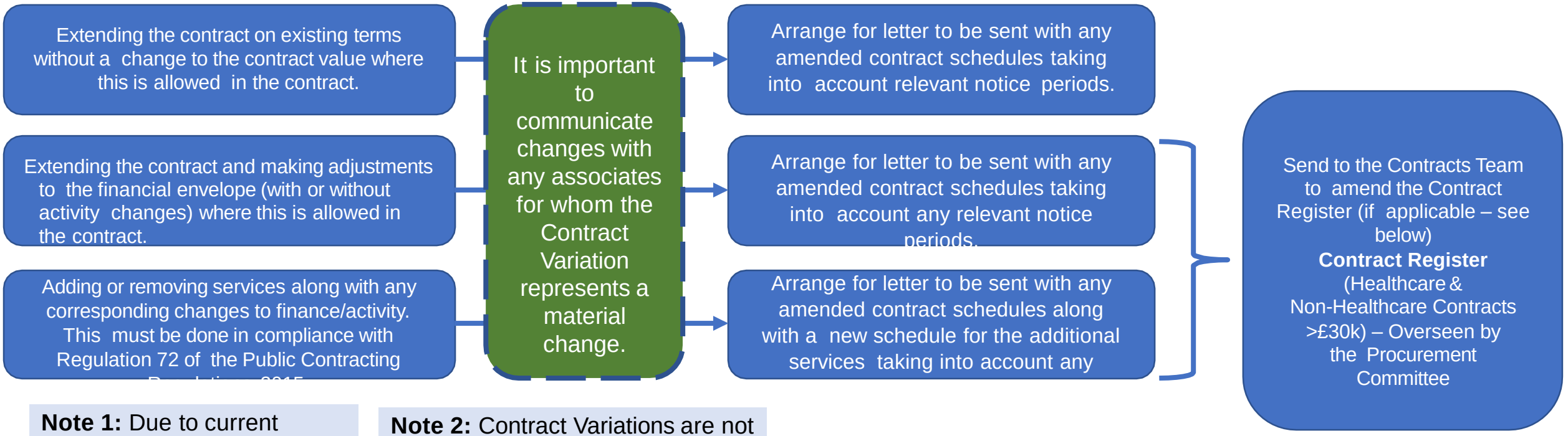
This process summarises the stages of a procurement. All procurements should be done in collaboration with the Procurement and Contracts Teams and should have an assessment panel formed to include all the relevant skills and disciplines (Clinical, Qual ity, Finance, Commissioning etc). The route is dependent on the Contract Lifetime Value (see Phase 1).



For any S75 or S256 Contracts you may also need to update the schedule accordingly.

Phase 3c: Contract Variations

This process covers allowable contract changes to NHS Contracts held either by an NHS or other Provider **where an STW is not required**. **Contract Variations should be agreed with finance first.** The last stage is to ensure that all providers agree the CV prior to formal letters being sent.



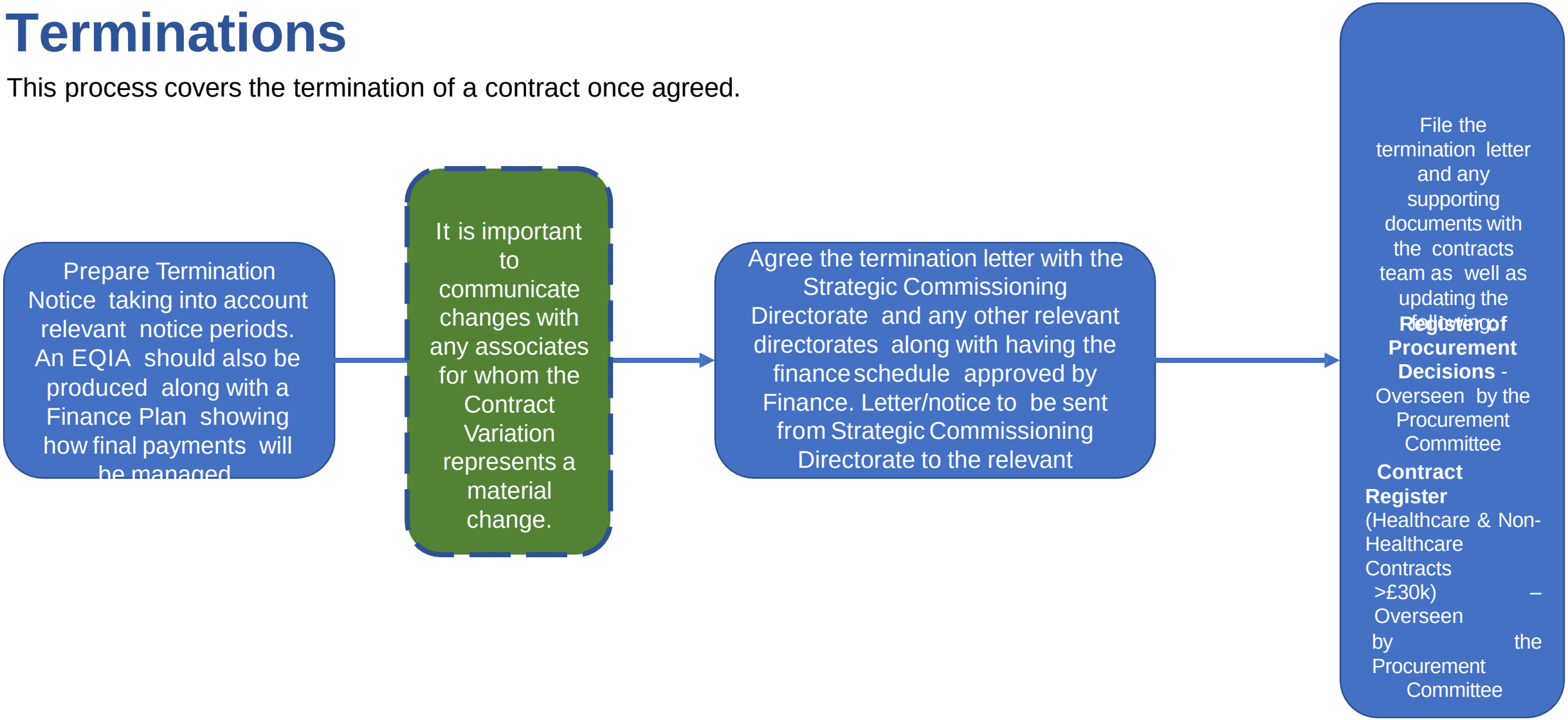
Note 1: Due to current Guidance most contracts are not able to be varied. This process therefore also covers Memorandum's of Understanding (MoU) where applicable.

Note 2: Contract Variations are not required for Mutual Aid arrangements for example where a provider transfers a fixed amount of activity to another provider as long as there is no impact on System Finances and also it is not a recurrent change.

For any S75 or S256 Contracts you may also need to update the schedule accordingly.

Phase 3d: Contract Terminations

This process covers the termination of a contract once agreed.



For any S75 or S256 Contracts you may also need to update the appropriate schedule accordingly

Overview of Partnership Agreements

NHS bodies and local authorities are not automatically established to undertake each other's roles but may, through the use of formal
arrangements, act as a host for managing another's functions on a day to day.

The NHS Act 2006 makes provision for payments to be made between local authorities and NHS bodies.

Section 75 - of the NHS Act 2006 allows NHS bodies and Councils to contribute to a common fund which can be used to commission health or social care related services.

- These agreements allow Councils to commission health services and for the NHS to commission social care
- Agreements can allow for the pooling of resources and delegation of certain health functions or can reflect aligned commissio ning, which requires organisations to work closely together.
- Section 75 is not a contract nor an operational model or a transfer of functions. S75 is a partnership whereby one partner can act as a "host" to manage the delegated functions, including statutory functions of both partners who remain equally responsible and accountable for those functions being carried out in a suitable manner.

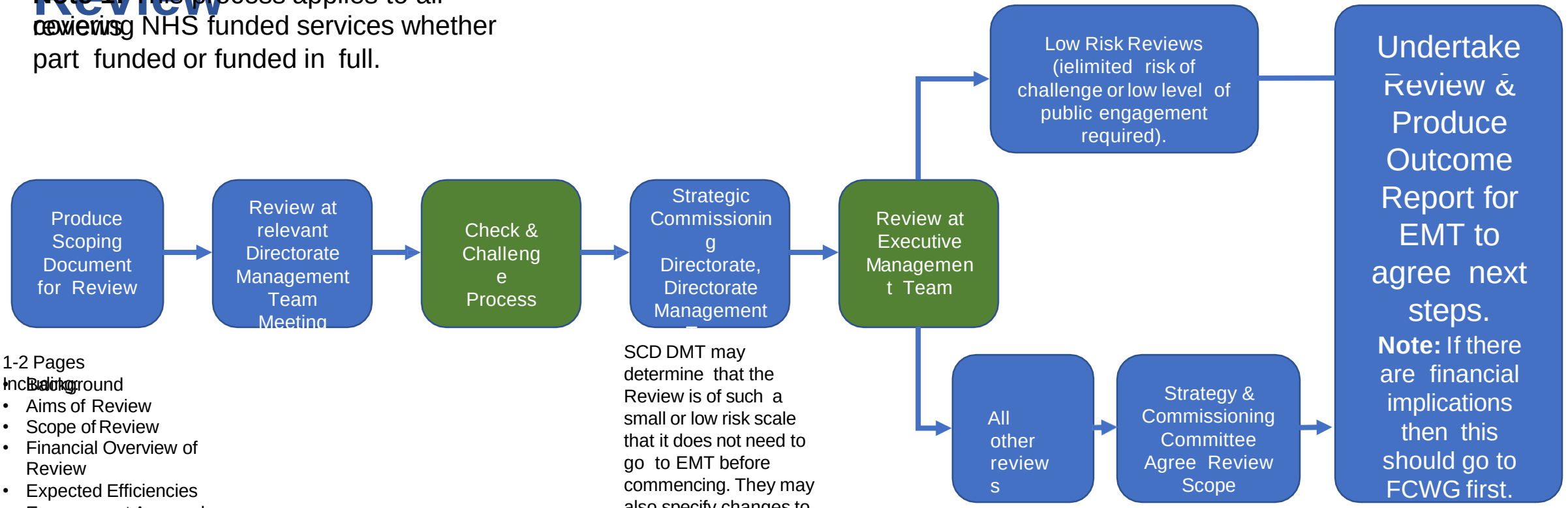
Section 256 – permits CCGs to make payments to a local authority for expenditure incurred or to be incurred by the authority in connection with the performance of any of the local authority's functions provided that in the opinion of the CCG those local authority's functions:

- have an effect on the health of any individuals,
- have an effect on, or are affected by, any NHS functions; or
- are connected with any NHS functions, i.e. any function exercised by a NHS body

Section 76 – permits local authorities to make payments to the NHS towards expenditure incurred or to be incurred by the body in connection with the performance by it of prescribed functions.

Undertaking a Service Review

Note 1: This process applies to all reviews reviewing NHS funded services whether part funded or funded in full.



1-2 Pages Including

- Background
- Aims of Review
- Scope of Review
- Financial Overview of Review
- Expected Efficiencies
- Engagement Approach
- Quality & Equality Issues
- Risks & Issues
- Timeline for Review
- Resourcing the Review

SCD DMT may determine that the Review is of such a small or low risk scale that it does not need to go to EMT before commencing. They may also specify changes to the proposed report to reduce the time taken to produce the outcome report or may add in additional requirements.

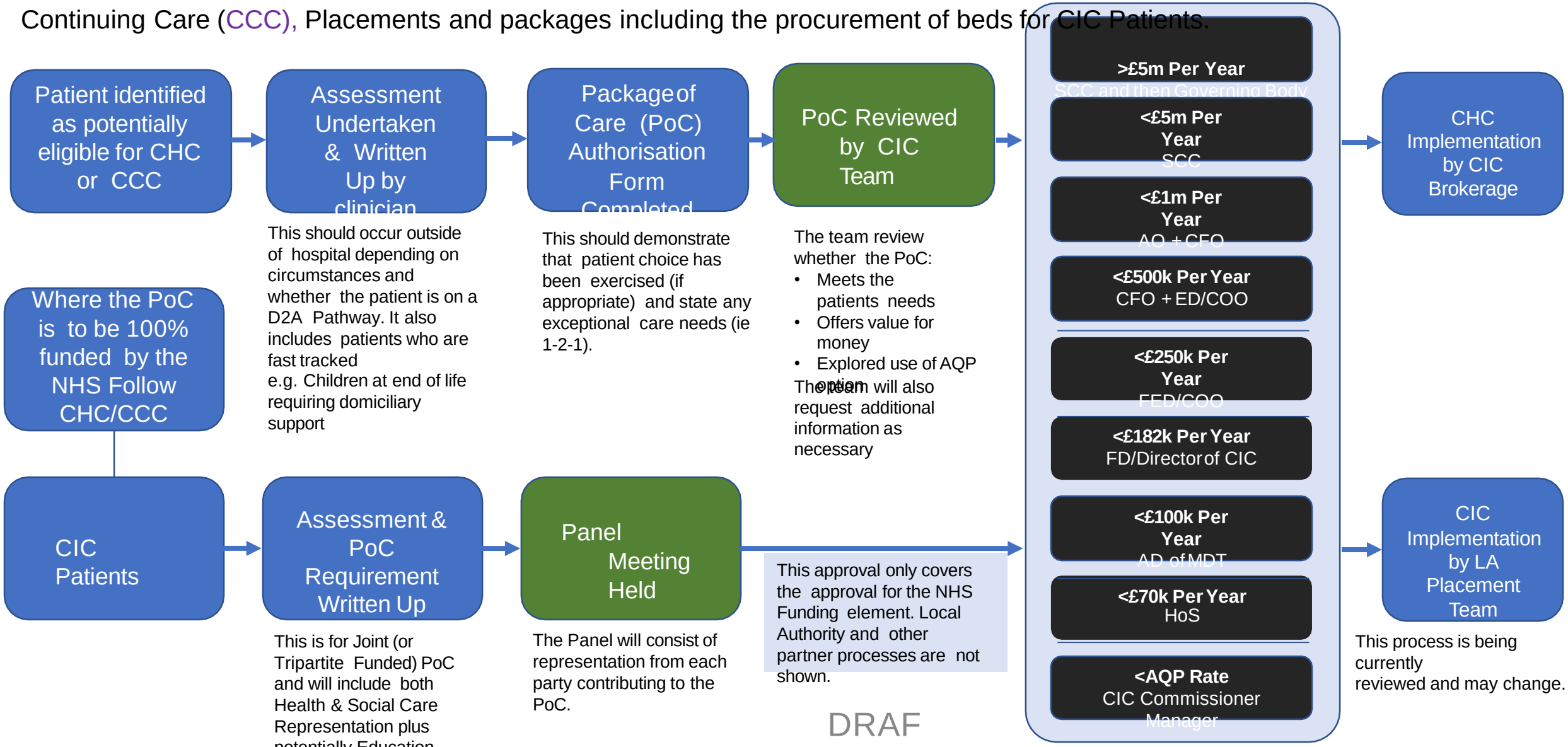
Report should include

- Background
- Aims of Review
- Scope of Review
- Proposed New Model of Care
- Recommendations
- Risks, Issues & Mitigations
- Financial Impact (including Efficiencies)
- Procurement/Contracting Issues
- Engagement Approach

Note: An initial EQIA should also be produced

CIC/CHC Approval Process

This slide covers the approval process for Complex Individualised Care (CIC) and Continuing Health Care (CHC) or Children's Continuing Care (CCC), Placements and packages including the procurement of beds for CIC Patients.



Our 5 Borough Partnerships

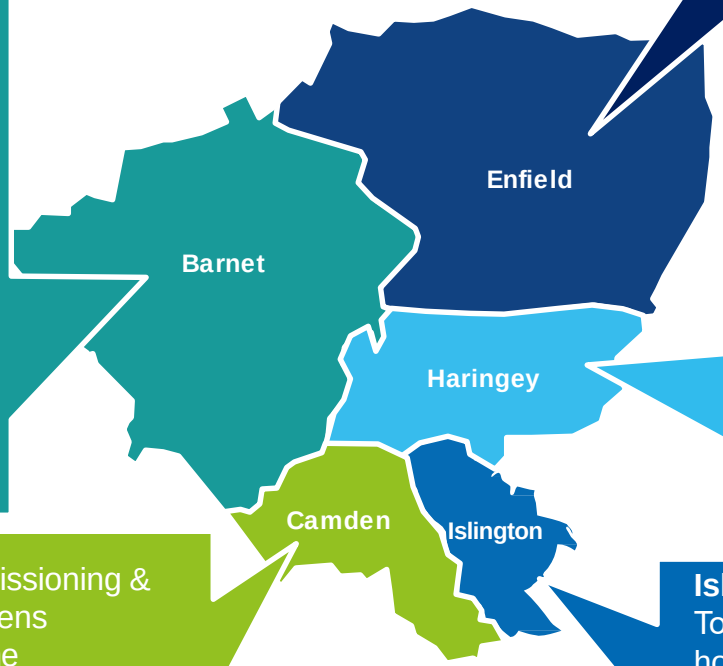
Partnerships continue to mature locally. Engagement is consistent and widespread. There are common features and many priorities are consistent, but with local nuance within each partnership. Currently each takes a slightly different approach to planning, leadership, delivery, oversight and governance.

Barnet - Significant NHS engagement plus strong community engagement & local govt. leadership. Older population gives rise to focus on proactive care, same day urgent care and support to remain independent. Cross cutting priorities include addressing health inequalities and enablers include co-production and engagement, neighbourhood model working and new governance workstream.

- 425,395 registered population
- 10 + 'organisations' represented (25+ members of delivery board)
- 7 PCNs
- Chair of Exec: John Hooton (Council);

Enfield – Borough Partnership Plan established in 2019/20 and the integrated working has accelerated during 2021/22. Four priority work-streams are well established and expanding with excellent collaboration including CVS organisations and Community & Resident engagement. A Provider Integration Partnership Group (chaired by Mo Abedi and Alpesh Patel) oversees delivery of all work-streams.

- 338,201 registered population
- 16+ 'organisations' represented (25+ members on Borough Partnership Board board)
- 4 PCNs (geographical and with neighbourhoods)
- Chair's Exec: Binda Nagra, (Council), Dr Chitra Sankaran (CCG)



Haringey – Established and ambitious partnership with strong relationships. Work is structured through partnership boards, start well, live well, age well and place – each addressing poverty, inequality, early health, prevention and responsive and accessible care.

- 298,418 registered population
- 15+ 'organisations' represented (25+ members of delivery board)
- 8 PCNs
- Chair Exec: Andy Donald (Council), Siobhan Harrington (Whittington Health)

Camden – Long partnership history with integrated commissioning & integrated delivery models. Strong focus on CYP, MH, citizens assemblies & dialogue with families & communities and the Neighbourhood model. Focus is accelerating provider joint working at PCN and borough level and connecting communities.

- 303,267 registered population
- 15 + 'organisations' represented (30+ members of delivery board)
- 7 PCNs
- Chair Exec: Martin Pratt

Islington – Active multiagency partnership under banner of 'Fairer Together' with input from all statutory agencies (incl. police, fire, housing). Senior leadership from Islington Council & CCG. Emphasises joint commissioning, operational joint working & expansion of locality level delivery.

- 257,135 registered population
- 15+ 'organisations' represented (25+ members of delivery board)
- 5 PCNs
- Chair Exec: Dr Jo Sauvage (CCG) Kaya Comer-Schwartz, Cllr (Council)

Borough Partnership – Key groups and leads

Below is an overview of the leadership in each Borough Partnership. Detailed structures by Borough can be found in the appendix.

	Barnet	Camden	Enfield	Haringey	Islington
Executive	**Barnet Executive** Rotating: John Hooton (Council CEX – current Chair); Dr Charlotte Benjamin (CCG Dep Chair); Debbie Sanders (Barnet Hospital COO), Mike Whitworth (GP Fed)	**Camden Executive** Chair: Martin Pratt (Council Dep CEX) Vice Chair: *TBC (was Kate Slemeck)*	**Enfield Borough Partnership Programme Board** Co-chair: Bindi Nagra (DASS); Dr Chitra Sankaran (CCG GB)	**Haringey Borough Partnership Executive Management Group** Co-chair: Andy Donald (Council CEX) Siobhan Harrington (Whittington Health CEX)	**Fairer Together Partnership Board** Cllr Kaya Comer-Schwartz (Leader), Dr Jo Sauvage (CCG Chair and Islington GB member)
Oversight	**Borough Partnership Delivery Board** Chair: Dawn Wakeling (Council). Vice chair: Colette Wood (CCG)	**Local Care Partnership Board** Chair: Graeme Caul (CNWL)	**Provider Integration Partnership Group** Co-chair: Dr Alpesh Patel (PCN), Dr Mo Abedi (BEH)	**Haringey Borough Partnership Board Leads** Chair: Rachel Lissauer (CCG), Beverley Tarka and Charlotte Pommery (Council)	**Integrated Care Board** Chair: John Everson (LBI) and Dr John McGrath (CCG GP) **Children's Partnership Board** Chairs: Cllr Ngongo (Council) and Jenny Lewis (Head teacher).
Delivery	9 priorities	5 focus area groups	3 task and finish groups	4 partnership boards	5 Delivery Boards

Our 5 Borough Partnerships – form and governance

Borough Partnership Executive

- Borough Partnership Executive groups tend to meet every 2 months
- Members are local partner organisations CEX or their deputy.
- Terms of Reference focus on sponsorship, guidance, oversight, unblocking and resourcing of projects.
- Partnership Execs do not have formal delegated decision making arrangements, but have collective authority by virtue of membership

Delivery boards

- Delivery Boards meet monthly
- Members are senior operational & clinical/professional leaders from local services plus Healthwatch, VCS, care providers, CCG, Council, patient reps and others.
- Terms of Reference focus on shaping and driving local integration and delivery of key projects
- Each Borough Partnership has increased the scope of 'partnership work' over time & regularly consider priorities.

Working groups

- All have active working / project groups supported by partners. They were set up to deliver agreed priority projects and tend to be focused on medium to longer term objectives.
- Provider & other colleagues provide the SRO function for these groups.
- There are many other projects progressed locally by partners than there are working groups. The COVID response and Vaccine delivery and the response to health inequalities are examples.

Governance & decision making

- Formal decision making and governance is still with individual agencies. No partnership has formal delegated authority. Partnerships support information sharing, coordination and collaboration around objectives the group have collectively agreed.
- There is a small PMO in place in all boroughs. All provide regular reports to the HWBBs and as requested to HASC.

Partnership priorities and projects – Winter 21/22

Barnet Community Innovation programme is delivering **digital inclusion classes** for people aged 55 + with a range of needs relating mental health, learning disabilities or isolation during COVID-19. Community Focus, a charity based in the North of the borough, has helped people build digital skills and confidence over 12 weeks, using their interests to engage them in use of computers and the internet.

Barnet Paediatric Integrated Clinics: joint SROs Dr Mike Greenberg (RFL) and Colette McCarthy (LBB) with Dr Jo Yong (GP/CCG). Multidisciplinary teams of Consultant Paediatricians and GPs to discuss complex cases and deliver joint clinics within PCNs. The borough partnership team have engaged the Royal Free Consultant Paediatrics team and PCNs in development of the MDT approach, tools and outcomes & joint paediatric clinics will now be mobilised.

Barnet Wellbeing Together – a partnership of 4 community organisations recruiting 14 WTE roles to deliver the integrated VCS offer in Barnet under the Core MH Teams. Staff will support residents who are being discharged from secondary care, helping to coproduce recovery plans and develop community connections.

Camden Urgent Community Response – focused on increasing the volume of referrals into Rapid Response and ensuring people are treated in the least intensive setting possible. Camden team completed 91% of referrals within the 2 hour target in Q3 (up from 60% in Q2). This is supported by the Frailty virtual ward which went live in December with a good response and operating at full capacity at times.

Integrated working as part of the Refugee response - Camden received a large number of Afghan refugees and asylum seekers in 2021. It rapidly developed an wraparound model of support for approx 2,000 people bringing together primary care, mental health, community, acute, VCS and council for health checks, MH and trauma support, GP registration, information and access to education

Camden Community Connectedness is a key priority for the local HWBB. This brings together local Social Prescribing provision, focuses on **active community outreach to support engagement with statutory and non-statutory services** and supports **access to VCS provision at a hyperlocal level**. It is person centred with a tailored offer supported by eligibility and referral pathways mapped across Camden.

Enfield Mental Health project is developing a **SOP for MH community teams to incorporate the VCS into the clinical pathway.** First draft (EIS, Recovery College and front door/ Personality Disorder Therapy / CRT PH/ SM Substances / Mental Health Service for Older People) is completed. Discussion underway with new Service User Network and Enfield carers to review pathways for comment.

Partnership priorities and projects – Winter 21/22

Inequalities Fund schemes include the **Black Health Improvement Programme (BHIP)** for Enfield Primary Care and development of Enfield Caribbean and African Community Health Network to build relationships across statutory services and communities (£70k). Also the **DOVE project (Divert and Oppose Violence in Enfield)** which is taking a Public Health approach to reducing Serious Youth Violence in the borough (£154k).

Haringey are seeking to transform services for people with autism. The **All Age Autism Plan** has been developed and agreed. Partners have coproduced a plan which addresses the wait times for Autism Spectrum assessment and early identification and support for neurodiverse children to address demand for a diagnosis through a wider offer of support across the system.

Haringey localities approach has three components - Integration of workforce, services and community engagement in hubs; Enablers (estates, IT, ID, information sharing) and, delivery of inequalities bids to support engagement and understanding of population health/social care needs. It is based on: understanding the community and meaningful co-design; early help and community based support; embedding a strengths-based approach and bringing teams together to offer integrated support. The **Healthy Neighbourhoods** programme supported with inequalities funding will add additional capacity to current community engagement and services for the most deprived part of Haringey.

Islington Health and Care Academy Is in place to **build strong links between training, employment and local residents**. Joint planning and outreach to the community via free jobs fairs and online engagement with local providers and employers for those who would like to find out more about careers in health and social care. Includes live job opportunities and overview of career pathways in the sector from registered nurse to care worker and everything in between including ancillary staff and community coodinators.

Islington's all age early intervention and prevention offer is being developed so residents of all ages are able to access timely early help which is strengths-based, relational and brings lasting positive change. The adults offer will sit alongside the partnership's integrated Bright Start offer (conception to 5) and developing Bright Futures offer (5-19). Local intelligence about unmet need in the borough plus experience of what works in delivering early help will shape the approach from the VCS, Council and Health.

Voluntary Sector have a deepening role in Borough-based Partnership working

Within the Borough Partnerships, local VCS organisations are:

- Supporting outreach, relationship development and engagement with local communities.
- Working with Statutory partners on new models of delivery and ways of working
- Providing SRO functions for key projects and acting as a local delivery partner (many Inequalities Fund projects have VCS leadership or involvement).
- Providing a route through which the work of the local partnerships is communicated to stakeholders
- Contributing to ICS outputs such as the VCSE Strategy and Community Engagement Strategy

Borough Partnership	Health Inequalities Project	VCS role
Barnet	**Barnet Community Innovation Fund**	Co-designed with Barnet Together - a collaboration of Inclusion Barnet, Volunteering Barnet and the Young Barnet Foundation. Launched spring 2021. Local projects that are helping Barnet residents improve their health and wellbeing.
Camden	**Identification of barriers to access to post-COVID syndrome services**	With the involvement of the partnership Delivery Board, Healthwatch led this project to engage residents and identify groups of people most at risk of not accessing Post-Covid support and to address this via general practice, community and UCLH services.
Enfield	**Black Health Improvement Programme**	The Caribbean and Health Network (CAHN) are leading on the implementation of the BHIP. The focus is an education and training package for General Practice staff to improve cultural awareness amongst NHS teams, ensuring primary care are helping enhance the overall wellbeing and experience of local patients
Haringey	**Enhanced management for people with LTCs in East Haringey**	Expanding provision of multi-disciplinary proactive support to people with long-term conditions in East Haringey. The voluntary sector are providing key engagement support with at-risk patients.
Islington	**Respiratory Wellness Programme**	Supporting patients with respiratory conditions who have high rates of emergency admissions via peer coach support. Voluntary sector organisations, including Help on Your Doorstep and Age UK, are leading on local outreach to deprived ward communities and linking with relevant community organisations.

Place based development – preparation for the ICS

Reflecting key themes in the **Integration White Paper**:

- Members of the Borough Partnerships are engaging in and contributing to development of **ICS programmes and outputs** e.g. to ICS Transition in NCL, NCL Outcomes Fmwk, VCSE Strategy, Community Engagement Strategy, MH and Community Service Reviews, NCL Long Term Conditions Locally Commissioned Service. With the volume of 'partnership work' increasing, there is a need to develop our channels for involvement and engagement to reduce reliance on monthly meets.
- Partners at place are actively working on the **enablers of integrated care**:
  - **Estates** schemes are being progressed and funded, with full involvement of local partners to model need, align strategic estates plans and development opportunities and engage with council functions via the LEFs (local estates forums). There are now £100m of projects in the 'local care' pipeline, 2/3rds of which have funding or identified funding opportunity
  - **HealtheIntent data** is helping **mobilise Neighbourhood working** – as the dashboards and registries go live, groups of partners are engaging collectively with the data to support long term condition management and support elective recovery via initiatives such as the PITs (proactive integrated care teams operating at neighbourhood level to review and manage waiting lists through either addressing the original need in the community or helping people to 'wait well').
  - **Workforce** is a growing theme, with Training Hub involvement in all partnerships and interest in local jobs as a key 'anchor' commitment. During the Omicron wave one of our greatest challenges has been capacity – partnerships are now bringing together expertise, skills and resources with the aim of taking an integrated approach to entry grade recruitment, training, development, career pathways/progression and retention at a borough level.
- Each partnership is developing its **ambition and approach** through work with **Leadership Centre**. This widespread engagement will help to articulate the ambition of Borough Partnerships within NCL; consider approaches to collaboration; capture individual and collective responsibilities and consider local accountability; consider interfaces with other parts of the system; and, develop the different identities partners hold across neighbourhood, place and system.

Place based development – preparation for the ICS

- **Leadership Centre has observed:**
  - *Strong support for shared decision making and accountability across partners locally for priorities and services that are under the auspices of Place and Neighbourhood.*
  - *The NCL view of the ICS as an enabler not a 'supervisor'*
  - *Desire to strengthen structures and approaches to collaboration at place but no desire to recreate the five CCGs – aim is making something new/distinctive*
  - *Where provider organisations work across multiple borough partnerships and at ICS, the need for OD to engage staff and connect them to a sense of place*
  - *Innovation at all levels - Neighbourhood, Place, System, Providers – but more work needed to galvanise and spread*
- **Strategy & Planning** – most boroughs have refreshed or are refreshing their HWB Strategy and Boro partnership priorities. However plans still proliferate and BPs are engaging in a much wider range of projects than they are formally 'overseeing' or 'delivering'. Meetings are variously spaces for setting priorities, high level planning, oversight of delivery, information s haring and engagement. Some have a wide scope and focus flexibly on 'hot topics' others have a more formalised project structure. Significant work and innovation happens outside the room. Purpose, function and priorities are relatively clear, however there is significant opportunity to deepen collaboration around delivery (of priorities, projects & services) as we move into the ICS.
- **Communications & engagement** – there is significant opportunity for partners to join up around communications and engagement with local patients/residents. There is also a need to strengthen communication within and outside of the partnerships to help people share learning, understand impact and ensure transparency. Some partnerships have been shaping this (for example the 'Islington Birds Eye View') but it would benefit from further work.

NORTH LONDON PARTNERS
in health and care

NCLs consideration of the five options to governance arrangements

Further work is needed to develop the NCL Framework to Operate

Governance and decision-making arrangements for consideration to support place based partnerships are:

Consultative forum A collaborative forum to inform and align decisions by relevant statutory bodies, such as the ICB or local authorities, in an advisory role. In this arrangement, the decisions of statutory bodies should be informed by the consultative forum.

Individual executives or staff Statutory bodies may agree to delegate functions to individual members of staff to exercise delegated functions, and they may convene a committee to support them, with membership that includes representatives from other organisations.

Committee of a statutory body A committee provided with delegated authority to make decisions about the use of resources. The terms of references and scope are set by the statutory body and agreed to by the committee members. A delegated budget can be set to describe the level of resources available to cover the remit of the committee.

Joint committee A committee established between partner organisations, such as the ICB, local authorities, statutory NHS providers or NHS England and NHS Improvement. The relevant statutory bodies can agree to delegate defined decision making functions to the joint committee in accordance with their respective schemes of delegation. A budget may be defined by the bodies delegating statutory functions to the join t committee, to provide visibility of the resources available to deliver the committee's remit.

Lead provider A lead provider manages resources and delivery at place-level, as part of a provider partnership, under a contract with the ICB and/or local government, having lead responsibility for delivering the agreed outcomes for the place (including national

Our provider alliance

As part of our commitment to becoming an ICS, **NCL has established a single multi sector alliance of 14 members** called the UCL Health Alliance**; and appointed a Managing Director.** The Alliance has also agreed its membership and initial priorities.

Purpose

To be the principle vehicle for service delivery in NCL.

Collaboratively seek to improve:

1. **Quality**
2. **Cost effectiveness**
3. **Resilience**

Governing objective: we exist to improve health value (healthy life expectancy/ costs) for the population we collectively serve; we do this by improving the quality and reducing the cost of health services above and beyond what can be achieved by partners working on their own.

Scope

The scope will cover health services, education and research.

The focus will be on both physical and mental health needs and consider whole pathways, working with other partners, from prevention through to complete tertiary treatment to address health inequality and access to treatment and care.

Members

- NCL GP Alliance
- Barnet, Enfield and Haringey Mental Health Trust
- Camden and Islington NHS Foundation Trust
- Great Ormond Street Hospital
- Moorfields Eye Hospital
- North Middlesex University Hospital
- Royal Free Hospital
- Royal National Orthopaedic Hospital
- The Tavistock and Portman NHS Foundation Trust
- UCLH
- Whittington Health NHS Trust
- Central London Community Healthcare Trust
- Central and North West London Foundation Trust
- University College London

Initial priorities

Waiting times: Work together to radically increase the pace of addressing NCL's waiting list challenge and substantially reduce the risk of poor outcomes for patients.

Workforce: Improve the morale, effectiveness, efficiency and inclusiveness of our combined workforce through shared sector-level initiatives which complement work at individual partner level.

Research into Action: Work to champion, facilitate and expedite translation of research into consistent change in practice and generate new research findings, above and beyond what individual partners and UCLP already deliver.

Lead roles: Map out the short, medium and long term programme for devolving to partners lead roles for providing. Coordinating and supporting services on behalf of the wider alliance where that reduces costs and increases quality; start proof of concept and benefits by getting going in a few areas.

A multi sector alliance for North Central London, that models collaboration, joint accountability, person-centred care and an outcomes focus throughout our system. Key governance documents concerning the formal setup of the Alliance to be agreed in April.

OFFI

GP provider alliance

NORTH LONDON PARTNERS in health and care

Statement of purpose

"The GP Provider Alliance brings together General Practice with a unified provider voice to strategically lead, influence and enable Primary Care provision at the North Central London level. We are a key partner in the Integrated Care System and ensure that our systems provide the best possible services for our communities, optimise health gains and reduce inequalities. We support General Practice through transition and change and are trusted and valued by our practices and partners."

GP Provider Alliance Charter (draft)

- Built on trusted relationships – professional and personal relationships underpin collaborative efforts
- Strong shared vision, focused on people served – coherence across partners as to ambitions, driven by central focus on best possible outcomes for people
- Aligned, not necessarily merged services and support – partners within collaboration work to make sure their supports and services are integrated and complementary while maintaining the distinct identity and offer of each partner
- Conscious broker into wider systems –GPPA plays an active role in strategic decision-making and planning for delivery of new models of care
- Share resource and in-kind support –make better use of limited resources flexibly using assets
- Catalysed by independent funding – crucial to the early development of collaboration, building relationships and testing ideas
- Data Driven – evidenced based decision making
- Learning system: an ethos of 'continuous improvement' adopting a QI approach

Members

The GPPA includes **representation from GP providers** from each NCL borough and **111** with **input from the LMC**

System priorities & opportunities for general practice to contribute

A. Workforce

B. Covid Response

C. Elective Recovery and Planned care

D. UEC

E. Primary Care Capacity

F. Population health management

G. Digital

H. Use of resources

I. ICB establishment

Agreed Functions for the next 12 months

1. Contributing General Practice provider understanding and perspective into the wider integrated care system to:

- Develop new and current programmes, services and quality improvements within Primary Care
- data effectively to help our system understand our population and plan for the future
- Strengthen infrastructure particularly workforce, digital and estates
- Inform needs analysis, pathway design and defining outcomes that leads to holistic and consistent care across the ICS

2. Enables NCL wide primary care service provision by:System priorities & opportunities for general practice to contribute

- Sharing best practice and developing innovative models together
- Collaborating to agree the best delivery model for any opportunity available to the GPPA
- Identifying the most appropriate lead provider for opportunities, enabling local delivery where possible
- Evaluating our provision using quality improvement techniques to continuously develop

Developing a Clinical and Care Professional Leadership Framework in North Central London

Clinical & Care Leadership in NCL

- NCL's **Health and Care Cabinet** – comprised of cross-sector clinical and care leadership – supported system decisions and provided clinical review and scrutiny to our initial plans as an STP.
- **NCL CAG (Clinical Advisory Group**) continues to play a crucial role in providing clinical oversight and scrutiny to decisions during the pandemic and recovery phase.
- A **comprehensive, independently led review of clinical leadership** in 2019/20 helped inform the **role of GP clinical leadership in NCL CCG Governing Body and boroughs.**
- At the borough level, **clinical leaders continue to work with DASS and Directors of Public Health to help establish local priorities.**
- NCL has also progressed towards developing **clinical networks** (orthopaedics, ophthalmology, ENT, gynaecology, general surgery, urology alongside dermatology- all at different stages of maturity) to support key clinical needs of our population.

Progress to date

- **Review objectives** were set with CCG Governing Body & ICS Clinical Leaders to shape the scope, approach, key lines of enquiry and key actions.
- Initial engagement undertaken on the **vision for future clinical and care leadership** with STP/ICS leads, NCL CCG Governing Body DASS, DPH, ICP Chairs, GP Alliance / Federation leads, Local Care Forum, NCL People Board, Training Hubs, Pharmacy leads, CCG Directors
- Ongoing developmental workstream in place to support the incoming **ICB Chief Medical Officer and Chief Nurse designates** in agreeing an interim framework for NCL clinical and care leadership for 22/23 at system and place level in line with the five core design principles set out in guidance.
- Baselining exercise conducted to provide a comprehensive picture of clinical leadership in the CCG; following the change of target date – over 93% of existing clinical leads have been extended in their current roles through September 2022.

Next Steps

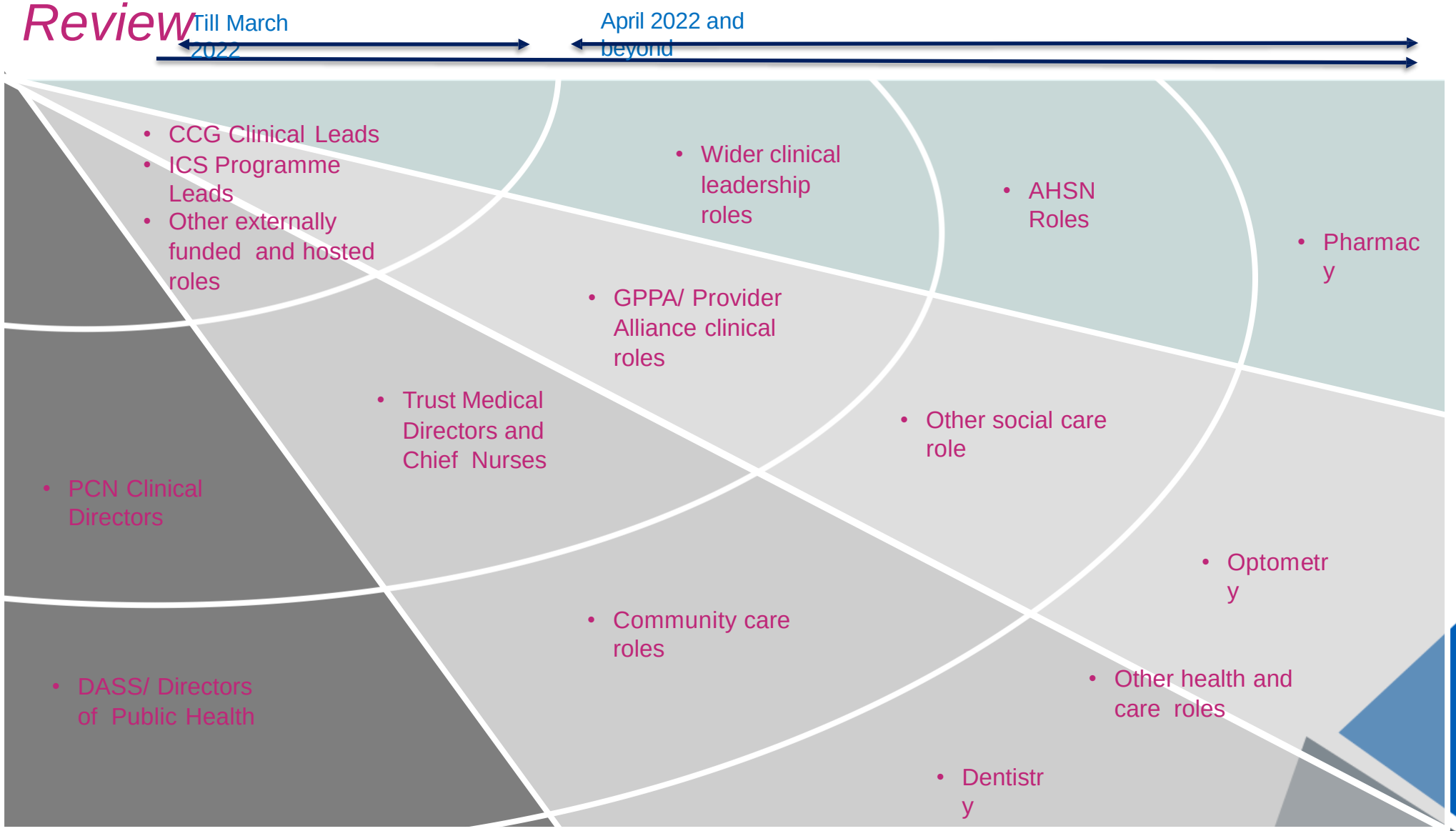
Work closely with appointed designate **NCL ICB Chief Medical Officer** and **Chief Nurse** to:

- Develop **arrangements for 22/23 that build from our current approach** and signal inclusivity and collaboration within the NCL ICS.
- **Support our existing clinical leaders through transition.**
- Develop a **future framework/ for clinical and care professional leadership through 2022-2023 and beyond in NCL** that ensures that clinical and care professional leaders are fully integrated into ICS functions and governance at every level of the system.

NORTH LONDON PARTNERS in health and care

NHS

Clinical and Care Leadership Review



Funding for implementing clinical and care professional leadership development guidance

To support the development of a clinical and care professional leadership framework in NCL it is proposed that funding will be used for:

- **Specialist resource capacity to support the technical transition of our existing clinical leads between now and July 2022**; ensuring this aligns with the longer term development of a thriving distributed multi-professional leadership within NCL.

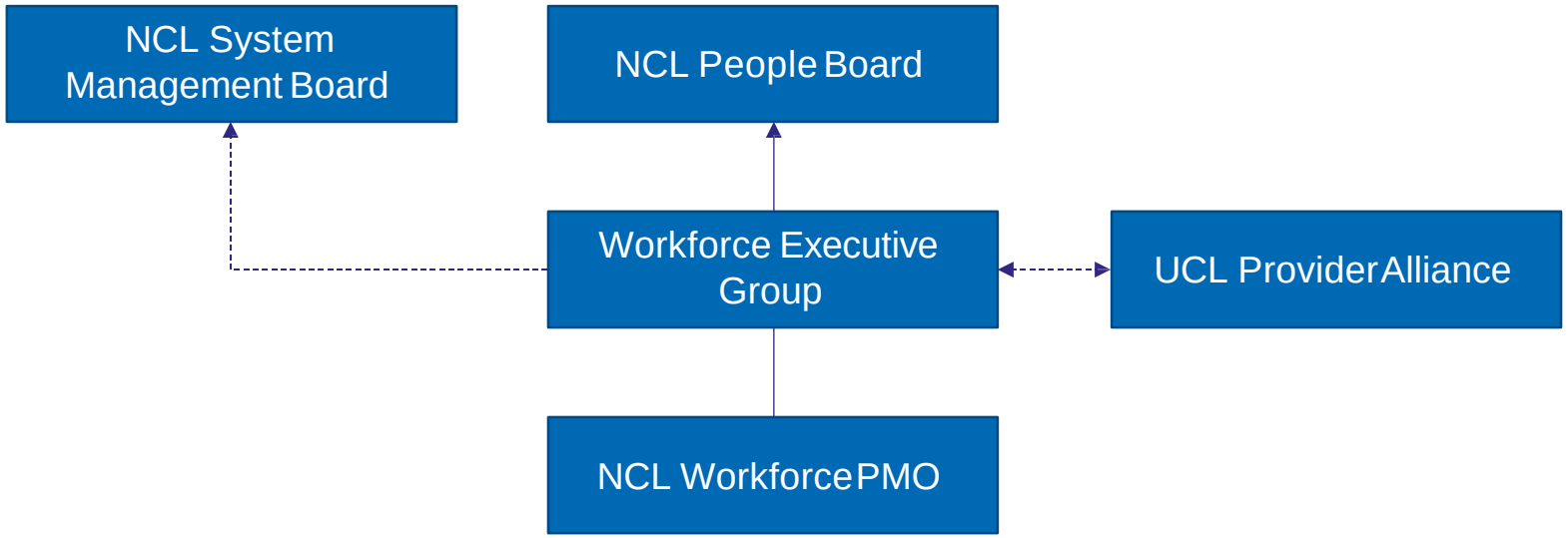
- **Engagement events** with the NCL Chief Medical Officer and Chief Nurse designates once appointed and the wider clinical, care and multi-professional leadership to support the development of a framework that describes how the five core design principles for effective clinical and care professional leadership will be delivered in the ICS.

Progress and system plans underway to establish the ICS people function

- Developing and taking care of our workforce and people is one of the key priorities in NCL
- To support workforce development and “one workforce” function across health and care, NCL is currently recruiting a full time Chief People Officer (CPO) to provide a dedicated and focus executive and leadership capacity across the system. We expect to be able to appoint a designate CPO by April 2022.
- The CPO will be accountable and responsible for functions including HR and Organisation Culture, Leadership Development, Equality, Diversity and Inclusion, and Workforce Integration
- Additional support is being secured to ensure the implementation of the agreed workforce workstreams and priorities during the transition period to an ICS People Function
- Plans are developed to engage with NCL wider stakeholders once designate CPO is in post to support the development of the ICS People Function delivery options and guide the review and establishment of an effective and efficient infrastructure to support this.
- NCL is currently strengthening the workforce analytical and modelling capacity as an integrated part of the ICS Intelligence Function.
- With support from EY and in conjunction with the 2022/23 operation planning, we are analysing NCL workforce historical data, establishing the ICS workforce baseline to support further workforce modelling across health and care system and inform the NCL workforce strategy.

Governance arrangements for the NCL workforce programme during transition to ICS People Function

NCL has a well established ICS Workforce programme governance arrangements including the NCL People Board, ICS Workforce Executive Group reporting into it, established groups such as HR Directors network, Nursing Directors Network, EDI and BAME network, and wider Workforce network. During the transition to the ICS People Function, NCL workforce programme will also report into the System Management Board.



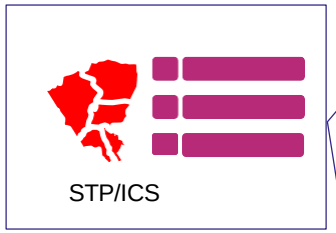
Programme governing principles:

- Don't slow down delivery - be responsive, effective and efficient, empower
- Make things happen
- Only do it if it adds value
- Decisions when they're needed, at the right level, consensus oriented, problem solving and quality assurance
- Do it with the right people, be equitable and inclusive, build accountability
- Self-sufficient, flexible and adaptable – it's everyone's responsibility to stay well informed and contribute to progress
- Trust and verify, be transparent and participatory

NCL Workforce High-Impact Priorities

Our developing ***North Central London ICS vision*** *for workforce is for* ***our community to receive high quality health and care services delivered by a representative and diverse workforce. A workforce where people are supported to achieve their full potential i n an inclusive and compassionate environment free from discrimination.***

Responsibility level of People Plan actions



Our identified NCL Workforce high impact priorities are aligned with the London and People Plan priorities

NCL high–impact priorities	London priorities	People Plan Priorities
Retention 1. Equality, Diversity & Inclusion 2. Staff wellbeing &tailored programmes 3. Talent management, progression and career pathw ays	Caring for and celebrating our people Training and development for critical care	Looking after our people Belonging in the NHS
Recruitment 4.Local w orkforce recruitment routes into health and care employment 5. Workforceplanning and modelling based on population	Attracting people into the NHS Sustaining and growing nursing	Growing for the future
System change 6. Working w ith & across sectors & NCL People Board	Enhancing medical education Ensuring productive working across London	New ways of working and delivering care Supporting our NHS people for the long term

Responding to new challenges and opportunities

The NCL People Plan can be found in the appendix

ICS People Function Design Principles

The following design principles should guide and drive the design and delivery of the ICS People Function.

Equitable	Promoting equity of opportunity and creates a professionally and demographically diverse health and social care workforce that reflects and serves the local community.
Aligned	ICS People Function are one connected whole. It is built as a whole system, and each sub-function aligned and positively contributes to the system at scale. There should be no isolated features or outliers. Enabling consistency across the system and ensure greater efficiency and availability of training for staff across the system. Develop a shared approach and consistent policies and practices across the system .
Collaborative / Co-productive	Building stronger networks and better collaboration across the system. Developing more equal partnerships between people who use services, carers, health and social care professionals. Enabling easier transfer of staff between organisational and service-level boundaries, encouraging multi-disciplinary approaches to service delivery and care.
Accountable	ICS People Function has clear governance structure, accountability, and decision-making arrangements.
Innovative	Curious and aspiring learning system which shares best practices, with clear commitment to work in new ways. Enabling to challenge the status quo. Testing new models of care and ways of working across health and social care.
Responsive	Responsive to local needs, that supports every member of our community, health and social care workforce to work effectively at the system, locality and neighbourhood level.
Funded	Appropriately funded across all functions, with clear process within the ICB to secure appropriate funding for agreed functions.

Working with people, communities and the VCSE sector

North Central London Integrated Care System (NCL ICS) is committed to helping all residents to start well, live well and age well. A critical focus will be how we work with people and communities, and our Voluntary, Community and Social Enterprise sector (VCSE), at neighbourhood, place and system level.

We have strong foundations to build on - the CCG, Councils and NHS Partners have strong relationships with the VCSE sector and Healthwatches, and a wide range of involvement programmes, forums and networks. Partnership working on engagement and involvement activity has been strengthened through the pandemic, and vaccine programme roll out, with an increasing focus on reducing inequalities.

Over the last six months we have undertaken in-depth discussions on our collective ambitions to working with our people, communities and our VCSE as an ICS and an Integrated Care Board (ICB). These have involved commissioners, joint commissioners, public health colleagues, patient networks, our VCSE Alliance and wider sector, as well as NHS and Council leaders.

We have also undertaken research with local residents, with a focus on what health and wellbeing means to them, their families and their communities.

Working with people, communities and the VCSE sector

Based on the dialogue over the last six months, we have co-developed two strategies for the North Central London Integrated Care Board: *Working with our People and Communities & Working with our Voluntary and Community sector.*

The principles and approaches outlined have received strong support from the NCL VCSE Alliance, and at CCG Committees, the NCL Community Partnership Forum, the NCL Local Care Forum, and Place-Based Partnership meetings and patient groups.

The strategies set out an ambitious system approach to community and resident involvement, working with and through our VCSE partners. They represent a shift towards more community participative and community power approaches, and to taking a more long-term investment approach.

Although these are ICB strategies, they are intended to provide a framework for the NCL ICS too. As such, both strategies build on existing best practice, in particular the experience of our Local Authorities and the Place-Based Partnerships in each borough.

Much of the activity to deliver our commitments will be undertaken at neighbourhood and place level. Year 1 delivery plans (2022/23) will be developed, with close alignment to the five Place-Based Partnerships.
An important element will be setting clear evaluation and outcome measures to demonstrate impact.

Our vision

We will support people to live healthier and more independent lives in thriving local communities by working in partnership with local people and communities to design solutions and services around their priorities, needs, experiences and strengths.

Principles set out in our strategies

Working with our People and Communities

1. We communicate with our local communities through clear, accessible and culturally competent public facing information on our vision, priorities, plans and progress to build understanding and trust.
2. We proactively seek to understand communities' and people's priorities, experiences and aspirations for health and care.
3. We put people and communities at the centre of our planning, decisions, and the design and delivery of services and wellbeing projects.
4. We proactively seek to hear from the diverse communities in NCL and build relationships with those who are socially excluded, vulnerable or experience the greatest barriers to accessing services and the highest health inequalities.
5. We use community development approaches that empower people and communities, building on community assets and strengths to improve health and wellbeing and reduce inequalities.
6. People are supported to look after their own health, including through enabling access to wellbeing and self-care opportunities across NCL.

Working with our VCSE

1. We ensure the VCSE are a strong strategic partner in the NCL ICS, and that the voice of the VCSE is heard and has impact
2. We take a strategic approach to VCSE investment, making best use of funding and resources to support a well-resourced, strong and thriving sector
3. We support the VCSE to work alongside statutory and mainstream services to ensure diverse communities have access to care in a way that reflects their needs.
4. We invest in community-led and strength based projects.
5. We have effective, scalable investment, contracting and procurement processes which support and enable the VCSE to work with us – from larger organisations to grass roots community organisations.
6. We ensure sustainable funding for our VCSE so that we develop community programmes that support and empowers local communities and the sector.

Transparent and inclusive governance

NCL Level:

- NCL Community Partnership Forum meets quarterly (since September 2021) as a key forum to ensure effective community and citizen participation runs throughout our work. Membership includes the ICS Chair, ICB Chief Executive, VCSE partners and NCL VCSE Alliance members, Healthwatches, public members, people with Lived Experience and partners from across ICS.

- NCL VCSE Alliance was established in late 2021. Through working in partnership with the Alliance we will ensure the rich voices of the sector, from grassroots to pan-borough, will inform and influence our work. The Alliance will also act as a facilitator between Place-Based Partnership VCSE networks and the NCL ICB and ICS.

- NCL ICS Population Health Management Committee: plays a key role in helping understand the needs of our population, setting priorities aligned to these, with a focus on improving population health. The Committee will ensure robust focus on issues specifically affecting communities facing multiple deprivations and inequality.

Place-Based Partnerships:

- All five Place-Based Partnerships have a board that, amongst other areas, oversees working with communities and VCSE at place. All boards have VCSE and Healthwatch representation and in future will also include local community input either via a community panel or resident members.

- Place-Based Partnership VCSE Forums will ensure the VCSE voice is strong within the developing Place-Based Partnerships and will work closely with the NCL VCSE Alliance to share key ways of working, concerns and themes that arise across the 5 Place-Based Partnerships.

NCL VCSE Alliance

- The NCL VCSE Alliance currently consists of a steering group made up of 5 VCSE umbrella organisations across the North Central London CCG alongside 5 other representative organisations that focus on homelessness, disability, refugee and migrant, deprivation and isolation and mental health across North Central London.
- The NCL Alliance will connect into the Integrated Care Board, Integrated Care Partnership and Community Partnership Forum, helping to ensure the diversity and wealth of insight held by the sector informs and influences our work.
- The *Working with VCSE Strategy* has been co-developed with the Alliance. We are currently in the process of co-designing a Year 1 Delivery Plan with the Alliance members, which will be aligned with delivering the ambitions set out in the strategy
- We are also developing an Alliance model to have strong VCSE forums in each Place Partnership, who work alongside the NCL VCSE Alliance. The NCL Alliance will act as a facilitator between Place-Based partnerships and NCL boards.

Wider community involvement

There are a wide range of structures already in place across NCL through which we will continue to involve and engage with our communities. These include:

- Health and Wellbeing Boards and Health and Care scrutiny committees
- System Quality Groups
- Public Engagement Groups
  - patient and public reference groups (for example, the NCL residents health panel)
  - citizens' panels
  - forums to engage with specific equalities protected groups
  - expert by experience and VCSE members of programme boards for specific workstreams
  - strategic co-production groups
  - patient participation groups (PPGs).
- Partners across the ICS – both NHS and local authority – have patient and resident groups that have active roles in local health and care work that is undertaken. We will work with our partners to join up the existing groups and build on the already established relationships and ways of working to ensure continuous improvement.

Examples of our work with communities facing health inequalities

- Health Inequalities Fund; working with our local providers & VCSE for innovative and community-based approaches and schemes that deliver high impact, measurable changes in inequalities across NCL, and address the underlying causes of health inequalities
    - Example Scheme: Haringey Healthy Neighbourhoods: Healthy Neighbourhoods is a collaboration between the statutory sector: primary care, NHS and Council, and voluntary sector engaging and working with local people aimed at promoting individuals' health, well-being and life chances in a way that makes sense to them because the approach and solutions are designed with communities and their representative groups. The model is initially being rolled out in east Haringey (around the 20% most deprived neighbourhoods, often the most diverse).
- Community Action Research Programme: investing in the development of strong local VCSE partnerships across NCL, to engage and work with local communities who experience high health inequalities, to raise their voices in the development of ICB and Place plans and to bring support and services to local people – co-designing solutions and interventions.
- Community Connectors initiative: Addressing under-diagnosis and improving self-management of patients with Hypertension likely to be living in under-served communities. Our approach is a collaborative model between primary care and the VCSE to develop community champions who can support local communities to identify where they may be at risk and encourage people to come forward for help, support, better diagnosis and management of their immediate needs with a plan to respond to these needs and help address wider issues in their lives. Working in this way we address not just their clinical needs but look at other factors in their life influencing their health.

Areas of focus for 2022/23

The two Strategies set out our long-term strategic approach – but a Year 1 (2022/23) Delivery Plan will be produced, including a focus on:

- Detailed Place-Based Partnership plan development, ensuring connection to the two NCL Strategies
- Developing methods to ensure ICB investment and decision making processes support community empowerment
- Developing ICB governance and assurance methods to ensure VCSE and communities are involved in decisions
- Developing strong evaluation methodologies
- Developing processes to centrally collect and report insights (Insight Bank) and a Social Value toolkit
- Supporting Primary Care Networks and neighbourhood team links into communities, and to help make every contact count to signpost residents to services and support
- Ensuring ICB commissioners are confident to champion the approaches set out in the two Strategies.

Systems plans for accountability and oversight from 2022/23

The NCL system MOU was agreed with NHSEI in September 2021. Guidance from NHSEI on the System Oversight Framework is expected Q1 of 2022/23. Following publication, the ICB will work with system partners to:

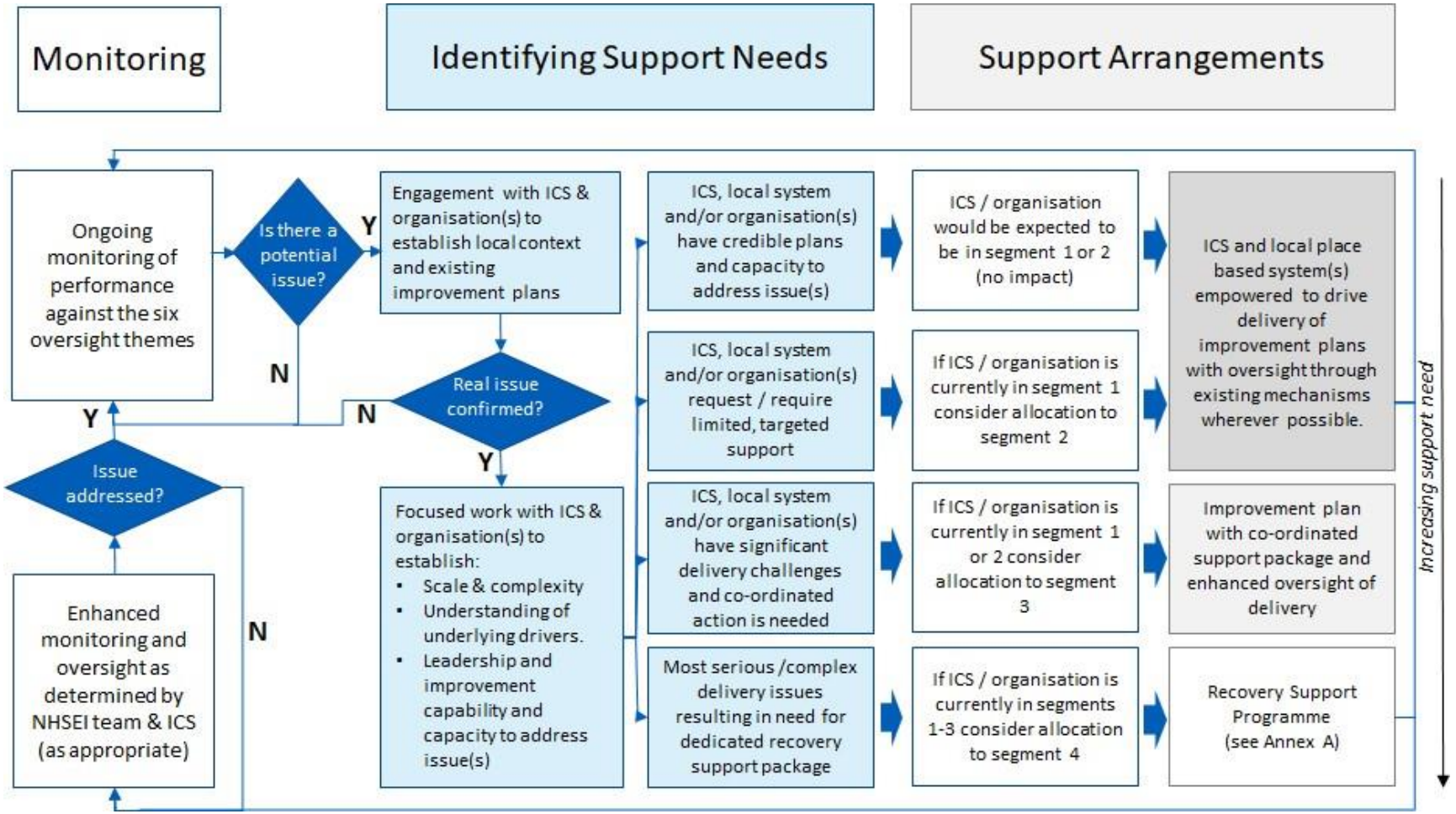
- We will be refreshing the existing MOU ahead of July 2022, subject to publication of updated guidance form NHSEI. This will account for the new governance and leadership arrangements within NCL. (Appendix A)
- Review principles that underpin the NCL Quality and Performance Oversight Model by August 2022 (slide 65)

There is ongoing development of the NCL Quality and Performance Oversight Framework to reflect emerging ICS governance (Slide 63)

For continuity, NCL ICS is planning to adopt existing 2021/22 Key Lines of Enquiry and Oversight Framework

Overview of NHS System Oversight Framework – 2021/22

RFL and NMUH have been allocated to segment 3 by NHSEI London Region in accordance with System Oversight Framework (SOF)



Source: NHS System Oversight Framework 2021/22, June 2021

Scope of System Oversight Framework

- Quality of Care, Access & Outcomes
- Preventing Ill-Health & Reducing Inequalities
- Finance & Use of Resources
- People
- Leadership & Capability
- Local Strategic Priorities

NCL ICS Local Strategic Priorities 2022/23:

- Barnet Community Innovation Fund
- Identification of barriers to access to post-COVID syndrome services
- Black Health Improvement Programme
- Enhanced Management for people with LTCs
- Respiratory Wellness Programme

Operating Model

Greater autonomy for ICSs to oversee system performance with NHSEI maintaining regulatory assurance responsibility

NHSEI – ICS Oversight MOU Key Principles:

- NHSE/I to assess the performance of the ICS as a whole, and gain its assurance of delivery by individual organisations and places through the ICS (other than in exceptional circumstances).
- For ICSs with Trusts in SOF3[1], NHSEI London will organise a quarterly call/meeting with the system to review progress against exit criteria and support provision.
- ICS to take lead role in the oversight of the delivery of key priorities in 2021/22, agree and co-ordinate any support and intervention carried out by NHSE/I London, other than in exceptional circumstances.
- ICS will lead meetings and process with providers in SOF3, keeping NHSEI London informed and agreeing the approach.
- System finance oversight to be delivered through ICS Finance & Coordination Group, NCL CFOs Meeting and SRE.
- Emphasis on early identification and resolution of issues before they have a material impact on performance.

NCL Quality & Performance Oversight Model:

- Aligns with System Oversight Framework. Supports delivery of Planning Guidance, Long Term Plan ambitions, and local strategic priorities.
- Risk-based approach to guide level of interaction between ICS and provider – principle of earned autonomy – ensuring a proportionate response to risks and issues.
- Aligning system assurance and oversight processes to be aligned to primary assurance processes within Trusts and CCG to reduce duplication.
- Shift to patient focus from an organisational focus. Emphasis on sustainable improvements and population health management approach where lens on NCL, borough partnerships, and individual organisations considers respective contributions to reducing health inequalities and improving the wider determinants of health.
- Enhanced assurance (SOF3) to be characterised by;

  Regular meetings focusing on material issues e.g. single item Quality Surveillance meetings.

  System Oversight Meetings with the right balance of support and assurance.

Proposed Approach

Meeting with NHSEI London to discuss key drivers for SOF3; and agree **Action Plan**, **Support Arrangements**, and **Exit Criteria**

Bi-monthly ICS-Led System Oversight Meetings supported by NHSEI London: Joint RFL, NMUH meeting to **monitor progress against Action Plan**

End-of-year meeting with NHSEI London to
(i) progress against Exit Criteria for SOF3 Trusts, and
(ii) CCG progress against SOF metrics, KLOEs

ICS System Oversight will aligned with ICS governance arrangements. Additionally, the CCG will continue to seek assurance from providers through existing forums where appropriate, including Trust Board sub-committees (e.g. quality committee), RFL RTT Steering Group, NMUH DQ SI Oversight Group and NCL Local Maternity and Neonatal System

[1] SOF3 – System Oversight Framework Support Segment 3

Principles that underpin the quality and performance oversight model

The principles that underpin the quality and performance oversight framework are focussed:

- Strategically - describing how we develop the framework including statutory requirements
- Operationally - describing how the system works together in the oversight model

Strategic principles:

- In the absence of changes to primary legislation, CCGs remain accountable for commissioning high quality, safe services for their population (as are other commissioners)
- Primary accountability for care lies at an organisation level. For NHS Trusts this is at Board level. For other NHS funded services the primary accountability for quality and safety sits with the commissioning organisation (local authorities, Public Health England, CCGs or NHS England)
- Quality assurance and oversight processes should not duplicate the primary assurance processes operating within Trusts and CCGs (for other NHS funded services) and should benefit all parts of our local system
- Issues are dealt with collaboratively at the most immediate (local) level that is consistent with resolution
- A risk-based approach will guide the level of interaction with systems and providers (earned autonomy)
- A shift to a patient focus from an organisational focus – from “Is my provider providing safe, high quality care?” to “Is the patient receiving safe, high quality care” (and how is my provider supporting that across their whole pathway?)

Operational principles:

To work effectively, a collaborative system wide approach to quality and performance assurance and surveillance will need to demonstrate the following operational attributes:

- Reduction of duplication – a principle unanimously identified as an essential aspiration for the new integrated arrangements across the NHS in London
- Proportionate mechanisms to provide assurance to the strategic commissioner about the quality and performance of commissioned services for the local population
- An open, transparent and honest culture between the strategic commissioner and providers of services, including shared use of benchmark information across all providers
- Joint decision-making involving providers and commissioners achieved by investing in building collaborative relationships
- A process for resolving quality and performance risks through collaborative forums
- Learning, good practice, ideas, innovations systematically disseminated across our health and care system
- A process for local economy intelligence sharing and escalation of risks, which aligns with the revised regional and national guidance, with local intelligence informed by multiple sources of data (both qualitative and quantitative)
- Robust and consistently applied safeguarding arrangements at borough and system level that provides professional leadership and expertise
- Greater emphasis on system quality and performance i.e. how providers are contributing to this and any support needs required.

Key lines of enquiry for CCG assessment 2021/22 & SOF Overview

Quality of care, access and outcomes
How has the CCG contributed to ensuring delivery of health services in the priority areas set out in the *2021/22 Operational Planning Guidance*?
How has the CCG monitored oversight of quality and patient experience?
How has the CCG supported the system to respond to emergency demands and manage winter pressures?
Preventing ill-health and reducing inequalities
How has the CCG supported actions to address inequalities in NHS provision and outcomes?
Does the CCG have effective systems and processes for monitoring, analysing and acting on a range of information about quality, performance and finance, from a variety of sources, including patient feedback, analyses of access to services and experiences of service users, so that it can identify early warnings of a failing service?
How has the CCG taken account of lessons from managing COVID-19, in a way that locks in beneficial changes and explicitly tackles fundamental challenges, including support for staff, and action on inequalities and prevention?
People
How can the CCG evidence that it has supported the health and wellbeing of its workforce?
How has the CCG contributed to the delivery of the priorities for the NHS workforce set out in the *NHS People Plan* and *2021/22 Operational Planning Guidance*, and the implementation of *Our NHS People Promise*?
Leadership
Has the CCG demonstrated effective system leadership and progressed partnership working, underpinned by governance arrangements and information-sharing processes, including evidence of multi-professional leadership?
Finance and use of resources
Evidence that the CCG has delivered its break-even target in-year and contributed to the reduction of system deficits.
Evidence that the CCG has delivered the Mental Health Investment Standard.
Involve and consult with the public
How does the CCG identify and engage with deprived communities, ethnic minority communities, inclusion health populations and people with disabilities (people with learning disabilities, autism or both, people experiencing mental ill-health and people experiencing frailty) and the full diversity of the local population?

National Domains	Overview
1. Quality, Access & Outcomes	• Primary and community services including new community services response times • Restoration of elective and cancer services • Improve cancer outcomes: early diagnosis and survival • Outpatient reform: avoidance of up to a third of outpatient appointments • Implementation of agreed waiting times • Maternal and children's health • Emergency care: on agreed trajectory for same day emergency care (SDEC) and integrated urgent care services (IUC) • Mental health • Learning disability and autism: reducing inpatient rate and increasing learning disability physical health checks • People will get more control over their own health by rolling out NHS personalised care model across the country • Delivering safe, high quality care overall
2. Preventing ill health and reducing inequalities	• Screening and vaccination programmes meet base levels in the public health agreement or national goals; • Improvements for people with conditions such as diabetes, CVD and obesity; • Reducing inequalities
3. Leadership and capability	• Quality of leadership, and • Aggregate score for NHS Staff Survey questions that measure perception of leadership culture
4. People	Supporting the health and wellbeing of staff and taking action on recruitment and retention; *People Promise, Looking after our people, Belonging in the NHS, Growing for the future*
5. Finance and use of Resources	• Performance against financial plan, • Underlying financial position, • Run rate expenditure, and • Overall trend in reported financial position

Finance as a critical enabler to build accountability and ensure sustainability of our systems

North Central London's sustainability and transformation partnership

The underlying financial position of the NCL ICS remains unsustainable

- Pre-Covid, the NCL system had a significant gap between available funding and underlying costs, with deficits (some sizeable) in most NHS organisations, additional pressures in local authorities and challenges in primary care. This gap and these challenges will return when we exit the Covid financial regime.
- We have a responsibility to work together as a system so that we spend the "NCL pound" where it is most needed, taking full advantage of the excellent organisations and brilliant leadership we have across the ICS.
- It is therefore important that we work together across all parts of the system including NHS providers, NCL CCG, primary care networks and local authorities to:
    - ensure strong short-term financial control, governance and accountability
    - have a strategic plan to achieve financial sustainability over the longer term whilst improving the care that is delivered to NCL residents and beyond and reducing inequality of access and health outcomes by aligning resource to where investment is most needed
    - acknowledge that all NCL partners have an important role to play in moving towards system financial sustainability and living within our means
    - help shape and inform the role that ICSs will have in funding for specialised services to ensure that these remain a key part of our financial strategy.

Scope of Our Strategy

Our financial strategy primarily focusses on NHS organisations – particularly those whose financial performance forms part of the overall ICS financial performance that we as an ICS are held to account to. However, the system financial principles (such as making decisions based upon system cost) stretch beyond NHS organisations and into primary care, local authorities and other partners, in support of the overall strategy to reduce health inequalities, invest in prevention and out of hospital services, and work across organisational boundaries to improve care pathways and overall value.

Overall financial strategy and vision

We have agreed the following top priorities for NCL's financial strategy, underpinned by principles for how we will work together. These have been agreed and endorsed through NCL organisations' boards and work in support of the financial principles described later in this document.

1. **We are focussed on improving the health of the population in North Central London within our available resources**
2. **We will address health inequalities across the sector and within our boroughs as a priority**
3. **We will maximise what we do locally in North Central London**

The way we work

We will focus on the benefit to the system, not on the impact to the individual organisation	We will ensure no individual organisation loses out for doing something in the benefit of the wider system	Strong clinical and operational engagement in everything we do
Close working with primary care and with local authority partners	Shared acknowledgement that system working will be required to address the challenges we face	We will be open and transparent with each other, sharing data and financial information
We will implement joint planning and more standardised processes across the system	We will hold each other individually and jointly accountable for system sustainability	We will focus on reducing the cost of service delivery, not income generation

Agreed NCL ICS Financial Principles

- For an integrated care system to work successfully it is essential to ensure strong financial governance and accountability – it is necessary for all working in the system to always think in terms of overall system impact, but this is insufficient and may lead to loss of financial control if we are not also clear what we expect from each part of the system.
- NCL ICS brings together 15 NHS organisations, primary care networks and five local authority partners to work as a system to the benefit of the population we serve. This level of collaboration is a new way of working and requires a new set of behaviours.
- Additionally some of the regulatory frameworks, as they currently stand, are not conducive for individual organisations to work in the interest of the whole system, as this is sometimes against their own individual benefit.
- NCL organisations have agreed financial principles that we will follow to encourage joint working between organisations within the system, which are designed to ensure that organisations are financially better off by acting in the overall system interest.
- In doing so these principles seek to **avoid** the need for Boards to act in a way that is against their own individual benefit in order to do the right thing for the system – the overarching principle is that contracts between organisations within the system should not have financial barriers to organisations acting in the best interests of the system as a whole.

Four key principles

1. **Provider to provider arrangements** – gain share arrangements to ensure no individual provider is disadvantaged from doing what is in the benefit of the system.
2. **Reductions in activity through removing secondary care demand** – recognition that activity reductions will lead to reasonable stranded costs within providers which will need to be funded.
3. **Change in model of care** – principles for sharing the benefit of new models of care.
4. **New ICS investments** – guiding principle that ICS investments should generate a system financial saving.

Our journey towards shared financial accountability and sustainability

North London Partners in health and care
North Central London's sustainability and transformation partnership

NHS

The story so far

- **Strong established Chief Financial Officer (CFO) Community –** weekly CFO meetings and good engagement from all organisations including those in neighbouring ICSs that provide community services to NCL.
- Established **ICS Finance Lead**.
- Collaborative working to **agree distribution of System Funding; and prioritising bids** in alignment with ICS priorities

⇩

Recent progress

- Agreed **ways of working and financial principles** across NCL organisation Boards.
- Establishing a clear **ICS finance leadership team.**
- System working to develop an ICS Financial Strategy and position. Managed through an NCL Finance and Oversight Committee with representation from NCL Trusts and CCG.
- **Establishment of the NCL Inequalities Fund,** top sliced from system allocation with agreement that this should be recurrent and incremental
- 2022/2023 operational planning is in progress

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Next steps

- **Engagement with Trust Boards, CCG GB, Heads of Finance**, dedicated workshops to continue to embed financial strategy.
- **Review specialised commissioning** and document an agreed approach.
- Continue to **integrate a population health based approach to finances.**
- Work with **wider system partners** to develop a whole-system view to finances.
- Establish a **baseline of what NCL allocations currently fund**, identifying the level of consistency across scope of commissioned services
- Singularly define what we mean by 'need' reflecting the work on deprivation, equity of access and inequality lead by the Population Health team for NCL leadership agreement
- Additional work to integrate financial planning with workforce and performance plans

NORTH LONDON PARTNERS in health and care

North Central London's sustainability and transformation partnership

NHS

Our Strategic Aims

We have identified five strategic aims to deliver our ambition and achieve our purpose. We have mapped life courses for residents from all our boroughs (see appendix) and are in the process of developing a set of outcomes that will enable us to track our progress towards achieving these aims. We continue to refine and further develop these aims with our system partners and residents.

Start well

Strategic Aim 1:

By working collaboratively with schools and communities, our children and young people will have:

- tools to manage their own health
- access to high quality specialist care
- safe and supported transitions to adult services.

Live well

Strategic Aim 2:

Our residents will have early support for health issues including:

- equitable access to high quality 24/7 emergency mental and physical health
- world-class planned and specialist care services
- true parity of esteem between physical and mental health.

Age well

Strategic Aim 3:

Our residents will:

- be supported to manage their long term conditions and maintain independence in their community
- receive seamless care between organisations
- experience high quality and safe hospital care that ensures they can get in and out of hospital as fast as they can.

Work well

Strategic Aim 4:

Our workforce will:

- have equal access to rewarding jobs, work in a positive culture, with opportunities to develop their skills
- have support to manage the complex and often stressful nature of delivering health and social care
- strengthen and support good, compassionate and diverse leadership at all levels.

Enabler s

Strategic Aim 5:

We will provide key enablers for success, including:

- digital technologies to connect our health and care providers with our residents and each other
- a fit for purpose estate in each locality
- being a financially balanced health economy driving value for money for the taxpayer.

The North London Partners Strategic Digital Journey

Our purpose is: *To improve outcomes and wellbeing, through delivering equality in health and care services for local people.*

Enable Personalisation of Health & Care Services

- **Which means** we can deliver the right care for individuals and care services to specific needs of individuals, to help manage their long term conditions and maintain independence.

Ensure strong governance to maintain secure patient data, clinical safety and financial rigour.

Enable transformation of services

- **Which means** we make full use of our digital investments to rapidly deliver improved services and outcomes.

Address digital exclusion

- **Which means** our solutions are accessible by all of our population, to allow equitable access to mental and physical healthcare.

Secure adequate funding provision for Digital and align to financially balanced health outcomes and ROI.

Digital Connectivity

- **Which means** joining up care settings and geographies, to support better care connectivity for patients w ith health and care providers wherever they may be.

Develop a full set of capabilities needed to effectively deliver digital transformation

Give patients access to their own records

- **Which means** providing patients the digital tools to actively manage their ow n health and care journey.

Enable Population Health Management

- **Which means** building an advanced data platform to support a true population health management approach.

Provide a Shared Record for Integrated Care

- **Which means** integrating health & care records across the system to provide better and more integrated, seamless and safe care.

Provide Primary Care SectorIT

- **Which means** we can fully support our primary care sector w ith 21st century digital solutions.

These themes highlight the NLP Digital strategic aims that support the overall NLP ICS Strategic aims.

Digital Strategy Vision

The digital strategy serves as an enabler for information flow, use of data to support and deliver the ICS vision of a coordinated fair, equitable and efficient healthcare system, with an engaged citizen population.

To Deliver

- Better integrated care, at lower cost and greater quality;
- Addressed inequalities in care;
- Across Health, Care and Home settings.

Key Enablers of the Digital Strategy

Resident/Patient: strategic imperatives we aim to achieve

- Provide a Shared Record for Integrated Care
- Enable Population Health Management
- Exploit emerging Digital tech
- Address digital exclusion
- Enable transformation of services
- Provide Primary Care SectorIT
- Digital connectivity
- Enable Personalisation of Health & Care Services

Enabling Digital Platforms: key digital components to support the ICS vision

- Health Information Exchange
- HealtheIntent
- Advanced Analytics Platform
- Person Held Record
- Workflow Management
- Digital First Support Clinical Pathw ays
- Remote Patient Monitoring
- Improved digital maturity of existing platforms

Organisational Development: people and organisational capabilities required

- Digital Literacy
- Digital Maturity
- Analytics capability
- Project delivery
- Organisation change/ Development
- Primary care Digital organisation
- Standards & Common platforms
- Business case management
- Data Management/ Data Stew ardship
- Service Management
- Clinical Safety Management

Internal Processes & Governance: organisational mechanics we need to establish for strategy execution

- Education
- Integrated & Agile transformation teams
- Systems convergence strategy
- Centres of Excellence
- Workforce plan & management
- Estates Strategy
- Clear, consistent and integrated governance
- Portfolio management/ strategy delivery
- Business as usual organisation
- Supplier/ Vendor Management

Funding Aspects: how the system funds the digital strategy

- Current Business Case covers HIE & HEL to March 2025
- £450k per year for core team in addition to Business Case
- New National funding
- System finance provision

Engaging with stakeholders

The North Central London Integrated Care System (NCL ICS) has developed and strengthened relationships with key stakeholders throughout the pandemic, which will be further built on as we move forward as a strategic partnership.

Stakeholders are updated on and engaged with ICS development through a wide variety of communications and engagement activity including email and newsletter updates, 1-2-1 or small group sessions, planned meetings and committee papers.

A detailed programme of engagement opportunities, leads identified for relationship management and forward planning has helped to reduce duplication and ensure key messages relevant to each stakeholder group are appropriately updated.

Feedback from stakeholders is captured so that questions asked can be answered and addressed through ongoing communications, and that their needs are met.

Engaging with stakeholders

Regulators and scrutiny
- DHSC
- national NHSE/I
- regional NHSE/I
- Healthwatch x 5
- HOSC/JHOSC
- Health and Wellbeing Boards

Elected representatives
- MPs
- Leaders of local authorities
- Lead members
- Councillors

Out of area stakeholders
- patients and residents living in bordering boroughs / CCG areas
- staff of neighbouring CCGs and trusts
- neighbouring governing bodies and boards
- neighbouring local authorities
- neighbouring Healthwatch

Patients, public and community groups
- patients/service users and carers
- patient and carer support groups
- residents
- VCSE and community groups
- seldom heard and/or marginalised groups
- protected characteristics groups
- campaigners (groups and individuals)
- trust membership networks
- CCG engagement and patient networks
- GP patient participation groups
- local authority citizen and residents groups
- patients and carers or their representative groups who use any specialised services across a wider catchment area
- local employers and business groups/forums
- faith groups

The media
- local and regional newspapers
- Local and regional radio
- online & social media
- trade media

System partners and leaders
- ICS Quarterly Partnership Council
- ICS Transition Board
- CCG Governing Body
- CCG EMT
- CCG Borough Dir of Integration
- CCG Heads of Primary Care
- VCSE Alliance members
- Community Partnership Forum members
- PH&I Committee

Trusts
- Trust boards
- Trust governors
- UCL Provider Alliance board/Chair

Local Authorities
- Boards
- Executive teams
- Directors (ASC, C&YP, MH etc)

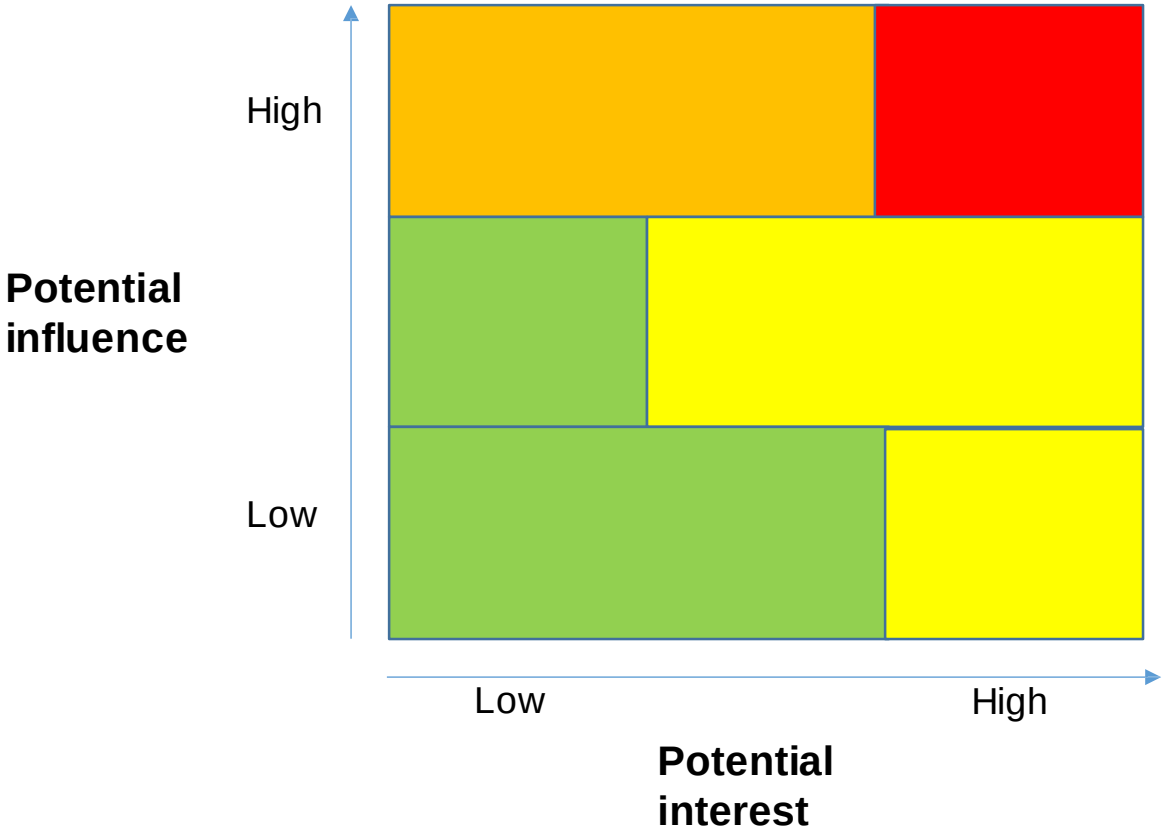
Place Based Partnerships
- CCG Heads of Place
- PBP Board members

Primary care
- LMCs
- Federation leads
- GP Provider Alliance board/Chair
- PCN clinical directors
- Primary care networks

Clinical experts
- Range of NCL groups - OIG, Critical Care Network etc.
- NCL Cancer Alliance
- Local medical/dental/pharmacy committees
- Academic health science networks
- UCLP etc.
- London clinical senate

Clinicians and front-line staff
- acute hospital trust
- mental health trust
- community health trust
- ambulance trust
- commissioners and CCG/ICS staff
- primary care – PCNs, GPs and primary care teams
- local authority public health and social care teams
- Voluntary Community and Social Enterprise (VCSE) sector providers
- Staff side and trades unions
- consultants committees
- nursing and allied health professional teams

Stakeholder mapping and prioritisation



Partner	*We need to work together* **Outcome:** It's ours
Involve	*We can work together on common ground* **Outcome:** Committed
Listen	*We will listen to you and respond* **Outcome:** Engaged
Tell	*We will inform you and provide information* **Outcome:** Aware

Source: Hood & Woolf

Prioritisation

Involve
Work together on commonground

- HWWBs
- LA Leaders
- Council Lead Members (H&C)
- NCL clinical forums / groups – OIG, Critical Care Network, Cancer Alliance
- AHSNs, UCLP etc.
- GP Leads
- PCN Clinical Directors
- Federation leads
- Local medical/dental/pharmacy/optical committees
- VCSE lead organisations
- Community Partnership Forum members
- Partner comms & engagement leads

Partner
We need to work together

- ICS Quarterly Partnership Council
- ICS Transition Board
- CCG Governing Body
- CCG EMT
- CCG Borough Dirs of Integration
- CCG Heads of Primary Care
- NCL PH&I Committee
- HOSC/JHOSC
- Trust boards
- UCL Provider Alliance board/Chair
- LA Executive teams
- LA Directors (ASC, C&YP, MH etc.)
- PBPs – exec / lead members
- PBPs - Heads of Place
- GP Provider Alliance board/Chair
- Healthwatch x 5
- VCSE Alliance members

Tell
Provide information

- Residents
- London clinical senate
- Neighbouring governing bodies and boards
- Neighbouring local authorities
- Neighbouring Healthwatch
- Local and regional newspapers / online media
- Local and regional radio
- Trade media
- Local employers and business groups/forums
- Campaigners (groups and individuals) (eg KONP)

Listen
We will engage and response

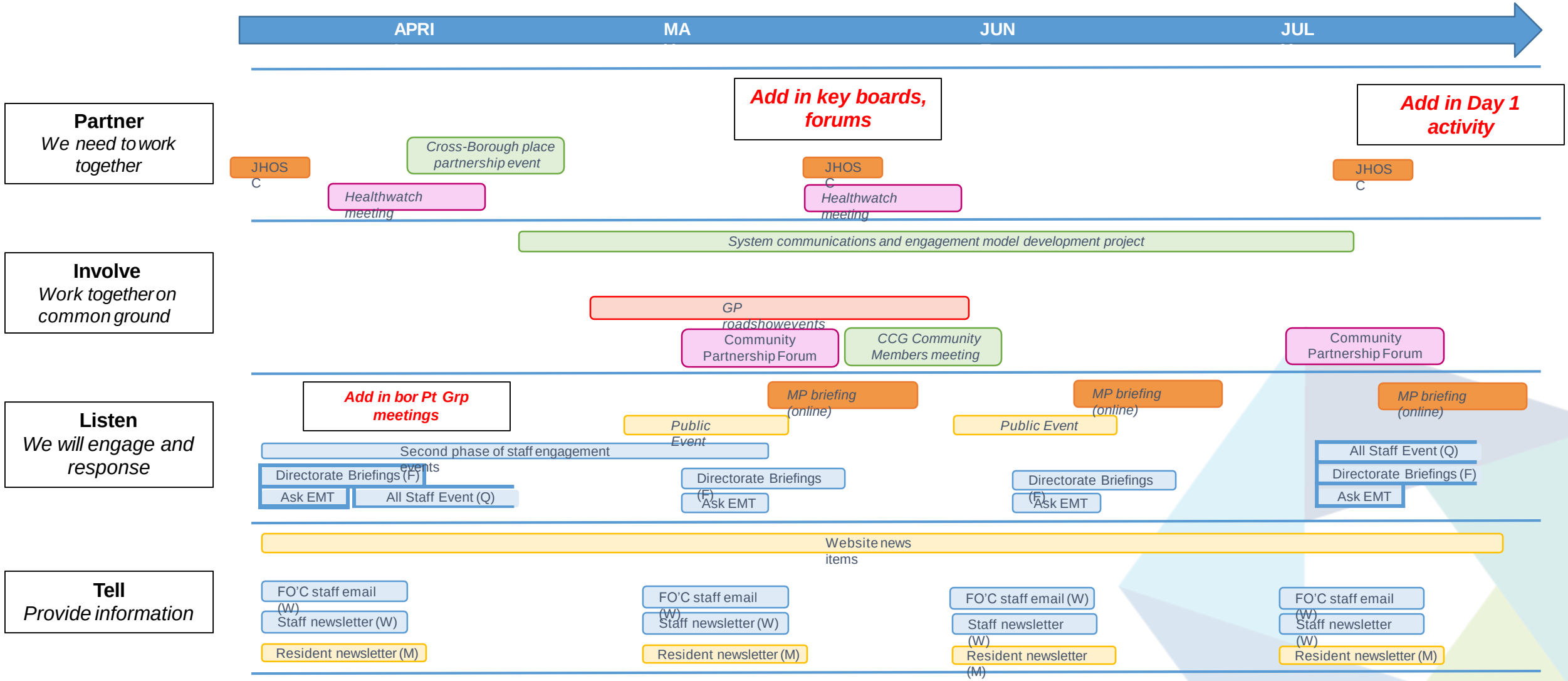
- MPs
- Councillors
- Patients/service users & groups
- Carers & groups/orgs
- Inclusion / protected characteristics groups
- Trust governors
- Trust staff
- CCG/ICS staff
- LA Boards
- LA public health and social care teams
- PCNs, GPs and primary care teams
- Nursing /AHP teams
- VCSE sector providers
- Staff side and trades unions
- CCG engagement and patient networks
- CCG Community Members
- PPG members / groups
- Trust membership networks
- LA citizen and residents groups
- Cultural and Faith groups

Activity overview

CCG staff | MPs/Cllrs
GPs | VCSF
System | Resident

Italics indicates activity TBC

North Central London Clinical Commissioning Group



Principles for communication and engagement

Effective communication and engagement across partnerships will be key to the ICS development and implementation. The key principles we will work to are. . .

- look to reflect on what works well and build on this to establish best practice and shared approaches
- communicate and engage with stakeholder groups including staff, partners and where appropriate, media
- ensure existing relationships are nurtured and new relationships are fostered
- keep our people and communities informed (‘doing to’)
- engage and support people to share their views (‘doing for’)
- work with patients and residents in partnership to ensure their voice is heard and their ideas help shape our work (‘doing with’).

Development of the Outcomes

- A draft NCL Population Health Outcomes Framework has been compiled (co-developed with Directors of Public Health)
- The NCL Population Health Outcomes Framework provides an overarching view of the outcomes we want our residents to experience,
  thereby providing a high level sense of where we need to act as an ICS
- This Outcomes Framework has been developed to underpin the vision for the NCL ICS and is complementary to the plans and objectives
  that sit at system, initiative and place based levels
- The Outcomes Framework is based on existing priorities and ambitions, particularly those set by place based partnerships (including Health & Wellbeing Board Strategies), driven by existing public health evidence, population health needs assessment and work that is already underway at a system and local level. It also aligns with the national approach to tackling inequalities – Core20PLUS5
- The Outcomes Framework is being shared with place based partnerships and system forums and will be refined following feedback received
- The Outcomes Framework will continue to iterate, alongside the development of the Population Health Improvement Strategy
- The Outcomes Framework also aligns with the ambitions of the recent Health & Social Care Integration White Paper, and we anticipate
  further iteration as our plans for person-centric and community driven change underpin our plans for our ICS and population health improvement
- This pack sets out:
  - The importance of the Outcomes Framework, the anticipated benefits, approach to building the Outcomes Framework
  - Principles for the Outcomes Framework
  - Summary of the Outcomes

Socialisation – themes

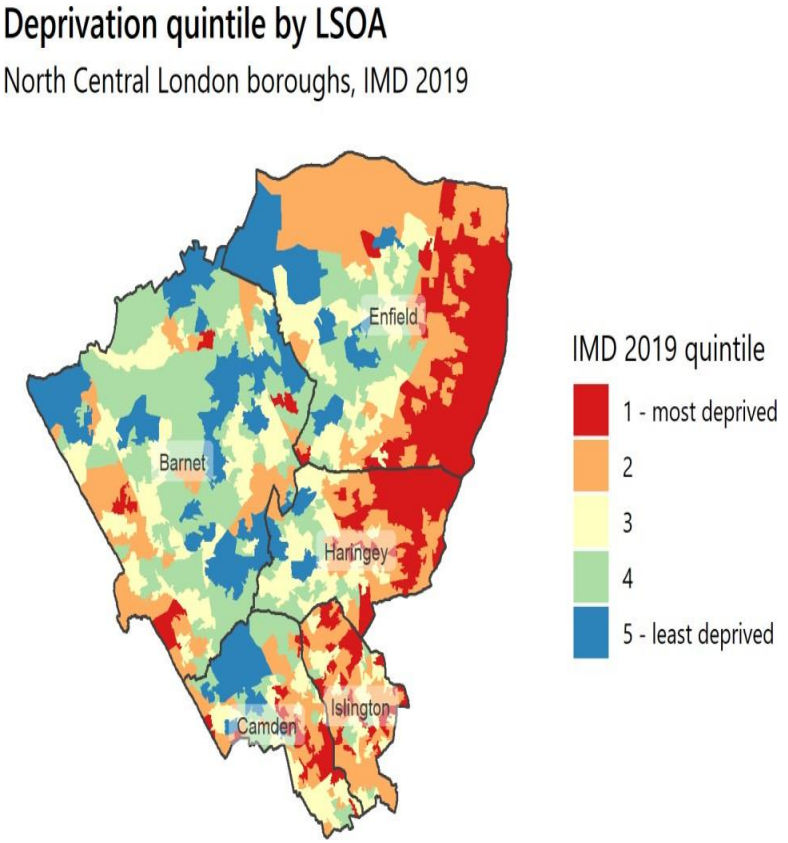
Overall feedback	• Overall, the feedback received has been **very positive**, with recognition that it provides a **helpful sense of direction** to support the ICS vision and that it is strongly aligned with other national strategies and local outcomes and priorities. • There was recognition that a lot of work is already happening at system and local level to contribute, however **we will need to change the way we do things** if we want to see a step-change in outcome achievement. • The Boroughs were pleased that it has been **co-produced with Directors of Public Health**. • There is an understanding from the Boroughs that a pragmatic approach needs to be taken, but they requested that we **do not lose sight of the wider determinants.** • There was an agreement that **tackling inequalities has to be central** to the Outcomes Framework.
Understanding the relationship between NCL and Borough outcomes & priorities	• There was recognition that there is **strong alignment** between NCL and Borough outcomes. • The Boroughs appreciated that **flexibility** remains for local priorities to sit alongside NCL priorities, in order to reflect the needs of their local communities. • Work to **map local outcomes** to NCL outcomes would be valued.
Outcomes Framework indicators	• There were queries around whether **performance measures** will be attached to the outcomes and some concern raised that an "industry" will be an inevitable result of having indicators attached to the outcomes. • **Baselining** of indicators will be key; Boroughs requested that there is a focus on those areas where there are the biggest gaps, in order to address inequalities.
Delivery and resources	• Clarifying where **responsibility sits for delivery** at all levels will be crucial. • There was a request for further information on **how this will be resourced**, and what resources will be required/ available to achieve these outcomes. • There was interest around whether **short and long term goals** will be set in order to successfully deliver these outcomes.
Principles & Outcomes	There has been feedback on some of the specific principles and outcomes. For example: • There was a request to **emphasise the importance of enablers** (finance, workforce, digital, anchor institutions, PHM), **strength-based approaches** and **prevention.** • It was proposed that '**parity of esteem** between mental and physical health' is too woolly; we need to be clearer around what the actual outcome will be and be stronger in our level of ambition.

Outcomes Framework - Next steps

- We will continue to collect feedback from our conversations with borough partnerships and system forums
- The Outcomes Framework will be updated, reflecting on the feedback and in parallel with the development of the Population Health Improvement Strategy
- We are developing a core set of indicators to be part of the Outcomes Framework, we will then:
  - Understand our baseline position
  - Develop goals & trajectories, with a focus on tackling inequalities
  - Build the indicators into HealtheIntent so that we have a near-real time view of the outcomes for the system, boroughs and care teams
- We know that we have some data quality issues and we are seeking to use levers such as DQIPs (NHS data quality improvement incentive) to improve data and ensure that all the dependencies are being tackled
- Work will continue to support the development of the Outcomes Framework and the Population Health Improvement Strategy, including:
  - Mapping of existing programmes to agreed outcomes
  - Understanding what is already in progress contributing to the outcomes and identifying gaps
  - Prioritise interventions and focus areas within each outcome
  - Identify specific population cohorts (e.g. where significant inequalities / poor outcomes exist in NCL)

What is the Inequalities Fund?

- **NCL CCG has created a £8.75m Inequalities Fund** by 2022/23 to help address the issues we see between different communities (all ages) living in the same Borough.
- This is in line with NHS Planning Guidance 2021/22 which highlighted **'gap' in health outcomes between most & least deprived communities nationally – typically up to 20 years in healthy life expectancy**
- Expectation in Planning Guidance is the Fund will particularly **benefit people living the most deprived 20% neighbourhoods** to improve equity of access, experience and outcomes
- In NCL, these neighbourhoods are in the east along the A10 corridor
- In many Boroughs, the **most deprived NCL neighbourhoods are also amongst some of the most ethnically diverse wards** in the Borough
- **There is also a legacy of COVID19 pandemic** – this is widely recognised as worsening the 'gap' in social and health outcomes
- We have agreed two phases of distribution of funds up to March 2023. **Phase 2 project mobilisation is currently underway**
- Many issues associated with health and wellbeing are deep rooted in psycho-social factors (e.g. isolation) and wider determinates of health (e.g. income and debt)
- **Funding to each Borough is proportionate to the level of need associated with socio-economic need**, i.e. based on the number of 20% most deprived neigbourhoods in each Borough. Borough allocation – 75% of the £8.75m allocation - is managed through the Borough Partnerships
- In addition, **15% of the IF funding is available for cross-Borough initiatives or for local priorities to support under-served groups** or communities outside deprived communities
- The remaining 10% of the funding was held as reserve and in now fully committed



Year	Funding
2021/22	£3,750,000
2022/23	£5,000,000
Total	£8,750,000

NORTH LONDON PARTNERS in health and care

NHS

Inequalities Fund – Phase 1 Projects

Oversight From	Project
Haringey/ Enfield ICPs	Family Mentoring Parentcraft
Haringey ICP	Start Well MH Arts/Sports
Haringey ICP	Tottenham Talk: MH Support
Haringey/ Enfield ICPs	People with Severe & Multiple Disadvantage (SMD) with HIU
Haringey/ Enfield ICPs	Multi-agency LTC Support Model
Enfield ICP	Black Health Improvement Outreach Project
Enfield ICP	Enfield Community Connections
Enfield ICP	Divert & Oppose Violence Worker
Enfield ICP	CS/Primary Care Smoking Cessation
Camden ICP	Focused autism and race equality project
Camden ICP	Barriers to Accessing Post-Covid Syndrome Services
Camden ICP	Camden Childhood Immunisation Programme
Camden ICP	MH Empowerment in Bengali & Somali Communities
Camden ICP	LD Annual Health Check Audit

Oversight From	Project
Camden & Islington ICPs	Primrose A
Camden ICP	Self-Care Community Champions
Islington ICP	Respiratory Well Project
Islington ICP	Early Prevention – Black Males & MH
Islington ICP	PHM Approach in 20% DRs
Islington ICP	Ambulatory outreach interventions on hard-to-reach groups
Camden ICP	Lifestyle Hubs
Barnet ICP	Early Years Oral Health
Haringey / Enfield ICP	Support Earlier Cancer Presentation
Cross NCL	NCL Children's Speech & Language Therapies (Now Phase II)
Camden ICP	Health Equalities Programme
Haringey ICP	Complex Autism Project
Camden ICP	Kilburn Ward Outreach

Inequalities Fund – Phase 2

Local Priority Projects:

- Learning Disability Risk Stratification
- Neuro-response Function
- Additional Investment in Lifestyle Hub model
- Enhanced Homeless Primary Care Health Service
- Cancer Link Workers
- NHS mentoring and support for young people
- NCL Somali Mental Health Support
- Islington Homelessness Health Inclusion Programme – Physical Health Needs
- Peer Support for CVD Prevention in Barnet

Camden ICP Projects

- Targeted Community Outreach Worker for Under-served groups/communities
- Improving lifestyle behaviours
- Improving Pathways for under-represented communities to access dementia support
- Annual Health Check Quality Improvement Project

Enfield ICP Projects:

- Life After Loss
- Addressing childhood obesity via community led activity
- Increasing access to healthier food and financial support
- Family Support - early intervention therapeutic support
- Diversity Living Services Programme
- Interstellar Walking Challenge
- Enfield Paediatric Asthma Nursing Pilot
- Increasing GP Registration & Participation in PPGs
- Analysis and system costs in Enfield

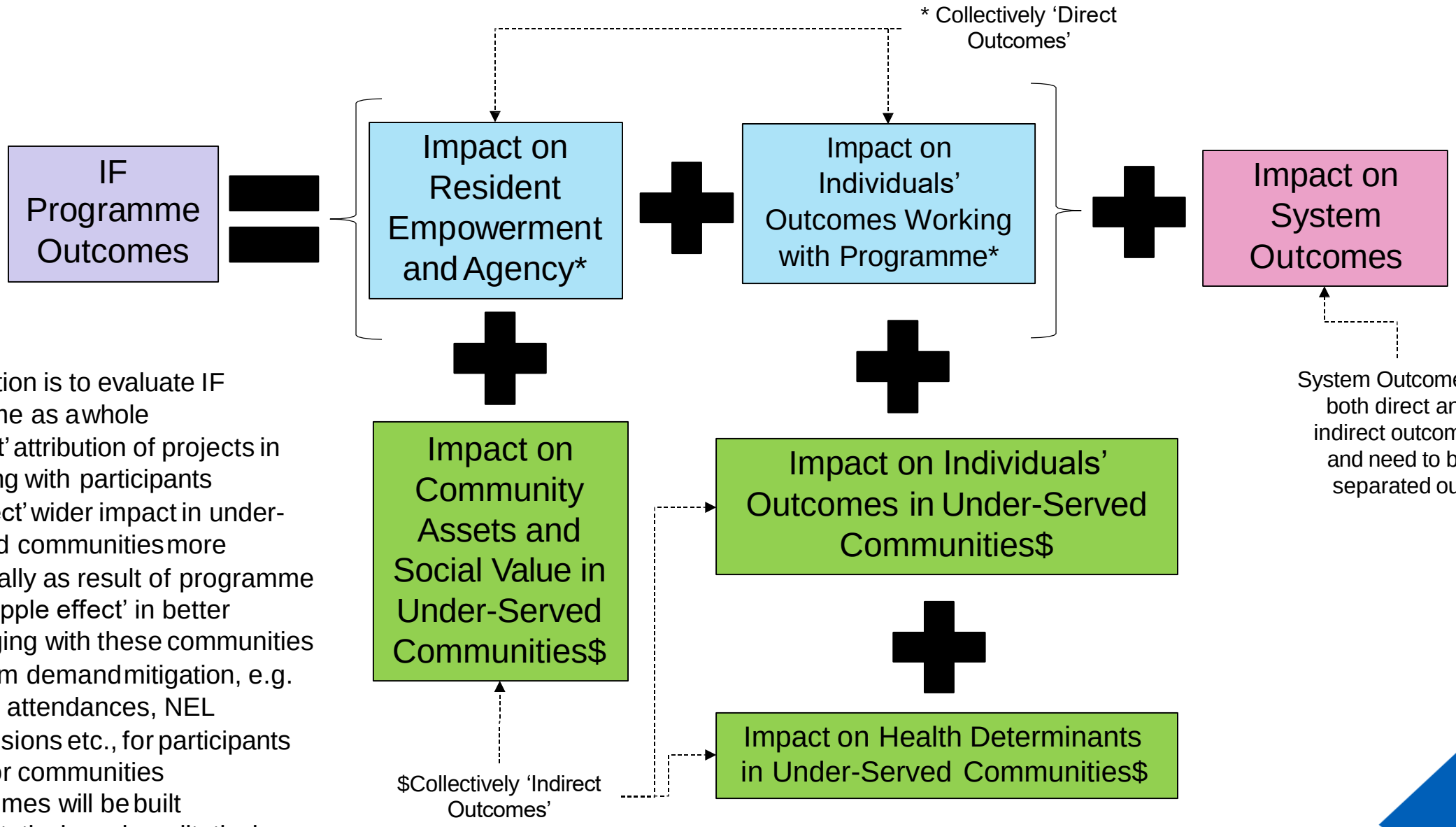
Islington ICP Projects:

- Islington Homelessness Health Inclusion Programme – Physical Health Needs
- Hand in Hand Islington – A Volunteer Peer Buddy Scheme
- Community Research & Support Programme
- Locality Virtual Spirometry Hubs

Haringey ICP Projects:

- Health Neighbourhoods Programme

Structure of Evaluation Domains



Our intention is to evaluate IF programme as a whole

- 'Direct' attribution of projects in working with participants
- 'Indirect' wider impact in under-served communities more generally as result of programme and 'ripple effect' in better engaging with these communities
- System demand mitigation, e.g. on ED attendances, NEL admissions etc., for participants and for communities
- Outcomes will be built quantitatively and qualitatively

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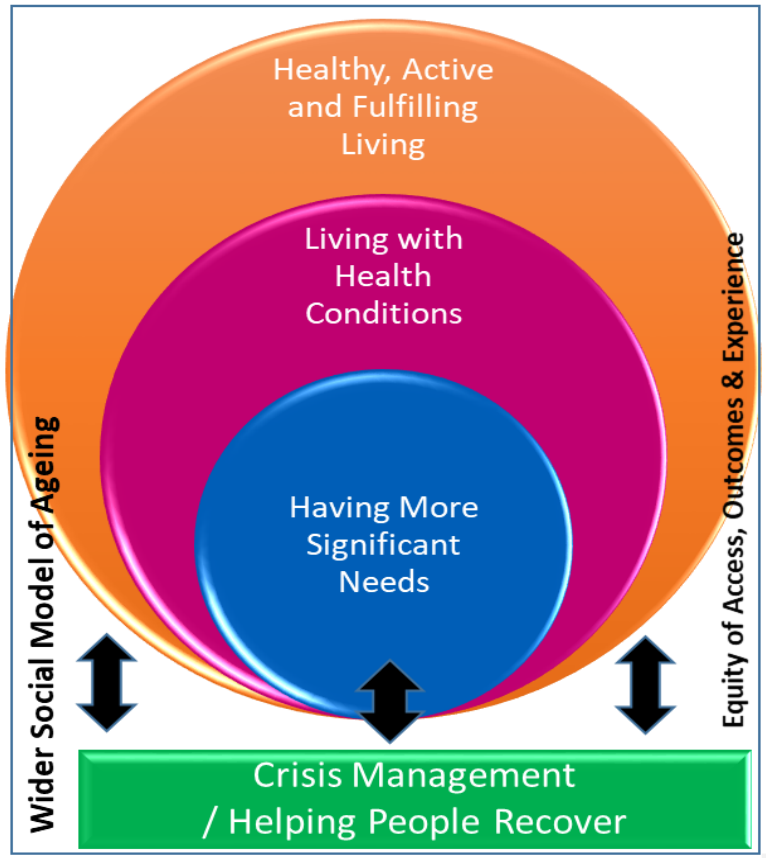
Framework for Outcomes

NHS

The key outcomes we are striving to achieve for individuals and the system **for the population** as a whole are likely to include the following (this includes outcomes in the NCL Outcomes Framework)



Individuals' Outcomes

- Enhance life chances & outcomes
- Be as physically and mentally health & independent as possible
- Have as healthy a lifestyle as possible
- Connected and thriving in families and local communities and with local solutions and services
- Make informed choices about life now and in future

AND

- Access to high-quality advice, support and care
- Early identification & treatment
- Good management of condition
- Well-prepared for changes in conditions/circumstances future
- Being as physically & mentally fit. well and independent as possible given underlying issues
- Able to manage social, financial & environmental issues impacting on condition

AND

- Living as fulfilling a life as possible
- Feeling care planning & delivery is built around your needs
- Good management of multi-morbidity or complex situations
- Access to valued high-quality integrated care and support
- Having a good death

- Know what to do if approaching crisis & mitigating it
- Access to high-quality crisis support & recovery services
- Promoting Recovering health, autonomy & independence post-crisis and adjusting to any new 'norms'

System and 'Under-Served' Population Benefits

- Improved equity of access to preventative solutions
- Enhanced healthy lifestyles, health promotion and life chances in communities and mitigated social gradients
- Improved and well-utilised of preventative solutions
- Mitigated healthy life expectancy social gradients
- Mitigated long-term demand ('need compression')
- Improved social capital, community power & cohesion between communities and with statutory services
- Enhanced capabilities of statutory organisations to demonstrate civic leadership and enhance life chances [Anchor]

AND

- Improved equity of access to services at right time
- Improved screening, diagnosis and tracking of common conditions in community
- Unwarranted variation in condition identification, management & outcomes, including mitigation of social gradients
- Increased utilisation of preventative/proactive solutions
- Mitigated risk of escalation & acuity;
- Promotion & achievement of personalised solutions & services, including non-statutory solutions
- Medium-term 'compression of need' to mitigate demand

AND

- Better personalised & integrated proactive care, ideally at home, with stated goals being achieved
- Improved access and outcomes in social gradient of outcomes & experience for people with more complex needs
- Assured plural & high-quality care solutions
- 'In Year' reduction in crises & crisis services
- NEL attendance & admission avoidance including social gradient
- Improved & timely hospital discharge
- Supporting as many people as possible to stay, or return, home
- Reduced need for long-term care or the intensity of this care

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What we want to achieve with population health management in North London

Understand the needs of different populations and communities across North Central London to ensure we are providing services to meet them appropriately

To identify **gaps in care** and make the shift towards **prevention and early intervention**

To identify **potential unwarranted variation** and improve the **quality of care, experience and outcomes**

To **widen the focus beyond *individual* healthcare utilisation** recognising that people live in families and communities

Moving towards **system-wide accountability** and **shared outcomes**

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HealtheIntent in North London

HealtheIntent is Cerner's population health management platform that is being deployed across North London to create an integrated health and care record to support direct care.

The aims of HealtheIntent and the Population Health Management programme are to enable:

- a system-wide population health approach, including prevention and early intervention
- a reduction in inequities in care and health inequalities
- fostering a learning system using data to frame problems and develop responses, particularly across different care teams
- improvements in the quality of care, with a focus on reducing unwarranted variation and delivering what matters to individuals

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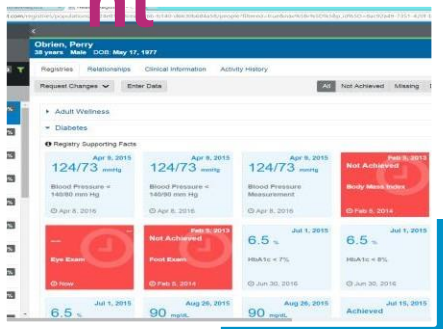
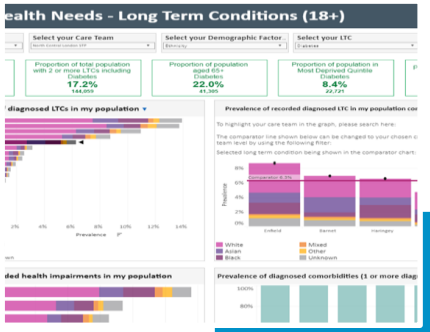
HealtheInte nt



Healthe Registries

view of the gaps in patients' care against a defined set of measures

- care quality for a specific population or cohort (e.g. adults with SMI, people with a learning disability, people with diabetes)
- support the identification of 'gaps in care' for individuals and populations and can be viewed at patient, practice & PCN level
- achievement is assessed against quality standards (e.g. NICE guidance)



Healthe Analytics

detect unwarranted variation and support case finding

- identify trends and unwarranted variation in population cohorts
- split out the cohort by equalities filters to monitor inequalities
- Case-find e.g. identify high-risk patients based on agreed indicators (e.g. frailty)
- enable care professionals to 'drill down' to see which of their patients/clients require specific action
- Monitor quality improvement of registries (e.g. track proportion of measures met at different levels)
- Review demographic information

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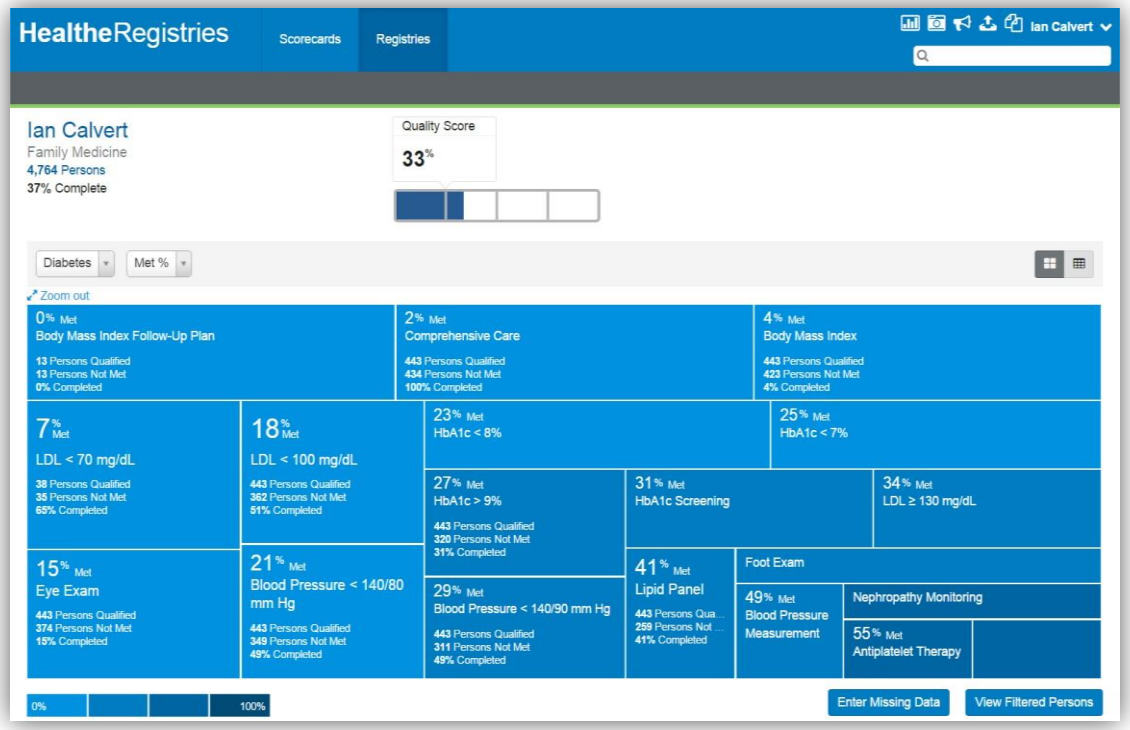
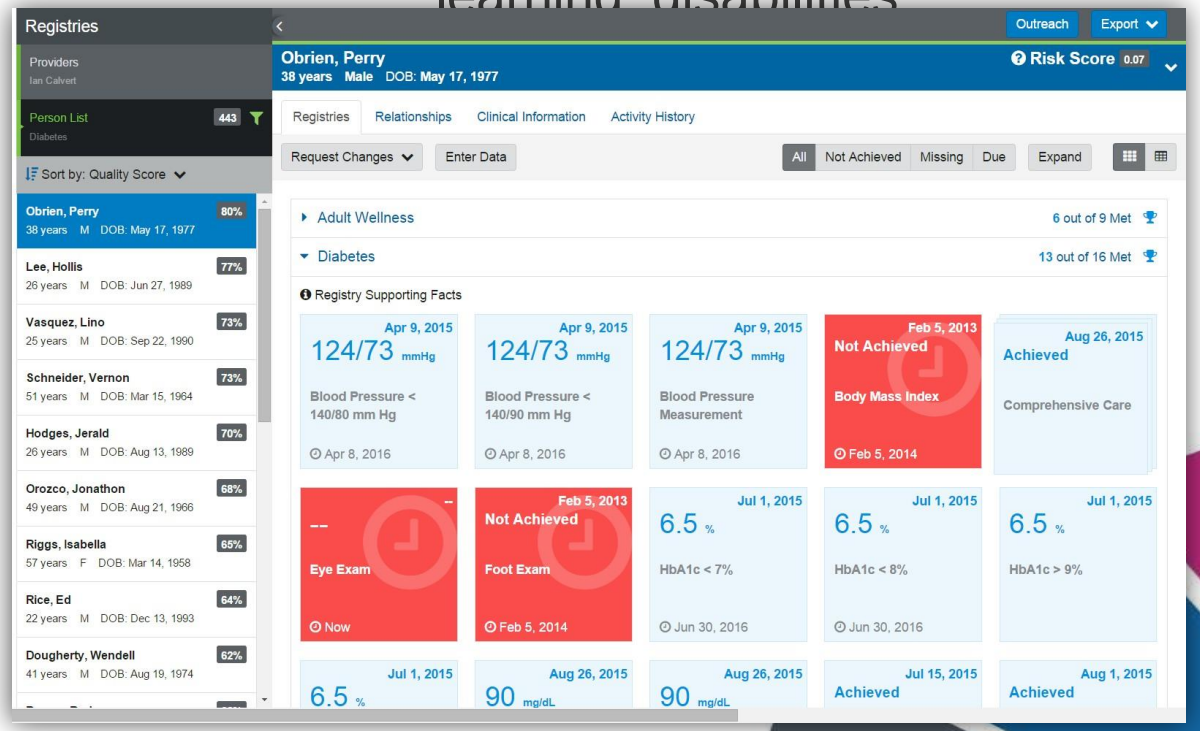
Registries - to close gaps in care

- Childhood asthma
- Diabetes
- Atrial Fibrillation
- COPD
- Physical health checks in people with SMI
- Living well after cancer*
- Physical health checks in people with learning disabilities*





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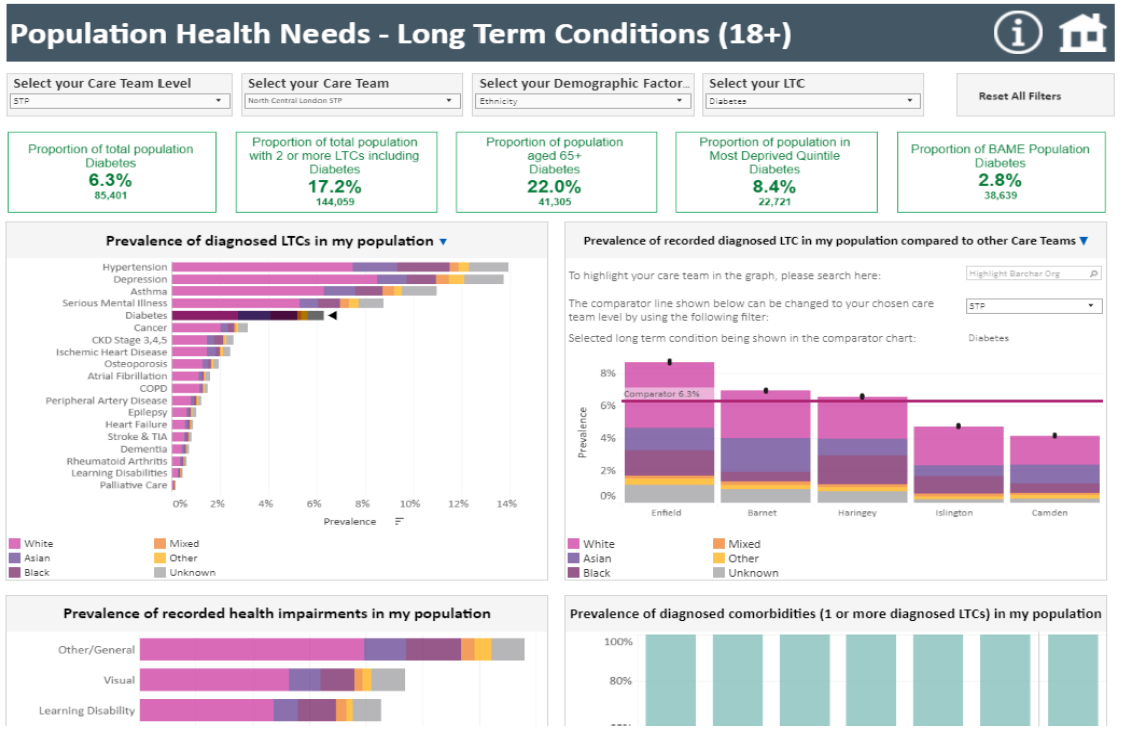
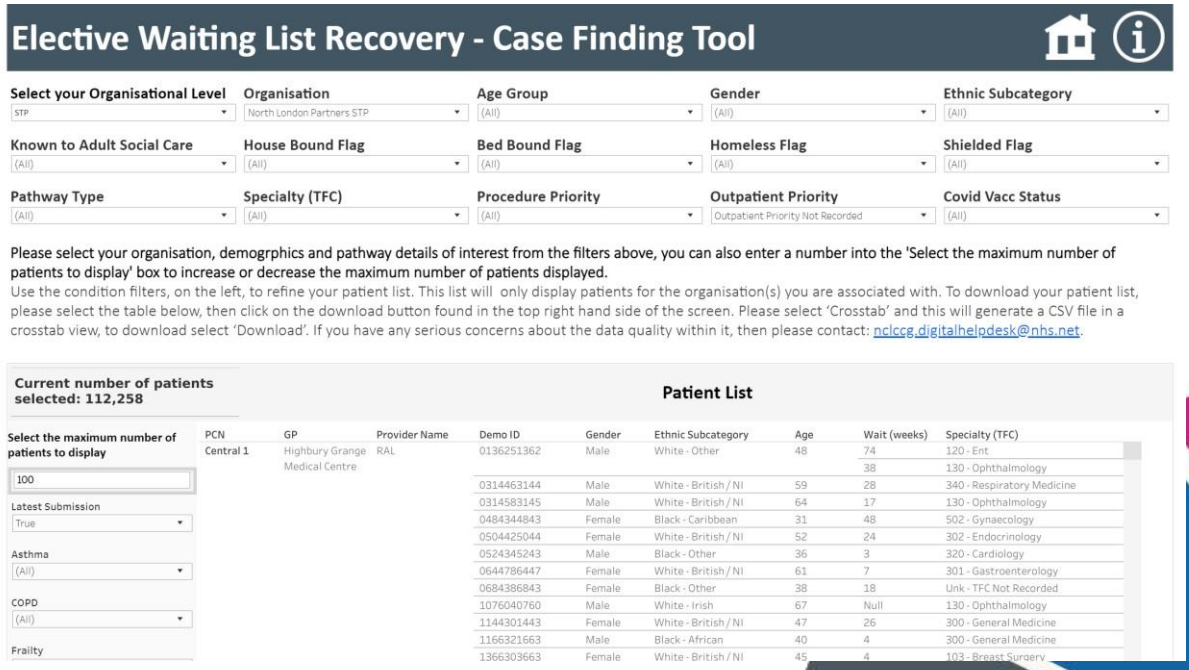
Analytics

- Population health needs and inequalities
- Flu and Covid vaccinations
- Covid discharge and management
- Frailty
- Childhood immunisations
- Quality improvement: childhood asthma, diabetes, atrial fibrillation, COPD and SMI*
- Elective recovery (one system PTL)
- Sodium valproate
- Critical care*
- Population segmentation*
- GP appointments / system-wide utilisation*
- *Proactive care***
- *Hospital discharge – social care focus***
- *Homelessness***

*in development; ***in scoping*





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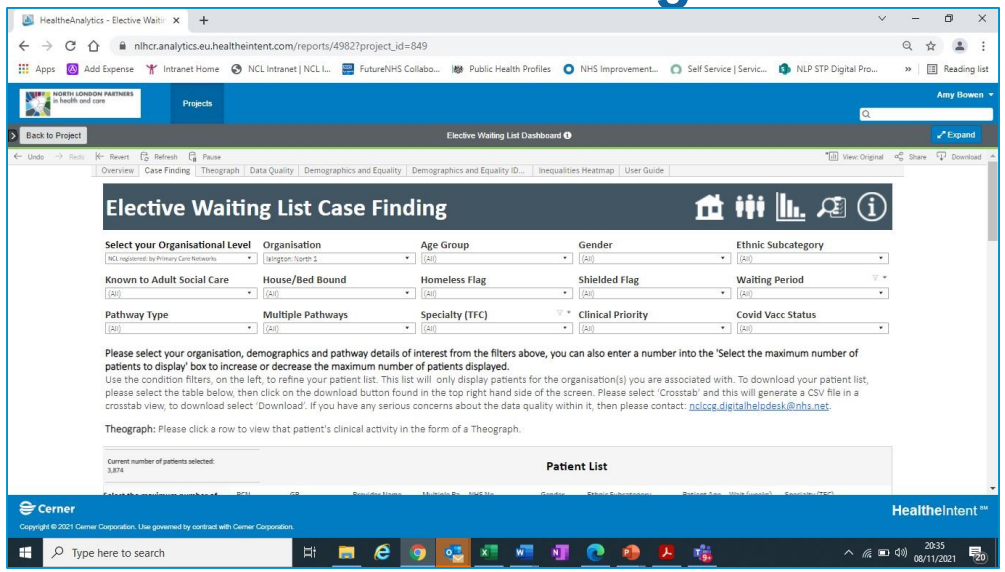
Proactive Integrated Teams – bringing population health management to elective

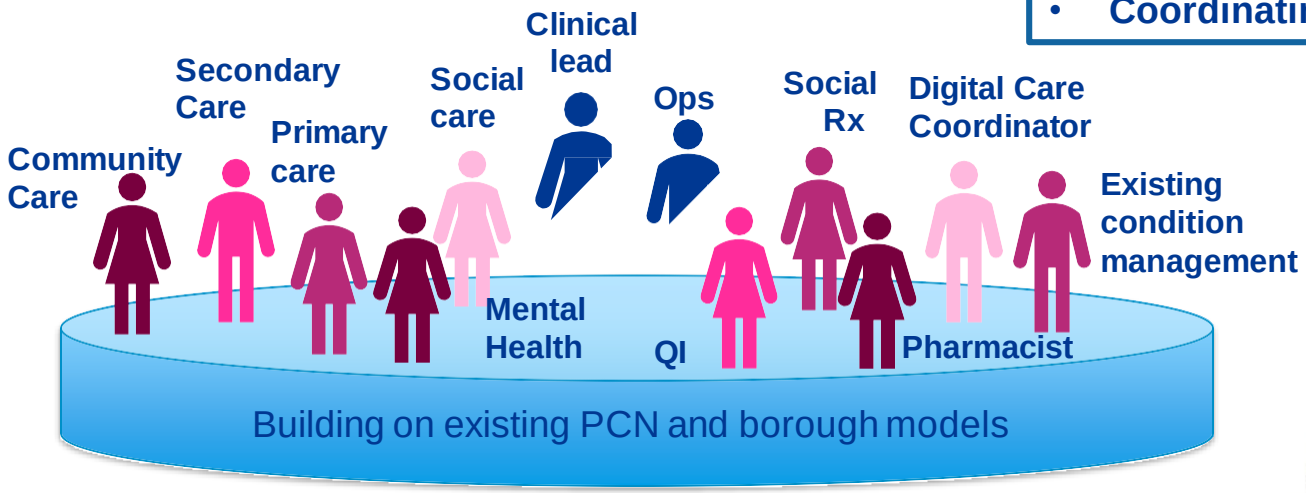
NHS

1 HealtheIntent Elective Waiting List Dashboard



2 Prioritised PCNs
- Numbers waiting
- Prevalence of LTCs
- Deprivation

3 Proactive Integrated Teams



4
- Improved outcomes
- Optimised health and well-being
- Re-prioritisation
- Coordinated care

Proactive Support
- Case management
- Holistic support
- Personalised care and support planning
- Remote monitoring
- Use of wider team
- Focus on health inequalities
- Closing gaps in care
- Coordinating with providers

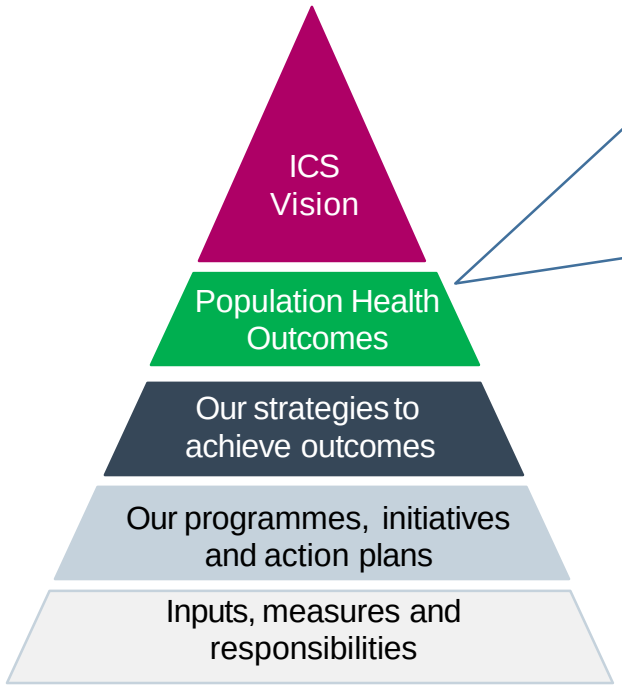
Purpose of the Population Health Improvement Strategy

- The Population Health Improvement Strategy is being developed to set out the approach and plans that the ICS is building to improve the health and wellbeing of its population
- The strategy will reflect the journey that we anticipate the ICS, as a partnership as well as its constituent organisations, will go on to embed the approaches and ways of working required to improve population health and tackle inequalities
- It is anticipated that this strategy will continue to evolve, based on learning, collaboration with communities and partnership working
- The strategy sits at the core of what the purpose of the ICS is, and will be used to drive and influence other strategies for the ICS, all working harmoniously to enable the achievement of the ICS vision and the Population Health outcomes
- This first iteration of the Population Health Improvement Strategy is being written for an internal ICS audience, with the aim of bringing partners together in support of the aims and objectives of the strategy, and will cover:
  - The needs of our population
  - Our vision and outcomes for our population
  - How we will embed population health approaches, tools, etc. to drive improvements and reduce inequalities

Development of the Population Health Improvement

- The PHI Steering Group is providing oversight of the development of the strategy, recognising:
  - The strategy is anticipated to be iterative – continuously learning from work undertaken at place and system
  - It will be a collaboration, with co-production and involvement from colleagues across the system
  - It will articulate a narrative that speaks to both place and system – to align the multiple delivery contributions that will enable achievement of the NCL Population Health Outcomes
- The strategy will focus on 3 core strands that will act as delivery mechanisms during 22/23:
  - The programmes / initiatives through which we will prioritise utilising a population health approach, e.g. Core20PLUS5, CYPM&N programme, LCS LTC, the proactive integrated teams, the inequalities fund, etc.
  - Ways of working – including collaboration and co-design with partners and residents
  - Tools and enablers – the embedding of HealtheIntent to support both front line delivery and strategic planning and transformation of services
- As the strategy will set out, building on existing work to support citizen involvement, increase collaboration, engagement and co-design is central to our approach. In due course, we will need to consider how we co-produce our approach to delivery in a meaningful way with our residents, building on place-based arrangements. We will actively reach out to communities to hear from them and to work together to develop ways in which they can shape and support delivery of our co-designed plans and initiatives at all levels
- The initial version of the strategy is anticipated to be shared with the PHI Committee in April for endorsement

Delivering improvements in population health outcomes will determine the success of the NCL integrated health and care system



Benefits and requirement of having an agreed NCL ICS Population Health Outcomes Framework

1. The Outcomes Framework provides an overarching view of the outcomes we want our residents to experience, thereby providing a high level sense of where we need to act
2. Links our vision to our mission, strategic aims/objectives and to our programmes of work to ensure that our day to day activities are aligned to our strategic direction
3. Supports the identification of areas where action at a system level, not just at a borough level, will be beneficial
4. Helps prioritise needs and thereby plan where energies and resources need to be utilised.
5. Enables system oversight for tracking progress to reduce health inequalities and to monitor and measure progress and relative success against objectives

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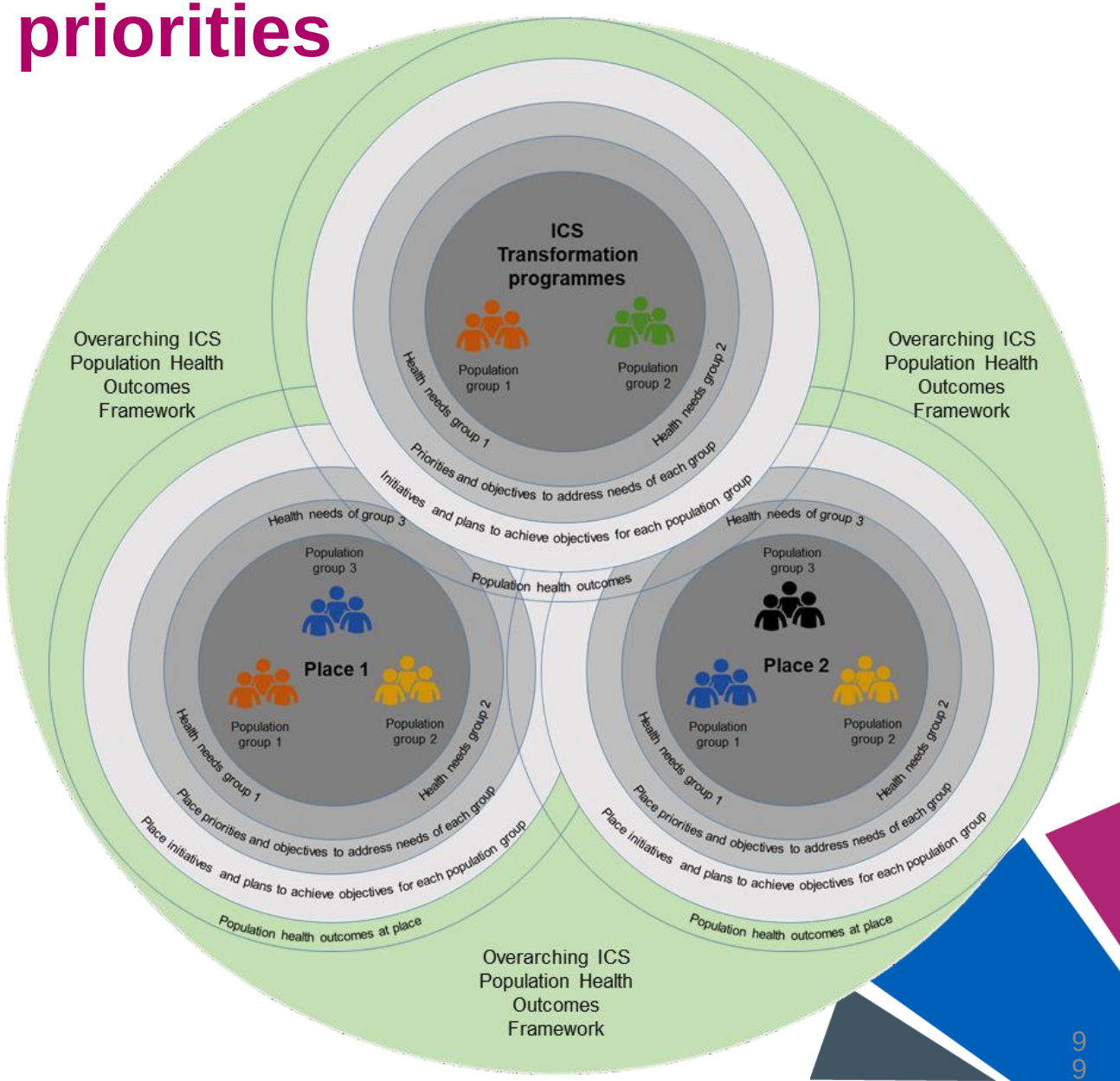
Building on local needs and priorities

Our NCL Population Health Outcomes Framework will enable us to identify and focus on where we will make a difference together at a system level.

The Outcomes Framework is informed by:

- Population needs and inequalities, including ethnicity and deprivation
- Health and Wellbeing Board strategies and priorities
- Place and borough priorities included in the system development plan
- National driven health inequalities interventions

Achievement of the outcomes will be dependent on delivery at all levels and with all system partners.



Proposed principles to developing the NCL Population Health outcomes and Population Health Improvement strategy

- Tackling health inequalities
- Prioritising prevention and early intervention
- Empowering communities
- Co-production and personalisation
- High quality of and equitable access to services
- Adding value
- Integration and doing things differently
- Sustainability and greener NHS
- Subsidiarity
- Sharing responsibility and accountability
- Maximising use of enablers: finance, workforce, digital, anchor institutions, Population Health Management

Our approach to developing the NCL Population Health Outcomes

We have worked closely with our Directors of Public Health to develop an approach to developing the outcomes that will reflec t our key population needs and inequalities and be achievable. The proposed outcomes are driven by existing public health evidence and work that is underway at local level, as well as aligned to the CORE20Plus5 approach.

Evidence-based

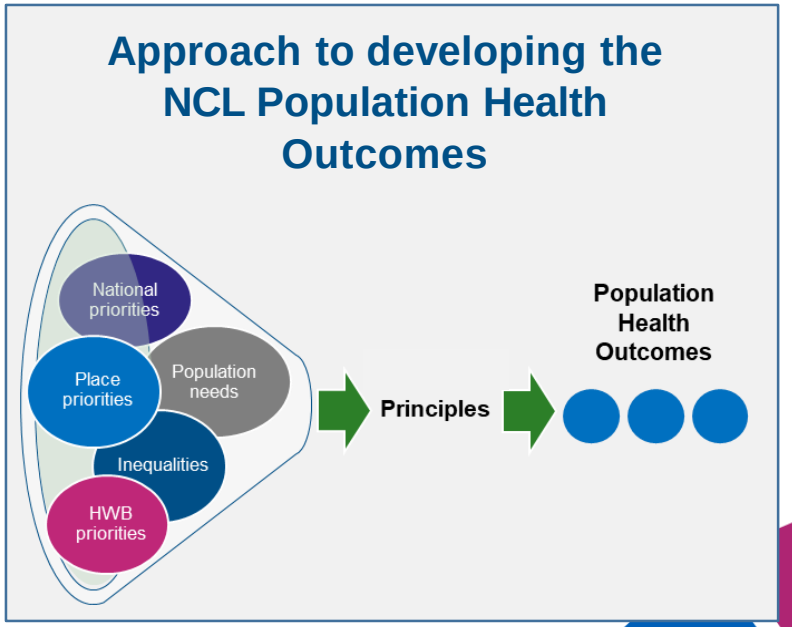
We looked at all the available data and information, including:

- ✓ Population needs and inequalities, including ethnicity and deprivation
- ✓ Health and Wellbeing Board strategies and priorities
- ✓ Place and borough priorities included in the system development plan
- ✓ National driven health inequalities interventions

Pragmatic and realistic

We needed to ambitious but realistic and achievable:

- ✓ Identified pragmatic priorities that would allow flexibility of interventions and build in more social and wider determinants of health over time
- ✓ Looked at where we can make an impact at a system level, but recognising initial levers will be NHS / health driven



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Proposed NCL Population Health outcomes framework

Start well

Every child has the best start in life and no child left behind

- Improved maternal health and reduced inequalities in perinatal outcomes
- Reduced inequalities in infant mortality
  Increased immunisation and new born screening coverage
- All children are supported to have good speech language and communication skills

All children and young people are supported to have good mental and physical health

- Early identification and proactive support for mental health conditions
- Reduction in the number of children and young people who are overweight or obese
- Improved outcomes for children with long term conditions

Young people and their families are supported in their transition to adult services

- All young people and their families have a good experience of their transition to adult services

Live well

Reduction in early death from cancer, cardiovascular disease and respiratory disease

- Reducing prevalence of key risk factors: smoking, alcohol, obesity
- Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease

Reduced unemployment and increase in people working in good jobs

- Support people to stay in jobs, including mental health and musculoskeletal services
- Anchor institutions to employ local people including those with mental health illness, physical disability, and learning disabilities, and to buy locally including by using social value-based commissioning and contracting

Parity of esteem between mental and physical health

- Reducing racial and social inequalities in mental health outcomes
- Improved physical health in people with serious mental health conditions
- Reducing deaths by suicide

Age well

Older people live healthy and independent lives as long as possible

- Ensure that people get timely, appropriate and integrated care when they need it and where they need it
- Prevent development of frailty with active aging
- Improved outcomes for older people with long-term conditions, including dementia

Older people are connected and thriving in their local communities

- Older people have fulfilling and meaningful social life
- Older people are informed well and can easily access support for managing financial hardship

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Ongoing development of North Central London ICS

We are committed to developing our ICS transition plan in order to meet the needs of our local population with the core objectives of:

- Improving outcomes in population health and care
- Tackling inequalities in outcomes experience and access
- Enhancing productivity and value for money
- Helping the NHS support broader social and economic development

We will continue to develop and further refine our transition plans as additional guidance is made available

Areas identified for continued work, that will evolve as guidance and policy develops:

1. **System Leadership and Governance**
   - ICS leadership development
   - ICS Constitution development
   - Functions and Decisions Map for NCL

2. **Financial Frameworks**
   - Clarity of funding flows
   - Allocation of risk and reward
   - Specialised commissioning

3. **System Assurance**
   - Development of MOU with NHS E and SOF
   - System data and reporting metrics

Risks and areas of specific further work for North Central London

North Central London's Trusts' (including UCLH, GOSH and Royal Free) service health needs beyond our local borough boundaries from across the country. For some this is a majority of their activity. We will continue to work with the national and regional teams to determine the implications of this for our financial and integration strategies.

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Key next steps to achieve the collective ambition of NCL Integrated Care System

- ✓ Co-producing a population health outcomes framework and strategy – with input from across the system.
- ✓ Engagement meetings between the NCL ICS Chair, NCL ICS Chief Executive and partners to consult on next steps in evolving NCL health and care partnerships and borough partnerships.
- ✓ By the end of June 2022, the Partnership will agree ambitions for the next few years, short term priorities and core principles for working together.
- ✓ Establish a board membership for the ICB including non-executive and partner members (council, NHS Provider and Primary Care).
- ✓ Iterate ICB Constitution with feedback from the engagement period
- ✓ Begin working with Local Authorities and other system partners to think through the implications of the recently published Integration White Paper ‘Joining up care for people, places and populations’.

Arrangements for the Integrated Care Partnership in NCL

In October 2021, NCL established the Quarterly Partnership Council with membership from all five local authorities, as well as provider trusts and CCG representatives, and chaired by the NCL Chair. This forum sits alongside the Community Partnership Forum established in Autumn 2021. The Quarterly Partnership Council forum will continue to develop and transition to the North Central London Health and Care Partnership with its first meeting scheduled for October 2022.

The key objective of the first meeting will be to develop further the NCL ICP Strategy based on the NCL ICS Population Health Outcomes and Strategy overseen by the NCL Population Health & Health Inequalities Committee, which will inform the NCL ICB 5-year plan.

In addition to the Quarterly Partnership Council, we established the NCL Local Authorities CEOs forum that meets monthly with the ICB CEO and Chair Designates. This is a dedicated shared forum to support co-design and co-development of key work of the emerging ICB and ICP. Key objectives of this forum are to:

1. Develop a shared workplan to support the development of the Integrated Care Partnership (ICP) and the work of the ICB
2. Agree plan for wider engagement with providers and communities at place to support ICP and ICB development
3. Problem solve key ICS issues and co-design shared programmes of work
4. Challenge and drive transformation, new ways of working and integration of services across NCL

Current NCL ICS Quarterly Partnership Council Membership (North Central London Health and Care Partnership)

Organisation/ Role
NCL ICS Chair Designate
NCL ICS CEO Designate
NCL CCG Chair
NCL CCG Executive Director of Corporate Services
NCL CCG Executive Director of Transition
Primary Care Lead
Barnet, Enfield & Haringey Mental Health Trust Chair & Camden & Islington NHS FT Chair
Central London Community Healthcare NHS Trust Chair
Great Ormond Street NHS FT Chair
Moorfield Eye Hospital NHS FT Chair
North Middlesex University Hospital Trust Chair & Royal Free London NHS FT Chair

Organisation/ Role
Tavistock and Portman NHS FT Chair
University College London Hospital NHS FT Chair & Whittington Health NHS FT Chair
Royal National Orthopaedic Hospital NHS FT Chair
Central & North West London NHS Trust Chair
UCL Health Alliance Managing Director
Council Leader London Borough of Barnet
Council Leader London Borough of Camden
Council Leader London Borough of Enfield
Council Leader London Borough of Haringey
Council Leader London Borough of Islington
NCL Local Authority Chief Executive

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List of additional documents to be added (in deck or appendix)

Section 5 Commissioning Arrangements	Appendix A	NCL Oversight MOU Final
Section 9 Arrangements for establishing the ICS People function	Appendix B	Working with People and Communities Strategy
	Appendix C	Working with our VCSE NCL ICB Strategy
	Appendix D	Developing NCL People Plan
Section 13 Data and digital transformation	Appendix E	NCL Digital Strategy