NHS
North Central London
Integrated Care Board

NHS North Central London ICB
Board of Members Meeting
Tuesday, 12 November 2024
2pm – 4pm
MS Teams

AGENDA
Part 1

Item	Title	Lead	Action	Page	Time
1.	**INTRODUCTION**				
1.1	Welcome and Apologies	Paul Najsarek	Note	Oral	2pm
1.2	Declarations of Interest (not otherwise stated)	Paul Najsarek	Note	3	
1.3	Draft Minutes of the NCL ICB Board of Members Meeting on 23 July 2024	Paul Najsarek	Approve	10	
1.4	Draft Minutes of Annual General Meeting on 19 September 2024	Paul Najsarek	Approve	24	
1.5	Matters Arising	Paul Najsarek	Note	29	2.05pm
1.6	Report from the Chief Executive Officer	Frances O'Callaghan	Note	31	2.10pm
2.	**STRATEGY AND BUSINESS**				
2.1	Population Health Outcomes Framework and Insight Report	Sarah Mansuralli Ibrahim Abubaker	Note	38	2.25pm
2.2	Primary Care Access Recovery Plan	Sarah McDonnell-Davies	Approve	88	2.45pm
2.3	NCL ICB Constitution Update	Ian Porter	Approve	114	3.05pm
3.	**OVERVIEW REPORTS**				
3.1	Integrated Performance and Quality Report	Richard Dale Jenny Goodridge	Note	150	3.10pm
3.2	Finance Report	Phill Wells	Note	172	3.25pm
3.3	Board Assurance Framework	Ian Porter	Note	192	3.40pm
4.	**ITEMS FOR INFORMATION AND ASSURANCE**				

4.1	Minutes of the Audit Committee Meetings on 11 June and 18 June 2024	Kay Boycott	Note		3.50pm
4.2	Minutes of the Finance Committee Meetings on 2 April and 30 July 2024	Usman Khan	Note		
4.3	Minutes of the Integrated Medicines Optimisation Committee Meeting on 2 July 2024	Jonathan Levy	Note		
4.4	Minutes of the People Board Meeting on 13 May 2024	Liz Sayce	Note		
4.5	Minutes of the Procurement Oversight Group Meeting on 3 May 2024	Phill Wells	Note		
4.6	Minutes of the Quality and Safety Committee Meetings on 14 May and 16 July 2024	Liz Sayce	Note		
4.7	Minutes of the Strategy and Development Committee Meetings on 19 June and 14 August 2024	Sarah Mansuralli	Note		
5.	**ANY OTHER BUSINESS**				
6.	**DATE OF NEXT MEETING**				
6.1	25 March 2025				

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
12 November 2024

Report Title	Declaration of Interests Register – NCL ICB Board of Members	**Date of report**	30 October 2024	**Agenda Item**	1.2
Integrated Care Board Sponsor	Paul Najsarek Chair, NCL ICB	**Email / Tel**		Paul.najsarek1@nhs.net	
Lead Director / Manager	Frances O'Callaghan Chief Executive, NCL ICB	**Email / Tel**		frances.o'callaghan@nhs.net	
Report Author	Steve Beeho Senior Board Secretary	**Email / Tel**		s.beeho@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications**		Not applicable.	

Report Summary

Members and attendees of the NCL ICB Board of Members meeting are asked to review the agenda and consider whether any of the topics might present a conflict of interest, whether those interests are already included within the Register of Interest, or need to be considered for the first time due to the specific subject matter of the agenda item.

A conflict of interest would arise if decisions or recommendations made by the Committee could be perceived to advantage the individual holding the interest, their family, or their workplace or business interests. Such advantage might be financial or in another form, such as the ability to exert undue influence.

Any such interests should be declared either before or during the meeting so that they can be managed appropriately. Effective handling of conflicts of interest is crucial to give confidence to patients, tax payers, healthcare providers and Parliament that ICB commissioning decisions are robust, fair and transparent and offer value for money.

If attendees are unsure of whether or not individual interests represent a conflict, they should be declared anyway.

Members are reminded to ensure their declaration of interest form and the register recording their details are kept up to date.

Members and attendees are also asked to note the requirement for any relevant gifts or hospitality they have received to be recorded on the ICB Gifts and Hospitality Register.

Recommendation	The Board of Members is asked to: • **NOTE** the requirement to declare any interests relating to the agenda; • **NOTE** the Declaration of Interests Register and to inspect their entry and advise the Board Secretary of any changes; • **NOTE** the requirement to record any relevant gifts and hospitality on the ICB Gifts and Hospitality Register.
Identified Risks and Risk Management Actions	The risk of failing to declare an interest may affect the validity of a decision / discussion made at this meeting and could potentially result in reputational and financial costs against the ICB.
Conflicts of Interest	The purpose of the Register is to list interests, perceived and actual, of members that may relate to the meeting.
Resource Implications	Not applicable.
Engagement	Not applicable.
Equality Impact Analysis	Not applicable.
Report History and Key Decisions	The Declaration of Interests Register is a standing item presented to every meeting of the Board of Members.
Next Steps	The Declaration of Interests Register is presented to every meeting of the Board of Members and regularly monitored.
Appendices	The Declaration of Interests Register.

NCL ICB Board of Members Declaration of Interest Register - November 2024

Name	Current Position (s) held- i.e. ICB Board, Trust, Member practice, Employee or other	Declared Interest - (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or Indirect?	Nature of Interest	Date of Interest				Actions to be taken to mitigate risk (to be agreed with line a manager of a senior CCG manager)
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	Date declared	Updated	
Members												
Mr Paul **Najsarek**	Chair of North Central London Integrated Care System	South East London ICB	yes	yes	no	direct	Non Executive Member	01/07/2022	current	15/10/2024		
Mr Paul **Najsarek**	Chair of ICB Board	The Health Foundation Company number 01714937	no	yes	no	direct	Director	01/03/2023	current	15/10/2024		
Mr Paul **Najsarek**	Member of ICB Finance Committee	Waythrough (formerly known as Humankind) Charity Company number 01820492	yes	no	no	direct	Trustee / Director	01/06/2024	current	15/10/2024		Services commissioned by the NHS. I am not involved in procurement in the ICB nor involved in my capacity as a Trustee
Mr Paul **Najsarek**	Chair of ICB Strategy and Development Committee	Paul Policy Practice Ltd Company number 13817053	yes	yes	yes	direct	Director	24/12/2021	current	15/10/2024		
Mr Paul **Najsarek**	Chair of ICS Community Partnership Forum	DA Languages Ltd which works with the NHS Company number 06207784	yes	yes	no	direct	Advisor		current	15/10/2024		Services commissioned by the NHS. I am not involved in procurement in the ICB nor involved in my capacity as a Advisor
Mr Paul **Najsarek**	Chair of Integrated Care Partnership	Care Quality Commission	yes	yes	no	direct	Advisor on LA assessment	01/05/2022	current	15/10/2024		
Mr Paul **Najsarek**	Attend other committees as and when required	Warrington Council	yes	yes	no	direct	Lead Inspector on a Best Value Inspection	01/05/2024	current	15/10/2024		
Mr Paul **Najsarek**		Haringey Council	no	no	no	direct	wife is an employee		current	15/10/2024		
Mr Paul **Najsarek**		Christ the King Primary School in Islington	no	yes	no	direct	School Governor and Vice Chair	01/09/2021	31/08/2025	15/10/2024		
Ms Frances **O'Callaghan**	Chief Executive of North London Integrated Care System	Labour Party	no	no	yes	direct	Member of Labour Party	25/05/2023	current	26/05/2023	15/08/2024	This declaration and any potential conflicts of interest were fully assessed by the Governance and Risk Team. Appropriate mitigating actions have been put into place and will be adhered to.'
Ms Frances **O'Callaghan**	Member of ICB Board of Members	UCL Partners	yes	yes	no	direct	Director	31/03/2023	current	15/08/2024		
Ms Frances **O'Callaghan**	Member of ICB Finance Committee											
Ms Frances **O'Callaghan**	Member of ICB Strategy and Development Committee											
Ms Frances **O'Callaghan**	Member of ICB Executive Management Team											
Ms Frances **O'Callaghan**	Member of ICB Community Partnership Forum											
Ms Frances **O'Callaghan**	Attend other ICB Committees as necessary											
Mr Phill **Wells**	Chief Finance Officer							01/12/2023	31/07/2024	06/12/2023	22/07/2024	
Mr Phill **Wells**	Member of ICB Finance Committee									10/07/2023	22/07/2024	
Mr Phill **Wells**	Member of Strategy and Development Committee									10/07/2023	22/07/2024	
Mr Phill **Wells**	Member of ICB Executive Management Team									10/07/2023	22/07/2024	
Mr Phill **Wells**	Member of ICB Community Partnership Forum	The Air Ambulance Service	no	yes	no	direct	Trustee and Chair of Audit and Risk Committee	27/02/2022	current	23/06/2022	22/07/2024	Where decisions to be taken by the ICB contain a potential or perceived conflict, I will recuse myself from the decision making process and a suitable deputy will act in my place
Mr Phill **Wells**	Attend Audit Committee	Labour Party	no	no	yes	direct	Member of the Labour Party		current	22/12/2023	22/07/2024	This declaration and any potential conflicts of interest were fully assessed by the Governance and Risk Team. Appropriate mitigating actions have been put into place and will be adhered to.
Mr Phill **Wells**	Attend other ICB Committees as necessary									06/12/2023	22/07/2024	
Mr Phill **Wells**	Member of ICS System Management Board									06/12/2023	22/07/2024	
Mr Phill **Wells**	Chair of Procurement Oversight Group									10/07/2023	22/07/2024	
Dr Jo **Sauvage**	Chief Medical Officer		yes	yes	yes	direct		01/07/2022	current	10/07/2022	17/06/2024	
Dr Jo **Sauvage**	Member of ICB Board		no	yes	no	direct			current	10/07/2022	17/06/2024	
Dr Jo **Sauvage**	Executive of CMO and Place Directorate	London Clinical Executive Group	no	yes	no	direct	NCL Clinical Representative		current	10/07/2022	17/06/2024	
Dr Jo **Sauvage**	Member of ICS Community Partnership Forum	London Primary Care School Board	no	yes	no	direct	ICS Representative		current	10/07/2022	17/06/2024	
Dr Jo **Sauvage**	Member of Primary Care Committee	London Primary Care Board	no	yes	no	direct	ICS Representative		current	10/07/2022	17/06/2024	
Dr Jo **Sauvage**	Member of Quality and Safety Committee	London Urgent and Emergency Care Board	no	yes	no	direct	NCL Representative		current	10/07/2022	17/06/2024	
Dr Jo **Sauvage**	Member of the Strategy and Development Committee	Greener NHS England, London	no	yes	no	direct	Clinical Director		current	10/07/2022	17/06/2024	
Dr Jo **Sauvage**	Member of ICB Executive Management Team	NCL ICB Sustainability Clinical Network	no	yes	no	direct	Clinical Lead		current	10/07/2022	17/06/2024	
Dr Jo **Sauvage**	Member of the Strategy and Development Committee	National: Membership Expert Advisory Group for Evidence based interventions. Hosted by Academy of Royal Colleges	no	yes	no	direct	Member		current	10/07/2022	17/06/2024	
Dr Jo **Sauvage**	Member of Population Health Improvement Committee	National: Net Zero Clinical Transformation Advisory Board	no	yes	no	direct	Member		current	06/07/2023	17/06/2024	
Dr Jo **Sauvage**	attend sub committees of the Board as and when required	London Sustainability Network	yes	yes	no	direct	Clinical Director		current	06/07/2023	17/06/2024	
Dr Jo **Sauvage**	Also participate in multiple work streams NHS England & Improvement and Health Education England, London Region listed in next column:	City Road Medical Centre	yes	yes	yes	direct	Salaried GP from 1st April 2024 (I am employed as a salaried GP by Islington GP Federation Ltd and work at City Road Medical Centre)	05/11/2018	current	10/07/2022	17/06/2024	excluded from discussions involving City Road Medical Centre

NCL ICB Board of Members Declaration of Interest Register - November 2024

Dr Jo **Sauvage**		NCL ICB Sustainability Clinical Network	yes	yes	no	direct	Clinical Director, interest pertains to clinical leadership at London regional level		current	17/06/2024		
Dr Jo **Sauvage**		Islington GP Federation	no	yes	yes	direct	GP Practice is a member	2016	current	10/07/2022	17/06/2024	
Dr Jo **Sauvage**		South Islington PCN	no	yes	yes	direct	GP Pracitce is a member	01/07/2019	current	01/07/2022	17/06/2024	
Mrs Kay **Boycott**	Non Executive Member, Member of the ICB Board,		yes	yes	yes	Direct		01/07/2022	current	11/07/2022	17/06/2024	
Mrs Kay **Boycott**	Chair of ICB Audit Committee	Eakin Healthcare Group	yes	yes	yes	Direct	Director	01/09/2021	current	11/07/2022	17/06/2024	
Mrs Kay **Boycott**	Member of ICB Finance Committee	London Fire Brigade	yes	yes	yes	Direct	Independent Audit Committee Member	30/10/2020	current	11/07/2022	17/06/2024	
Mrs Kay **Boycott**	Member of ICB Quality and Safety Committee	English Heritage Trust	yes	yes	yes	Direct	Director	01/01/2022	current	11/07/2022	17/06/2024	
Mrs Kay **Boycott**	Member of ICB Strategy and Development Committee	Isle of Wight Youth Trust	no	yes	no	Direct	Chair	12/07/2023	current	12/07/2023	17/06/2024	They are commissioned by the Hampshire and Isle of Wight ICB to provide counselling services, not involved in any NCLICB work
Mrs Kay **Boycott**	Member of ICB Remuneration Committee	UK Research and Innovation, Medical Research Council	yes	yes	no	Direct	Senior Independent Member	31/03/2024	current	27/03/2024	17/06/2024	
Mrs Kay **Boycott**		Diigitalhealth.London	no	yes	no	Direct	Assessor		current	17/06/2024		
Mrs Kay **Boycott**		NHS Innovation Assessor	no	yes	no	Direct	Assessor		current	17/06/2024		
Mrs Kay **Boycott**		Various	yes	yes	yes	Direct	Advisor		current	11/07/2022	17/06/2023	These are infrequent and under NDA - In previous NHS roles I have agreed I would declare if relevant to a specific agenda item
Mrs Kay **Boycott**		PWC	no	no	no	Indirect	Husband is a partner	06/07/2023	current	06/07/2023	17/06/2024	
Ms Liz **Sayce OBE**	Non Executive Member, Vice Chair and member of the ICB Board							01/07/2022	current	26/08/2022	16/10/2024	
Ms Liz **Sayce OBE**	Chair of ICB Remuneration Committee										16/10/2024	
Ms Liz **Sayce OBE**	Chair of ICB Quality and Safety Committee	Action on Disability and Development International	no	yes		direct	Trustee	26/01/2021	current	26/08/2022	16/10/2024	
Ms Liz **Sayce OBE**	Member of ICB Primary Care Committee	London School of Economics	yes	yes		direct	Visiting Professor in Practice		current	26/08/2022	16/10/2024	
Ms Liz **Sayce OBE**	Chair NCL People Board	Royal Society of Arts	no	no	yes	direct	Fellow		current	26/08/2022	16/10/2024	
Ms Liz **Sayce OBE**	Member of ICS Community Partnership Committee	Government commissioned independent review of Carer's Allowance overpayments	yes	no	no	direct	Chair	01/11/2024	30/04/2025	16/10/2024		
Ms Liz **Sayce OBE**		Furzedown Project, Wandsworth, Charity no 1076087	no			direct	Trustee	24/11/2022	current	24/11/2022	16/10/2024	
Ms Liz **Sayce OBE**		Consultancy roles	no	no	no	indirect	My partner offers consultancy across the UK to mental health services, sometimes working with NHS Trusts, local authorities or voluntary sector organisations		current	26/08/2022	16/10/2024	
Professor Ibrahim Ibrahim **Abubakar**	Non Executive Member, Member of the ICB Board									23/11/2023	02/07/2024	
Professor Ibrahim Ibrahim **Abubakar**	Chair of ICB Population Health Committee	University College London	yes	yes	no	direct	Pro-Provost (Health)	2023	current	23/11/2023	02/07/2024	
Professor Ibrahim Ibrahim **Abubakar**		Faculty of Population Health Sciences, UCL Professor of Infectious Disease Epidemiology.	yes	yes	no	direct	Dean	2016	current	23/11/2023	02/07/2024	
Professor Ibrahim Ibrahim **Abubakar**		UCL Partners	no	yes	no	direct	director	Dec-23	current	02/07/2024		
Professor Ibrahim Ibrahim **Abubakar**		UCL Health Committee	no	yes	no	direct	Committee member	2023	current	02/07/2024		
Professor Ibrahim Ibrahim **Abubakar**		Great Ormond Street Hospital Biomedical Research Centre Strategy Board	no	yes	no	direct	Co Chair	2023	current	02/07/2024		
Professor Ibrahim Ibrahim **Abubakar**		UK Safety Agency, Medical Directorate	no	yes	no	direct	Hon Consultant	2016	current	02/07/2024		
Professor Ibrahim Ibrahim **Abubakar**		Royal Free Hospital, Respiratory Medicine	no	yes	no	direct	Hon Consultant	2012	current	02/07/2024		
Professor Ibrahim Ibrahim **Abubakar**		Fotude Ltd, Company number 13479358	yes	yes	yes	direct	Director	Jun-21	current	23/11/2023	02/07/2024	Fotude does no business with the NHS and is a global health entity but registered in the UK
Professor Ibrahim Ibrahim **Abubakar**		National Institute for Health and Care Research	yes	yes	no	direct	Senior Investigotor	2017	current	23/11/2023	02/07/2024	
Professor Ibrahim Ibrahim **Abubakar**		Global Preparedness Monitoring Board.	no	yes	no	direct	Member	2022	current	23/11/2023	02/07/2024	
Professor Ibrahim Ibrahim **Abubakar**		Research Projects- various	yes	yes	no	direct	Led, co-led a range of research projects and thei	2019	current	23/11/2023	02/07/2024	
Professor Ibrahim Ibrahim **Abubakar**		Employment by Mount Vernon Cancer Centre	no	no	no	indirect	Partner	2018	current	23/11/2023	02/07/2024	
Professor Ibrahim Ibrahim **Abubakar**		NTM Network UK (new charity for Non Tuberculous Mycobacteria)	no	yes	no	direct	Trustee	Dec-23	2025	23/11/2023	02/07/2024	
Dr Christine **Caldwell**	Chief Nursing Officer	Middlesex University	no	yes	no	Direct	visiting honorary Professor	30/03/2023	current	30/03/2023	08/08/20204	
Dr Christine **Caldwell**	Member of ICB Board	Barnet Enfield Haringey MHT	no	no	no	indirect	daughter is an employee	01/01/2023	current	06/07/2023	08/08/2024	
Dr Christine **Caldwell**	Member of Executive Management Team											
Dr Christine **Caldwell**	Member of Quality and Safety Committee											
Dr Christine **Caldwell**	Member of Strategy and Development Committee											
Dr Christine **Caldwell**	Member of Primary Care Committee											
Mr Mark **Lam**	Standing Participant of the ICB Board		no	yes	no	Direct	Member	01/03/2023	current	12/04/2023	26/06/2024	
Mr Mark **Lam**		Royal Free Hospitals	yes	yes	no	Direct	Chair	01/04/2021	current	12/04/2023	26/06/2024	
Mr Mark **Lam**		North Middlesex University Hospital	yes	yes	no	Direct	Chair	01/10/2021	current	12/04/2023	26/06/2024	
Mr Mark **Lam**		UCL Partners	yes	yes	no	Direct	Director	12/04/2021	current	12/04/2023	26/06/2024	
Mr Mark **Lam**		JT Global (Channel Islands) Ltd	yes	yes	no	Direct	Non Executive Director	01/04/2023	current	12/04/2023	26/06/2024	
Mr Mark **Lam**		Games Workshop Group PLC	yes	yes	no	Direct	Chair (from 01/11/2024)	12/04/2023	current	12/04/2023	10/10/2024	
Mr Mark **Lam**		Lowland Investment Company PLC	yes	no	yes	Direct	Non Executive Director	17/12/2023	current	11/01/2024	26/06/2024	
Dr Usman **Khan**	Board Member ICB		no	yes	no	Direct	Member		current	07/09/2022	08/07/2024	

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Dr Usman **Khan**	Chair of ICB Primary Care Committee	ModusEurope	yes	yes	yes	Direct	director	29/11/2012	current	07/09/2022	08/07/2024
Dr Usman **Khan**	Chair of ICB Finance Committee	Motor Neurone Disease (Sales) Ltd	no	yes	yes	Direct	director	27/06/2022	current	07/09/2022	08/07/2024
Dr Usman **Khan**	Member of ICB Audit Committee	London Metropolitan University	yes	yes	yes	Direct	Vice Chair of Governors and Chair of Finance & Audit Committee	01/08/2022	current	07/09/2022	08/07/2024
Dr Usman **Khan**	Member of ICB Remuneration Committee	Motor Neurone Disease Association	no	yes	yes	Direct	Chair of Trustees / director	01/07/2021	current	07/09/2022	18/07/2023
Dr Usman **Khan**		KU Leuven University, Belgium	yes	yes	yes	Direct	Visiting Professor in Health Management and Policy		current	07/09/2022	08/07/2024
Dr Usman **Khan**		South East Coast Ambulance Service	yes	no	no	Direct	Chair	15/04/2024	31/05/2027	16/04/2024	08/07/2024
Dr Usman **Khan**		New York University (London)	yes	no	no	Direct	Global Lecturer		current	20/03/2024	
Dr Usman **Khan**		Bevan Commission	no	no	yes	Direct	member		current	20/03/2024	08/07/2024
Dr Usman **Khan**		European Health Forum Gastein	no	no	yes	Direct	Advisory Committee member		current	20/03/2024	08/07/2024
Dr Usman **Khan**		Health Shared (Axiom Medical Ltd)	no	no	no	Direct	ad hoc advice pro bono	01/03/2024	current	16/04/2024	08/07/2024
Baroness Julia **Neuberger DBE**	Partner Member of the Board ICB			yes	yes	direct	Member	01/07/20222	current	07/07/2022	13/06/2024
Baroness Julia **Neuberger DBE**	Member of ICB Strategy and Development Committee	UCLH	yes	yes	yes	direct	Chair	25/02/2019	current	07/07/2022	13/06/2024
Baroness Julia **Neuberger DBE**		Whittington Health Trust	yes	yes	yes	direct	Chair	01/04/2020	current	07/07/2022	13/06/2024
Baroness Julia **Neuberger DBE**		Walter and Liesel Schwab Charitable Trust	no	yes	no	direct	Trustee	06/12/2001	current	07/07/2022	13/06/2024
Baroness Julia **Neuberger DBE**		Rayne Foundation	no	yes	no	direct	Trustee	09/09/2018	current	07/07/2022	13/06/2024
Baroness Julia **Neuberger DBE**		Independent Age	no	yes	no	direct	Trustee	09/10/2019	current	07/07/2022	13/06/2024
Baroness Julia **Neuberger DBE**		The Lyons Learning Trust	no	yes	no	direct	Trustee	13/04/2016	current	07/07/2022	13/06/2024
Baroness Julia **Neuberger DBE**		Leo Baeck Institute	no	yes	no	direct	Trustee	15/07/2020	current	07/07/2022	13/06/2024
Baroness Julia **Neuberger DBE**		Yad Hanadiv Charitable Foundation	no	yes	no	direct	Trustee	2021	current	07/07/2022	13/06/2024
Baroness Julia **Neuberger DBE**		UK Commission on Bereavement	no	yes	no	direct	Member / Bereavement Commissioner	2021	current	07/07/2022	13/06/2024
Baroness Julia **Neuberger DBE**		House of Lords	yes	yes	no	direct	Independent Cross Bench Peer	2011	current	07/07/2022	13/06/2024
Baroness Julia **Neuberger DBE**		West London Synagogue	no	yes	no	direct	Rabbi Emirata	01/03/2020	current	07/07/2022	13/06/2024
Baroness Julia **Neuberger DBE**		Public Voice Representative	no	no	no	direct	Public Voice Representative	01/11/2022	current	16/07/2023	13/06/2024
Mr David **Probert**	Member of ICB Finance Committee		no	yes	no	Direct	Member		current	21/06/2023	21/05/2024
Mr David **Probert** (represents Julia Neuberger in her absence)		UCLH	yes	yes	yes	direct	Chief Executive	31/08/2021	current	21/06/2023	21/05/2024
Mr David **Probert** (represents Julia Neuberger in her absence)		UCL Global Business School for Health	no	yes	yes	direct	Honorary professor	22/12/2022	current	21/06/2023	21/05/2024
Mr David **Probert** (represents Julia Neuberger in her absence)		UCL Partners	no	yes	yes	direct	Board Member	31/10/2017	current	21/06/2023	21/05/2024
Mr David **Probert** (represents Julia Neuberger in her absence)		St Dunstan's College	no	yes	no	direct	School governor	09/12/2022	current	21/06/2023	21/05/2024
Mr David **Probert** (represents Julia Neuberger in her absence)		Audio Books for Dad (Bedside Books 1195094)	no	yes	no	direct	Trustee	07/08/2021	current	21/06/2023	21/05/2024
Mr David **Probert** (represents Julia Neuberger in her absence)		Homerton NHSFT	no	yes	no	indirect	spouse is Chief Nurse and Director of Clinical Governance	01/12/2021	current	21/06/2023	21/05/2024
Ms Harjinder **Kandola MBE**	Partner Member of the Board ICB							01/07/2022	current	21/07/2022	11/06/2024
Ms Harjinder **Kandola MBE**		Barnet Enfield Haringey Mental Health Trust	yes	yes	yes	direct	Chief Executive	16/07/2018	current	21/07/2022	11/06/2024
Ms Harjinder **Kandola MBE**		Camden and Islington Foundation Trust	yes	yes	yes	direct	Chief Executive	01/10/2021	current	21/07/2022	11/06/2024
Ms Harjinder **Kandola MBE**		UCL Partners Ltd	no	yes	no	direct	Director	27/01/2023	current	11/06/2024	
Mr Ian **Porter**	Executive Director of Corporate Affairs	no interests declared	No	No	No	No		01/11/2016	current	01/07/2022	10/06/2024
Mr Ian **Porter**	Board Attendee ICB										
Mr Ian **Porter**	Audit Committee, attendee										
Mr Ian **Porter**	Procurement Oversight Group, voting member										
Mr Ian **Porter**	Remuneration Committee, attendee										
Mr Ian **Porter**	Member of ICB Executive Management Team										
Mr Ian **Porter**	System Management Board, attendee										
Mr Ian **Porter**	Member of NCL Community Partnership Forum										
Mr Ian **Porter**	Other working groups as required										
Dr Jonathan **Levy**	Partner Member of the ICB Board		yes	yes	no	Direct		01/07/2022	current	04/07/2022	21/09/2024

NCL ICB Board of Members Declaration of Interest Register - November 2024

Dr Jonathan **Levy**	Member of ICB Quality and Safety Committee Chair of ICB Integrated Medicines Optimisation Committee	James Wigg, Queens Crescent GP Practices	Yes	Yes	No	Direct	GP Partner	01/11/2015	current	10/09/2019	21/09/2024	
Dr Jonathan **Levy**		JS Medical GP Practice	Yes	Yes	No	Direct	GP Partner	01/10/2024	current	21/09/2024		
Dr Jonathan **Levy**		Enterprise Medic Limited	Yes	Yes	No	Direct	Consultancy services to James Wigg and Queens Crescent Practice. Sole Director and sole shareholder	01/09/2015	current	10/09/2019	21/09/2024	
Dr Jonathan **Levy**		South Kentish Town Primary Care Network	Yes	Yes	No	Direct	Practice is a member of PCN	06/07/2020	current	06/07/2020	21/09/2024	
Dr Jonathan **Levy**		South Kentish Town PCN Ltd (Company number 12723647)	Yes	Yes	No	Direct	Practices are members of the PCN and I am the Clinical Director	06/07/2020	current	06/07/2020	21/09/2024	
Dr Jonathan **Levy**		Enterprise Textiles (Properties) Ltd (00995733)	Yes	Yes	No	Direct	Director and Shareholder	10/01/2024	current	01/03/2024	21/09/2024	This company does not contract with NCLICB / any part of the NHS
Dr Jonathan **Levy**		Camden Health Partners (06584530)	Yes	Yes	No	Direct	Shareholder in GP Federation	01/09/2015	current	10/09/2019	21/09/2024	
Dr Jonathan **Levy**		James Wigg Practice Ltd	Yes	Yes	No	Direct	Director and Shareholder	01/09/2015	current	13/06/2024	21/09/2024	THE company has never traded and has been dormant since its creation
Dr Jonathan **Levy**		N15 PCN	Yes	Yes	No	Direct	JS Medical Practice is a member of PCN	01/10/2024	current	21/09/2024		
Dr Simon **Caplan**	Partner Member of the ICB Board		yes yes	yes	no	Direct		01/07/2022	current	04/07/2022	10/06/2024	
Dr Simon **Caplan**	Member of ICB Audit Committee	Fernlea Surgery	yes yes	yes	yes	Direct	Partner	1990	current	26/01/2021	10/06/2024	
Dr Simon **Caplan**	Member of ICB Strategy and Development Committee	NCL GP Providers Alliance	no	yes	yes	Direct	Board Member (Haringey rep)	01/05/2022	current	04/07/2022	10/06/2024	
Dr Simon **Caplan**	Chair of Medicines Clinical Reference Group	Jewish Care (National charity)	no	yes	yes	Direct	Member of Clinical Governance Committee	2010	current	26/01/2021	10/06/2024	
Dr Simon **Caplan**		Federated4Health	no	yes	yes	Direct	Practice is a member	2016	current	26/01/2021	10/06/2024	
Dr Simon **Caplan**		Welbourne PCN	no	yes	yes	Direct	Practice is a member	01/06/2020	current	26/01/2021	10/06/2024	
Dr Simon **Caplan**		NHSE & I (London region) Medical Directorate	yes	yes	yes	Direct	Senior Clinical Advisor NHSE & I	01/04/2020	current	26/01/2021	10/06/2024	
Dr Alpesh **Patel**	Board Member Attendee and Chair of GPPA	White Lodge Medical Practice	Yes	Yes	No	direct	GP Partner	1998	current	27/01/2016	04/10/2024	
Dr Alpesh **Patel**	Member of ICB People Board	General Practice Providers Alliance (GPPA)	Yes	Yes	No	direct	Chair	2022	current	11/07/2023	04/10/2024	
Dr Alpesh **Patel**		Gemini Health	Yes	Yes	No	indirect	Director	Aug-17	current	27/01/2016	04/10/2024	
Dr Alpesh **Patel**		Enfield Healthcare Cooperative	Yes	Yes	No	indirect	Co Chair and Executive Director	Sep-17	current	27/01/2016	04/10/2024	
Dr Alpesh **Patel**		Enfield One Ltd	Yes	Yes	No	indirect	Director			27/01/2016	04/10/2024	
Dr Alpesh **Patel**		White Lodge Medical Practice Ltd	Yes	Yes	No	indirect	Director	2009	current	27/01/2016	04/10/2024	
Dr Alpesh **Patel**		Enfield Health Partnership Limited, Provider of community gynaecology service	Yes	Yes	No	indirect	Shareholder 5%	Mar-13	current	27/01/2016	04/10/2024	
Dr Alpesh **Patel**		Enfield Healthcare Alliance	Yes	Yes	No	indirect	Shareholder less than 5% (as White Lodge	2015	currernt	27/01/2016	04/10/2024	
Dr Alpesh **Patel**		BEH MHT	No	Yes	No	indirect	spouse is a Pyschiatrist at Trust	27/01/2016	currrent	27/01/2016	04/10/2024	
Dr Alpesh **Patel**		Evergreen Surgery	Yes	Yes	Yes	direct	Director	2007	current	27/01/2016	04/10/2024	
Dr Alpesh **Patel**		NCL training Hub	Yes	Yes	Yes	direct	Clinical Lead	01/04/2022	current	12/12/2022	04/10/2024	
Dr Alpesh **Patel**		NHSE	Yes	Yes	Yes	direct	GP Appraiser	2016	current	12/12/2022	04/10/2024	
Dr Alpesh **Patel**		Enfield Borough Partnership Convenor	Yes	Yes	Yes	direct	Convenor	01/05/2023	current	11/07/2023	04/10/2024	
Dr Alpesh **Patel**		Enfield Health Partnership Limited (Federation)	Yes	Yes	Yes	direct	co-chair	mid 2020	current	12/12/2022	04/10/2024	
Dr Alpesh **Patel**		Enfield Care Network	Yes	Yes	Yes	direct	Practice is a member of PCN	01/07/2019	current	08/05/2020	04/10/2024	
Dr Alpesh **Patel**		P3 Partners Ltd (10145052)	Yes	Yes	Yes	direct	director	25/04/2016	current	09/05/2024		this entity does not currently contract directly with the NHS.
Dr Alpesh **Patel**		Northiam Associates Ltd (10099504)	Yes	Yes	Yes	direct	director	04/04/2016	current	09/05/2024		this entity does not currently contract directly with the NHS.
Mr Richard **Dale**	Executive Director of Transtion and Performance	No interests declared	No	No	No	No		03/07/2018	current	04/09/2019	05/08/2024	
Mr Richard **Dale**	Member of Executive Management Team											
Mr Richard **Dale**	ICB Board of Members, attendee											
Mr Richard **Dale**	Finance Committee, attendee											
Mr Richard **Dale**	Audit Committee, attendee											
Mr Richard **Dale**	Strategy and Development Committee, attendee											
Mr Richard **Dale**	Quality and Safety Committee, member											
Mr Richard **Dale**	ICS Digital Board member											
Mr Richard **Dale**	System Management Board, member											
Mr Richard **Dale**	ICS Community Partnership Forum, member											
Sarah **Mansuralli**	Chief of Strategy and Population Health	No interests declared	No	No	No	No		07/11/2018	current	07/11/2019	10/06/2024	
Sarah **Mansuralli**	Member of Executive Management Team											
Sarah **Mansuralli**	Attend ICB Board of Members											
Sarah **Mansuralli**	Exec Lead for Strategy and Development Committee											
Sarah **Mansuralli**	Attend Finance Committee											
Sarah **Mansuralli**	Attend Procurement Oversight Group											
Sarah **Mansuralli**	Attend other committees as required											
Sarah **McDonnell-Davies**	Executive Director of Place	No interests declared	no	no	no	no		20/06/2018	current	20/06/2018	10/06/2024	
Sarah **McDonnell-Davies**	Member of Executive Management Team											
Sarah **McDonnell-Davies**	Attend ICB Board of Members											
Sarah **McDonnell-Davies**	Attend Strategy and Development Committee											
Sarah **McDonnell-Davies**	Exec Lead for Primary Care Committee											
Sarah **McDonnell-Davies**	Exec Lead for Integrated Medicines Optimisation Commmittee											
Sarah **McDonnell-Davies**	Member of ICS Digital Board											
Sarah **McDonnell-Davies**	Member of System Management Board											
Sarah **McDonnell-Davies**	attend other NCL / Borough related meetings as required											
Sarah **Morgan**	Chief People Officer Member of the Executive Member Team		yes	yes	no	Direct	01/07/2022	04/07/2022	current	04/07/2022	16/06/2024	
Sarah **Morgan**	Member of ICB People Board											
Sarah **Morgan**	Voting member Primary Care Committee											

Sarah **Morgan**	Member of the Strategic Development and Population Health Committee											
Sarah **Morgan**	Chair of People and Culture Oversight Group											
Sarah **Morgan**	Attend Remuneration Committee											
Sarah **Morgan**		Good Governance Institute	no	no	yes	Direct	Faculty member	01/12/2020	current	04/07/2022	16/06/2024	
Sarah **Morgan**		Fresh Visions People Ltd Charity no 1091627	no	no	yes	Direct	Trustee / Director and Chair from 6 December 2023	22/04/2022	current	04/07/2022	16/06/2024	Ensure that any contractual arrangements that may involve Fresh Visions or the parent organisation Southern Housing are declared as a conflict of interest as operate out of London
Sarah **Morgan**		Kaleidoscope Health and Care (not for profit Social Enterprise)	no	yes	no	Direct	Member of a professional network of health and care professionals including alumni of the NHS general management graduate scheme	2016	current	13/12/2023	16/06/2024	Manage any contractual arrangements through procurement team
Sarah **Morgan**		University of Birmingham, School of Social Policy, Health Services Management Centre	no	no	yes	Direct	Honorary Associate Professor	01/10/2023	current	13/12/2023	16/06/2024	manage contributions in line with ICB guidance
Sarah **Morgan**		Southern Housing Group	no	yes	no	Direct	Independent Member	01/06/2024	current	16/06/2024		Manage any contractual arrangements through procurement team

North Central London
Integrated Care Board

Draft Minutes
Meeting of NHS North Central London ICB Board of Members
23 July 2024 between 2pm and 4pm
Clerkenwell Room

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

* Standing Participant

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	Mike Cooke welcomed attendees to the meeting. Apologies had been received from Chris Caldwell, Dr Jonathan Levy, Sarah McDonnell-Davies, Baroness Julia Neuberger, Dr Alpesh Patel and Ian Porter. David Probert was attending on behalf of Baroness Neuberger.
1.2	**Declarations of Interest relating to the items on the Agenda**
1.2.1	Mike Cooke invited Members to declare any interests relating to items on the agenda. There were no additional declarations.
1.2.2	The Board of Members: • **NOTED** the requirement to declare any interests relating to the agenda; • **NOTED** the Declaration of Interests Register and the requirement to inspect their entry and advise the Board Secretary of any changes; • **NOTED** the requirement to record any relevant gifts and hospitality on the ICB Gifts and Hospitality Register.
1.3	**Minutes of the NCL ICB Board of Members Meeting on 7 May 2024**
1.3.1	It was highlighted that the Long Term Workforce Plan should be described in the seventh bullet point of paragraph 2.3.2 as NHS-centric and the NCL People Strategy should be referred to as a 'one workforce' approach, rather than vice-versa.
1.3.2	The Board of Members **APPROVED** the minutes as an accurate record, subject to the above amendment.
1.4	**Matters Arising**
1.4.1	The Board of Members **NOTED** the Action Log.
1.5	**Report from the Chief Executive Officer**
1.5.1	Phill Wells provided an overview of the report, which had been written while he was still Acting Chief Executive Officer. He began by welcoming Frances O'Callaghan back to the ICB after her career break and thanked the Executive Management Team for their support while he was covering Frances, in particular Sarah Mansuralli, who was Deputy Chief Executive Officer during the period and Bimal Patel, who took on the role of Interim Chief Finance Officer. He also thanked the wider ICB for its outstanding work over the eight months in question. He then highlighted the following points: • Urgent Emergency Care (UEC) continues to be an operational pressure in NCL. There has been a strong focus on supporting NMUH through internal flow actions and there are now signs of improvement, particularly with regards to ambulance handover delays and Emergency Department waits. There has been tremendous support from across the system, although there is still more which needs to be done, especially around Category 2 response times. NCL performance in this area is the worst in London and this needs to be addressed • The NCL system experienced significant disruption as a result of the global IT outage on 19 July. The internal response to support secondary care and primary care was outstanding • The Month 3 outturn figures show a marginal deterioration in the adverse variance. The ICB will work closely with providers on what is driving this and remains committed to keeping as close to the financial plan as possible before recovering the position later in the year • Good progress has been made on the processes in train within the system on organisational alignments. The Royal Free and NMUH Boards have both approved the business case for the merger of the two Trusts and it is hoped that this will take place in early 2025. The planned merger of BEHMHT and Camden and Islington NHS Foundation Trust is also well advanced • Highgate East, a brand new purpose-built 78 bed mental health facility, has now been opened

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

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

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

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

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

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

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

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

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

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

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

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

North Central London
Integrated Care Board

Draft Minutes
Annual General Meeting of NHS North Central London ICB
19 September 2024 between 9.15am and 9.50m
MS Teams Live

Present:	
Liz Sayce	Deputy Chair, NCL Integrated Care Board
Frances O'Callaghan	Chief Executive Officer
Kay Boycott	Non-Executive Member
Dr Chris Caldwell	Chief Nursing Officer
Dr Simon Caplan	GP - Provider of Primary Medical Services
Richard Dale*	Executive Director of Performance and Transformation
Mark Lam	Chair, Royal Free Hospitals and NMUH
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Sarah McDonnell-Davies*	Executive Director of Place
Sarah Morgan	Chief People Officer
Ian Porter*	Executive Director of Corporate Affairs
Dr Jo Sauvage	Chief Medical Officer
Phill Wells	Chief Finance Officer
Minutes:	
Steve Beeho	Senior Board Secretary
Apologies:	
Victoria Lawson	Chief Executive, Islington Council
Jinjer Kandola	Chief Executive Officer, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust
Usman Khan	Non-Executive Member
Sarah Mansuralli	Chief Strategy and Population Health Officer
Dr Alpesh Patel	Acting Chair, GP Provider Alliance
David Probert	Chief Executive, UCLH NHS Foundation Trust

1.	**INTRODUCTION**
1.1	**Welcome and Apologies**
1.1.1	Liz Sayce welcomed attendees to the Annual General Meeting (AGM) of North Central London ICB. Apologies had been received from David Probert, Victoria Lawson, Alpesh Patel, Jinjer Kandola and Sarah Mansuralli.
1.2	**Summary of the Year and Key Achievements**
1.2.1	Frances O'Callaghan reflected on the highlights of the work of the ICB over 2023/24: • The primary objective of the ICB and the system as a whole is to improve the health and wellbeing of its communities. The team has delivered a vast range of activities over 2023/24 in partnership with its NHS, local authority, primary care, community, non-statutory and voluntary sector partners, as well as patients and residents, although there is still more to be done to improve partnership arrangements.

* Standing Participant

Population Health

- Population Health is central to the work of the ICB. There are numerous NHS organisations with responsibility for delivering care and the ICB's focus is on healthy lifespans and improving life expectancy, recognising that there is currently a 20-year variance in healthy life expectancy between the most and least affluent areas in NCL
- This year the ICB launched its Mission, Delivery Plan and the NCL Outcomes Framework which make the ICB's objectives very clear while also enabling it to monitor progress against its target outcomes, identify opportunities to improve and reduce variation.

Start Well

- The ICB has defined three key population health delivery commitments for local residents: Start Well, Live Well and Age Well. Significant work has been taking place on the Start Well programme, working with clinicians, patients and service providers to ensure that the future delivery of maternity services is sustainable, of the highest possible quality, and accessible to all
- A public consultation was conducted between December 2023 and March 2024 which focussed on proposed changes to maternity, neonatal and children's surgery. The ICB is pleased with the extensive and thoughtful feedback received and is grateful to everyone who gave their time and input.
- These kind of decisions are not easy but there is a general recognition that maintaining the status quo is not in residents' best interests and the ICB therefore has a responsibility to rise to this challenge
- As part of the next steps the ICB will be looking at the feedback in full, finalising the clinical model and ensuring that it is supported by clinicians, before developing a more detailed business case by the end of 2024 or early 2025.

System pressures

- The impact of industrial action has continued to be a major concern across the system. The news that the BMA has accepted the government's pay offer is therefore particularly welcome. However, many GPs across the country have started to take what is called collective action, which may reduce some services offered at GP practices in NCL. Practices remain open and the ICB is working with primary care colleagues to agree contingency plans and public messaging.

Tackling waiting times

- Waiting times within the Integrated Care System (ICS) remain challenging, including emergency and elective care. NCL is delivering record amounts of care for patients, but the number waiting for treatment has also continued to increase. Despite this, the numbers of patients waiting the longest (78 weeks) has been reduced to 152 in June 2024. The ICB recognises that it is unacceptable for anybody to be waiting for this length of time and it is actively reviewing how services can be offered to patients to minimise the waiting period.
- There is a national focus on patients waiting for more than 65+ weeks for treatment and the number waiting in NCL has reduced over 2023/24
- The system is continuing to deliver more elective activity than in the previous year and progress is being made in terms of access to services
- Cancer performance also remains challenging, with too many people waiting more than 62 days for their first definitive treatment after an urgent GP referral. The ICB is working hard with providers around early diagnostics and access to services to ensure that patients are treated in a timely way. NCL continues to have among the highest one and five year cancer survival rates in the country but there is still more to do.

Primary care

- General practices in NCL now offer 50,000 more appointments a month than before the pandemic and nearly two-thirds of these are face to face, which is a return to the pre-pandemic level.

- NCL general practices consistently met the national expectation for 90% of appointments to be booked within two weeks, as well as outperforming the national average for the percentage of patients receiving a same day appointment in 2023/24.
- Waiting lists at local community providers have decreased by over 6,600 in the year to March 2024. The new eye surgery hub at Edgware Community Hospital enables 3,000 more procedures a year and improvements in the UCLH discharge pathway have reduced the number of beds occupied by patients who do not need to be in an acute hospital, meaning that more patients are being treated in the right environment
- The Welbourne Health Centre in Tottenham Hale opened to patients in July, offering new, purpose-built facilities to 25,000 local residents and space to train new GPs and nurses.
- The ICB has ensured that 5% of its capital budget is ring-fenced for primary care. This is the beginning of NCL rebalancing its commitment between hospitals and primary care, in line with the recent Darzi Report.
- Two new primary care projects have been delivered every year since 2021, including the Welbourne Health Centre in Tottenham, Muhammed Akunjee Health Centre in Haringey and Belsize Priory in Camden. The ICB has also prioritised smaller investment and this year progressed digitisation and conversion of patient record space across 25 practices. This has freed up space for clinical and digital consulting rooms, providing opportunity for 370,000 additional appointments a year.

Mental health

- Pressure on mental health services has grown exponentially since the pandemic and it is recognised that the way people access services often does not accord with their needs. To address this, the 'NHS 111 press 2' offer has been introduced, which allows people to move directly to a mental health support conversation, rather than having to navigate other processes. This new single point of access to clinical support is available 24 hours a day.
- The Section136 (S136) hub was launched November 2023 to support the Right Care, Right Place initiative as part of the NHS's relationship with the Metropolitan Police. The hub is intended to ensure that people with mental health problems are dealt with by an appropriate clinical professional. From November 2023 to May 2024, 64% of S136s were applied by the police before accessing the hub, so there is more work to be done to ensure that the police seek advice from the hub earlier.
- There has been enormous progress in reducing the number of patients requiring adult acute mental health inpatient care being inappropriately placed out of their home area. This can be distressing for patients and families alike.
- There have been some significant changes in the system in mental health. The merging of the two local trusts into the North London Mental Health Partnership represents a significant opportunity to ensure consistency of access to care and improve services for users. The formal opening in July of the Highgate East Mental Health hospital was a major milestone in terms of providing appropriate facilities within an outstanding environment and recognising parity of esteem in terms of care provision. This is seen as the blueprint for how mental health care should be delivered.

Pharmacy

- The role of pharmacy has developed significantly since the pandemic. Through the national Pharmacy First initiative, virtually all NCL pharmacies can now treat people for seven common conditions, to relieve pressure on GPs. NCL Pharmacies took 30,000 consultations in first six months of the initiative. Under 3% of these resulted in people being referred to GPs, showing how effective this can be.
- To complement the expansion of Community Pharmacy, NCL Is implementing a new locally commissioned Self-Care Medicines Scheme in all five Boroughs. This provides free over-the-counter medicines to patients who meet key criteria. To date 103 pharmacies have registered to take part in the scheme.

Vaccinations

- The ICB has been working with partners to mitigate the risk of a significant outbreak of Measles. 85% of children have now received at least one dose of the MMR

	vaccination. A key factor in this is the MMR vaccination bus, a partnership between UCLH, Camden Council, NCL ICB, Middlesex University, voluntary organisations and vaccination delivery sites, which was shortlisted in 2024 Nursing Times Awards. • Building on the learning from the pandemic, work has been taking place to address vaccine equity to improve uptake among different communities • The importance of vaccinating care home residents was also highlighted during the pandemic. Over 75% of local care home residents have been vaccinated against Covid-19, compared with the England average of 66%. **Setting up for success** • Looking ahead, it is important to recognise that the ICB has been through significant changes as an organisation and as a system. Although it may feel as if it has been in operation much longer, 2023/24 was the ICB's first full financial year. This has been a challenging time for the NHS, during which the ICB was formally required by the Secretary of State to reduce its running costs by 30% while still establishing a new organisation. It is important to commend the professionalism and dedication of the staff who participated in the Organisation Change Programme during this difficult period. • Although the process was challenging, it enabled the organisation to refocus on its core purpose through the Population Health and Integrated Care Strategy to provide communities with better care, better support and more joined-up and sustainable healthcare services. It was also important for the ICB to ensure in a transparent way that its structures and processes are fit for purpose. The ICB has successfully met the Running Cost Allowance reduction set by NHS England as part of this process. • This work has been comprehensive, complex and difficult for colleagues, as it has created significant uncertainty • As part of the Organisational Change Programme, the ICB was pleased to be able to offer staff the option of voluntary redundancy following approval from NHS England. This scheme enabled the ICB to minimise compulsory redundancy as far as possible and give affected staff a choice about their futures. • The ICB is confident that the team it is building, as well as the new structure, and the expertise among staff, will put it on a firm foundation going forward, and it is grateful to everybody for their continued hard work. **New Government, New emphasis?** • On 8 July, the ICB was pleased to welcome the new Secretary of State for Health and Social Care, Wes Streeting MP, when he visited Abbey Medical Centre in Camden on one of his first days in office. He spoke with staff and patients, and was accompanied by NHS England Chief Executive Amanda Pritchard and Phill Wells, the ICB Chief Finance Officer • The change of Government has offered a change of tone regarding the importance of what the NHS is here to do but it is clear that there are challenges ahead with in terms of the financial envelope and around any expectations of change being met within the existing financial envelope. It is important to be realistic about the challenges which this might pose while also being optimistic about the commitment to the NHS. • The recent Darzi report is expected to be the precursor to the Government's 10-year plan and there is good reason to be optimistic about this. It will mean a comprehensive change in the way that the NHS relates to its communities and how it tackles ill-health and its root causes in partnership with communities and the wider system • The ICB is committed to ensuring that more care is delivered outside hospitals, that it is preventing illness and poor health and where possible, making greater use of digital solutions to support communities in terms of rapid access, alongside face to face care.
1.3	**Annual Accounts 2023/24**
1.3.1	Phill Wells provided an overview of the 2023/24 accounting year: • The ICB has three key financial duties in respect of revenue expenditure: o To spend within its total allocation (£3.69 billion for 2023/24)

	○ To deliver its financial plan as part of a system (a surplus of £10.6m for 2023/24) ○ To spend within its Running Cost Allowance The ICB met all three of these duties for 2023/24. • 2023/24 represented the second of two years where the operating plan guidance indicated that achieving financial balance for the ICB and the system in both years would result in the historic debts of the five legacy CCGS being written off. NCL is one of only 11 systems in England to have achieved this objective. This tremendous achievement leaves NCL with considerably more revenue expenditure for future years than it would otherwise have had • In order to put the ICB's expenditure into perspective, the size of the gap between the ICB's financial plan and its actual outturn represents half an hour's worth of expenditure in NCL • Half of the ICB's financial allocation is spent on acute and integrated care services, including urgent and emergency care services and maternity and elective care • Approximately £0.5 billion is spent on mental health services for children and adults, two-thirds of which is spent directly with Barnet, Enfield and Haringey Mental Health Trust and Camden and Islington NHS Foundation Trust. It is also important to note that NCL met the Mental Health Investment Standard in 2023/24. This ensures that the growth in mental health spending exceeds the growth in acute expenditure • Just over one-third of the ICB's allocation is spent on other services , including primary care and the Better Care Fund. As previously mentioned, during 2023/24 the ICB continued with its commitment to primary care providers in terms of capital allocation and the ICB has re-committed to this for 2024/25. • The ICB also met its 2023/24 capital requirement to live within its budget • In 2023/24 the ICB took responsibility for commissioning Dental, Ophthalmic and Pharmacy services. This is the first time that NHS England has delegated this responsibility to the ICB, which represented almost £160m expenditure in NCL in 2023/24 • Looking forward to 2024/25, the ICB has set another surplus financial plan (£14.6m) as part of the balanced financial plan for the NCL system. This has been achieved by relatively few ICBs and ICSs across England and the ICB is determined to maintain its commitment to financial sustainability • There is a material non-recurrent element within the ICB's financial plan, which indicates that it has not yet met its long-term objective of financial sustainability. It will continue to focus on this by identifying recurrent efficiencies and then working hard to deliver them. The Cost Improvement Plan for 2024/25 is £26.2m. Achieving this will be difficult but the ICB is confident that it can do so. • The general financial framework that NHS England operates in has continued into 2024/25. Alongside this, in anticipation of the Comprehensive Spending Review that the Government will run in the spring, the ICB is in the process of developing a Medium Term Financial Plan for both the ICB and the system as a whole to demonstrate how it will achieve long-term financial sustainability in the coming years.
1.4	**Questions from the Public**
1.4.1	There were no questions from members of the public.
1.4.2	Liz Sayce thanked Frances and Phill for presenting and everybody involved in the ICB's achievements over 2023/24. She thanked everybody for attending and closed the meeting.

North Central London
Integrated Care Board

North Central London ICB
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12 November 2024 - Action Log

On Agenda	
Needs Urgent Update	
In Progress	
Completed	

Meeting Date	Action Number	Action	Lead	Deadline	Update
7 November 2023	19	**Mental Health Update Paragraph 2.1.5** To lead a discussion on Mental Health at a future Board Seminar, building on the discussion at today's meeting.	Jinjer Kandola Sarah Mansuralli	December 2024	This will now form part of the discussion around the progress made in the system to implement both the Mental Health and Community Services core offers at a future meeting of the Strategy and Development Committee.
7 November 2023	20	**Update to Governance Arrangements Paragraph 4.1.4** To circulate to Board Members a summary of the ICB Procurement Policy and its approach to procurement.	Sarah Mansuralli	December 2024	We have drafted changes to the procurement policy to reflect PSR and had been waiting for the launch of the Procurement Act to incorporate this policy change at the same time. As the procurement act implementation has been delayed, we will circulate the updated version of the procurement policy in December 2024.

26 March 2024	21	**Sustainable Healthcare: Green Plan Annual Report** **Paragraph 2.2.5** To bring a paper on the ICB work around social value and anchor for discussion at a future Board Seminar.	Sarah Mansuralli	December 2024	A discussion will take place at a future Board Seminar. This will not be in December due to other competing demands on the Board Seminar forward plan.
26 March 2024	22	**Sustainable Healthcare: Green Plan Annual Report** **Paragraph 2.2.6** To arrange for the Estates Board to review its programmes/projects of work, ensuring appropriate attention is paid to the 'Green' agenda.	Bimal Patel (Now Paul Allen)	November 2024	Working closely with the Estates Teams in the ICB and ICS, a section on sustainability has now been included in the recently signed-off NCL Infrastructure Plan refresh. This will ensure the inclusion of sustainability, with next steps included in both this plan to support actions in individual organisations' sustainability/estate plans and within the estates/energy section of the NCL Green Plan refresh planned for 2025. In the interim, a set of actions will be incorporated into the existing Green Plan as capital opportunities develop in Q3 2023/24, e.g. in primary care.
26 March 2024	23	**Primary Care Access Recovery Plan** **Paragraph 2.3.4** To arrange for the Board to review the Primary Care infrastructure position (estates and digital) at a future Board Seminar.	Sarah McDonnell-Davies	December 2024	A discussion around primary care infrastructure will take place at the Board Seminar on 10 December 2024.
23 July 2024	27	**Board Assurance Framework (BAF)** **Paragraph 3.3.6** To ensure that the St Pancras transformation programme risk score on the BAF is harmonised with other documents.	Andrew Spicer	August 2024	This risk score has now been harmonised.

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
12 November 2024

Report Title	Chief Executive's Report	**Date of report**	28 October 2024	**Agenda Item**	1.6
Lead Director / Manager	Not applicable.	**Email / Tel**		Not applicable.	
Board Member Sponsor	Frances O'Callaghan Chief Executive, NCL ICB				
Report Author	Frances O'Callaghan Chief Executive, NCL ICB	**Email / Tel**		Frances.o'callaghan@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Not applicable.			
Report Summary	The Chief Executive's Report shares highlights from the work of the ICB and its partners and key issues for the Board of Members' consideration that are not covered elsewhere on the agenda.				
Recommendation	The Board of Members is asked to **NOTE** the Report.				
Identified Risks and Risk Management Actions	Where applicable, any risks are identified within the report.				
Conflicts of Interest	There are no conflicts of interest arising from this report.				
Resource Implications	There are no direct resource implications arising from this report, although areas described have resource implications for the ICB.				
Engagement	Engagement activities are highlighted as appropriate.				
Equality Impact Analysis	There are no equality impacts arising from this report.				
Report History and Key Decisions	This report is a standing item on the agenda of Board of Members meetings.				
Next Steps	None.				
Appendices	None.				

1. Introduction

1.1 This report shares highlights from the work of the ICB and our partners and key issues for the Board of Members' consideration that are not covered elsewhere on the agenda.

2. Winter Planning and System Pressures

2. 1 The system continues to operate under significant pressure and in preparation for Winter 2024/25 NCL has worked to evaluate and refine last year's dynamic plan, resulting in the winter play book. This builds in the NHSE recovery plan for urgent and emergency care services which was published in January 2023 and the recent seven UEC priorities which are:

- Increasing capacity in **NHS 111 and 999 services**
- Supporting **ambulance services** and reducing response times
- Improving **in-hospital flow** and discharge processes
- Expanding **Same Day Emergency Care (SDEC)** services
- Increasing **Urgent Treatment Centre (UTC)** availability
- Boosting **mental health crisis care** services
- Enhancing **virtual wards** and remote monitoring capabilities

2.2 Recognising the breadth of UEC pathways we have included all parts of the system in our Winter Plan with a focus on proactive actions informed by data to target the interventions.

2.3 Our providers are focussed on delivering improvement plans developed as part of the annual winter planning exercise. System & Provider Priorities for driving performance improvement remain Improving front door and ambulance handovers, better utilisation of ambulatory pathways, improving flow and discharge and strengthening local partnership engagement

2.4 We have also increased primary care capacity via schemes that will deliver proactive care this autumn to support at-risk cohorts to stay well in winter. NCL is one of the only systems to direct winter capacity funding to primary care systematically.

2.5 Emergency Department (ED) activity in NCL is up 5% from last year most notably in over-65 patients. Nevertheless, NCL has seen month-on-month improvements in 4-hour A&E performance since May 2024,

2.6 Ambulance response times for Category 2 incidents remain challenging. However, improvement in the handover processes and performance have led to a reduction in average response times for Category 2 calls. Although over the last six weeks, the average response time has been 50 minutes—still notably above the 30-minute target.

2.7 During October, the total number of patients waiting 78+ weeks has decreased to 114, down 7 from September. The highest 78+ week waits are present at Great Ormond Street Hospital and the Royal Free Hospital and the highest 104+ week waits position remains at Great Ormond Street Hospital, with the Trust reporting a sustained position of 6 patients waiting. The total number of patients waiting 65+ weeks decreased to 571 from August to September end.

2.8 In August 2024, NCL ICS returned to the top-performing System for Diagnostic Performance in London, and England, achieving a six week wait performance of 8.5%. Magnetic Resonance Imaging (MRI), Non-Obstetric Ultrasound Scans (NOUS) & Neurophysiology are key modalities reporting the highest backlog growth and clearing 13+ week waits remains a key challenge for NCL in year, with the system total increasing to 650 patients waiting longer than 13 weeks for a diagnostic test in August.

3. Change NHS: Helping to shape a health service fit for the future

3.1 With the launch of the engagement phase to deliver a 10-Year Health Plan in the spring, a joint national team has been established between NHS England and the Department of Health and Social Care, but the aim is for the plan to be co-developed with the public, patients, staff and stakeholders through a nationwide engagement exercise.

3.2 This is being called ‘Change NHS: a health service fit for the future’, and the ask is for everyone to share their experiences of the NHS - good and bad - so that they can help to shape its future.

3.3 There are going to be lots of different engagement opportunities, including a new online portal, where patients, residents and staff working in the NHS and wider health and care can share their views, online workshops and face to face sessions - staff specific engagement workshops and events are being planned for February / March to try to avoid the peak of winter pressures.

3.4 In addition, all parts of the NHS are also invited to share an organisational level response by 2 December. This is a tight timeframe so we are currently reviewing all the existing feedback we've had from communities and system partners, including the voluntary sector as part of our regular engagement to ensure that we are representing key themes that have already come up, and exploring engagement opportunities to ensure any additional points can be reflected in our submission.

4. Great Ormond Street Hospital for Children Royal College of Surgeons invited review of the Orthopaedic department

4.1 In June 2022, Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) invited the Royal College of Surgeons (RCS) to review its Orthopaedic department, including the Limb Reconstruction Unit, due to concerns about a consultant. The department, a tertiary centre for specialist paediatric orthopaedic conditions, consists of eleven consultant surgeons and is supported by a multidisciplinary team. The final report, published in October 2023, highlighted issues around culture, leadership, and incident reporting, while also noting examples of good practice.

4.2 To address the recommendations, GOSH has been conducting Clinical Harm Reviews for affected patients, with support from specialist surgeons from other centres. A total of 723 patients treated by the consultant are being reviewed, with a focus on those deemed higher clinical priorities.

4.3 The review process, expected to take around 18 months, is overseen by a Lower Limb Programme Board established in April 2024. This board, which is led by NHS England (NHSE) in their role as the responsible commissioner for this service, is taking forward the implementation the RCS recommendations and ensuring ongoing communication with affected families. The process is monitored and has been assured by NHSE and the ICB is playing an active part in supporting the programme board given future intentions for the service to be delegated to the ICB. From an ICB assurance perspective, updates are being taken through the Quality Oversight Group and the ICB will continue to ensure the collaborative efforts to improve patient care and safety continue at pace.

5. NHS England Test Sites Programme – Primary Care

5.1 NCL ICB is taking part in a national initiative aiming to test new ways of supporting General Practice. There is national recognition that General Practice is under considerable pressure and facing increasing demand.

5.2 This Programme will quantify and evidence the gap between demand and resourcing and test interventions that may help to close this gap and make general practice more accessible and sustainable. The aim is to improve patient and staff satisfaction and ensure the foundations of the NHS are strong.

5.3 This is a two-year initiative which formally launched in September 2024. It is a partnership between NHS England (NHSE), 7 ICBs and 22 selected PCNs covering a population of just over 1 million. In NCL 3 PCNs (Barnet PCN 3, Central and West Camden and Kentish Town Camden) were selected following significant interest. The ICB will share learning across NCL and offer regional leadership by engaging partners in London. Learning from the programme will shape national and local policy.

6. Vaccination

6.1 The Autumn/Winter 24 vaccination programme launched on 1 September 2024. We have been focusing over since on key communities including those who are pregnant, children aged 2 & 3, adults aged 65 and over, residents in care homes and those with certain health conditions or vulnerabilities (in line with recommendations from JCVI).

6.2 We have increased the number of vaccination sites to 136 (up from 112 in 2023/24) and there has been a rapid start to the campaign in NCL. To date we have delivered over 80,000 vaccinations, with the majority having been administered since 2 October 2024.

6.3 COVID vaccination for care home residents continues to be a highlight in NCL – as of 21 October 2024 we have visited 111/137 (81%) of eligible care homes, making NCL one of the best systems in the country when it comes to protecting some of our most vulnerable residents.

6.4 This year we have also launched Respiratory Syncytial Virus (RSV) vaccinations for adults aged 75 to 79 years and those who are pregnant. Since September 1st we have delivered 10,812 RSV vaccinations to older adults (26% of the eligible population) and a further 1,238 vaccinations to pregnant people within NCL.

6.5 We are continuing our efforts to improve uptake of vaccinations, engaging with our population to strengthen information and improve the access to these important preventative interventions. We continue to offer outreach vaccination capacity within our communities, working closely with Local Authorities, community groups and faith leaders to support those less likely to be vaccinated.

7. Community Pharmacy

7.1 As we enter the Winter period, we are raising awareness of our locally commissioned *Self-Care Medicines Scheme* which is available in all NCL Boroughs and complements *Pharmacy First*. It offers free over the counter medications to patients who would otherwise struggle to pay for them. To date 126 pharmacies have gone live with this service and it has been used 2,480 times in the first 3 months. Early feedback suggests 92% of patients would have sought an appointment elsewhere if this service was not available.

7.2 NCL is also mobilising a new *Independent Prescribing Pathfinder* programme, run by NHSE. From September 2026, all newly qualified Pharmacists will be independent prescribers on the day of their registration. This programme will explore what this means for the provision of clinical services from Community Pharmacy. NCL will work with 3 Pharmacies and trial Hypertension management and Statin initiation/titration services. The ICB is currently working with partners on readiness and the aim is to launch during Autumn.

8. Long Term Conditions

8.1 The Primary Care Long-Term Conditions Service is delivering proactive care to everyone in NCL with a diagnosed long-term condition. It includes funding to narrow health inequalities so practices can work closely with key communities. Each person receives planned appointments and personalised support to get ahead of problems and improve outcomes.

8.2 Our PCN outcomes support diagnosis and treatment. We have agreed a focus on High Blood Pressure with all practices given the link to heart disease, stroke and other conditions.

We await final data but at mid-year are seeing promising trends, especially in PCNs with the biggest gap to close between expected prevalence and diagnosis.

8.3 Our model has stimulated further work across NCL. We are working with the NCL Provider Alliance to test an innovative service coordinating Consultant input for people in our higher risk long term condition population where multiple hospitals and hospital teams may be involved in their care.

8.4 They will trial new Long Term Condition Consultants who will work across different specialties and link directly with PCNs and practices. Five early adopter sites have been selected (one per Borough) with the first two (Islington and Haringey) launching this Autumn. We are starting to develop 'neighbourhood' working for this population group, bringing Primary and Acute work together with Community, Mental Health, Councils and the VCS. We want the support we offer to be more streamlined, holistic and impactful for patients.

9. Mental Health Core Offer and Assertive Outreach

9.1 The Mental Health "Core Offer" aims to deliver consistent and equitable mental health services across North Central London over its multi-year implementation plan. During 2024/25, mental health providers are focused on expanding capacity within community teams in order to support more people close to home, transform the acute pathway in order to reduce bed occupancy and out of area placements and start to reduce waiting lists in areas with increased need such as neurodevelopment disorders (NDD) amongst adults and children and Children's Mental Health services.

9.2 Following the CQC's Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust, the ICB has worked closely with North London Mental Health Partnership (NLMHP) to review Intensive and Assertive Community Mental Health Care Services within NCL against key recommendations arising from this review. Our assessment of provision confirms that NCL has made positive progress in meeting most requirements but that there is further work that needs to take to ensure equity of access across NCL.

9.3 To respond to this, North London Mental Health Partnership (NLMHP) has set up a programme of work, overseen by its Chief Nursing Officer to risk review service users under its care and ensure they are receiving support that fully meets the updated requirements. This first stage of work is due to be completed by the end of October.

10. Research Education Network (REN)

10.1 REN is a partnership across our ICB, Islington HDRC, VCSE and research partners focused on raising awareness of research in our most under-served communities, driving inclusivity in research and considering how research can support our aim to address health inequalities; we received national funding in 2023/24 to trial new ways of working with our most under-served communities.

10.2 We worked with over 3,000 local people across Enfield and Haringey within our Black and Gypsy Roma Traveller (GRT) communities and were able to demonstrate our communities are interested in research which is meaningful and accessible for them. Importantly, we connected wider community health & wellbeing with health research, bringing both into community settings, through working with community leaders. Through this approach we built strong community relationships and strengthened trust, alongside developing a network of interested research partners.

10.3 We have successfully received a further £110k of funding to continue delivering the programme in 2024/25. Working with local communities we have identified Heart Health as the community research and health priority area and are working closely with the Heart Health programme team.

11. Work Well Programme

11.1 NCL's bid to become one of 15 WorkWell Vanguard programmes in England was successful, generating funding of £2.9 million for the NCL system. The number of people economically inactive because of long-term sickness has risen by 400,000 since the start of the

coronavirus (COVID-19) pandemic, amounting to over 2.5 million people. NHS data confirms that 1 in 5 people who are off work due to sickness for more than 4 weeks do not return to work.

11.2 The WorkWell programme aims to support a person who is disabled or has a health condition to start work if they have recently become unemployed or to develop a Work and Health plan to help them retain employment if they are at risk of being signed off sick or already on sick leave. Our System Workforce team has rapidly engaged with partners across 5 borough councils, Primary Care Networks, Job Centre Plus and the VCSE sector to design a WorkWell service offer that meets local needs.

11.3 The WorkWell service went live as planned on 1 October 2024 and is already receiving referrals from local people. Alongside the service, NCL are working with the Institute of Employment studies to develop an Integrated Work and Health Strategy which will develop a proactive approach to greater integration between health and care, employment and wider community, place-based services.

12. Your Local Health Team campaign

12.1 NCL ICS has launched a big new campaign to help residents find out how best to get the health care they need, whether that's via their GP, their high street pharmacy, other health professionals, or online. The 'Your Local Health Team' campaign, which is being coordinated by the ICB with strong backing from our local councils and NHS trusts, brings together key messages on how to access primary care, get vaccinated, and stay well.

12.2 Over the next 18 months, social media, outdoor ads, local council magazine articles, flyers, and engagement events will invite NCL residents to find out more on our campaign hub on the ICS website: nclhealthandcare.org.uk/localhealth. One of the key ways we will evaluate the impact of campaign is through ongoing surveys of our Community Voices Panel which is made up of 1,000 residents representing the demographic make-up of North Central London.

13. **Camden Neighbourhood Development**

13.1 Neighbourhood development is a key ambition for the borough of Camden, there is a collective vision that "In Camden, people and place lead the way. We are accessible to people where they live and want everyone to be empowered to live a good life. Our services will be local, connected and built on relationships, enabling people to find solutions".

13.2 Across the Camden Borough partnership there is commitment to this vision with Adult Social Care, Community Health services (provided by CNWL) and Mental Health services (provided by NLMHP) aligning teams to the five-neighbourhood geography.

13.3 Camden Council have also worked with their place-based services and housing teams to also align to this neighbourhood approach. Camden are taking a collaborative, co-design approach to neighbourhood working and are testing this approach through co-location in one neighbourhood.

13.4 Teams from Camden Council and CNWL have co-located in Kentish Town where they are working jointly with primary care, mental health and VCS to test interventions to improve staff experience and ultimately deliver better outcomes for residents on their caseload. The East INT launched their co-location in Kentish Town Health Centre in October 2024 with learning from this test being utilised to expand to the other neighbourhoods.

14. Formal Launch of the Integrated Front Door

14.1 The Islington Borough Partnership is pleased to announce the launch of the Integrated Front Door Service on Tuesday 1 October 2024. This is a new integrated health and care model that is hosted jointly by Whittington Health and Islington's Adult Social Care Services and is based on the 4th Floor of 222 Upper Street in Islington.

14. The service is designed to act as a single point of access for all adult social care, urgent community health and hospital discharge referrals for Islington residents. By creating this single point of access, the service aims to provide a timelier response to residents' care needs with care plans developed and delivered in a more holistic, multi-disciplinary and coordi2nated way.

14.3 The ambition is to enable residents to live healthy independent lives for as long as possible in their own home setting. This aligns with the vision of the NCL Population Health and Integrated Care Strategy for proactive care, and is part of Islington's Integrated Care Programme to bring care closer to home and embed locality / neighbourhood-based models of care.

Frances O'Callaghan
Chief Executive

26 October 2024

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
12 November 2024

Report Title	NCL Outcomes Framework: 2023/24 Annual Insights Report	**Date of report**	23 October 2024	**Agenda Item**	2.1
Lead Director / Manager	Sarah Mansuralli	**Email / Tel**		Sarah.mansuralli@nhs.net	
Board Member Sponsor	Sarah Mansuralli, Chief Strategy & Population Health Officer, NCL ICB				
Report Author	Katie Ferguson, Public Health Consultant	**Email / Tel**		katie.ferguson10@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** None.			
Report Summary	In North Central London (NCL) we have developed an outcomes framework, supported by an indicator set, to enable us to understand the health needs of our population across the life course and highlight variation and disparities across our system. In February 2024 we launched an online dashboard for the outcomes framework, accessible on the NCL ICS website. In July 2024 we produced the first annual outcomes framework insights report, providing a stocktake of key findings from the latest data in the dashboard. It is these key findings which are summarised in this report, with the full insights report included as an appendix for this item. The outcomes framework underpinned the development of and supports delivery of the NCL Population Health and Integrated Care Strategy. Notably, the importance and value of delivering our strategy has been confirmed by the recent review of the NHS by Lord Darzi, highlighting the need to move towards more equitable, integrated, and proactive healthcare system that prioritises prevention and community involvement. The insights contained within the report are intended to enable monitoring and assessment of impact to enable course correction, whilst also taking into account longer term trends that the Outcomes Framework will highlight. The aim is to supplement these insights with more comprehensive research-led deeper dives on the underlying issues driving these measures, e.g. those associated with inequalities to inform future planning, including the next iteration of the NCL Outcomes Framework, Insights Report and Delivery Plan in 2025. The data in the 2023/24 insights report indicates that, despite some progress, the five areas of focus we have prioritised strategy continue to be the primary population health risks within our resident population. This confirms the need for ongoing and concerted system focus in these areas with much more work to do				

	at system, place and neighbourhood to improve outcomes throughout the life course. While there are many areas of good and improving performance at system and borough level drawn out throughout the report, it also highlights areas where boroughs are performing worse than peers, and where there is strong variation across the five boroughs, there may be learning from boroughs which are performing better. The Insight Report is one of the many tools we will utilise to determine the progress we are making on achieving the improvements described in our strategy and Delivery Plan over the next 18 months. Other tools and evidence includes analysis from Inequalities Fund projects, the Research Engagement Network outputs, and progress against the emerging Population Health Core Metrics. Taking all of these into account will enable the ICB to respond to the themes identified in the Darzi Review, and to prepare for the heralded content of the ten-year plan. Understanding the variation between boroughs and/or population cohorts, as set out in the Outcomes Framework provides the ICB with insights as to where best practice is being achieved, and where we can build on this best practice to achieve the necessary shifts signalled in the Review. Fundamentally, the insights report is designed to shift the thinking towards variation at place and population segmentation level, e.g. deprivation / age / ethnicity, rather than activity being the driver of improved outcomes and effectiveness. Taken together, the online Outcomes Framework, Insights Report and the NCL Delivery Plan are enablers to support achievement of the ambitions we have set out for improved population health in NCL. It is intended that these enablers are used to inform and support delivery of improvement action at system, place and neighbourhood and should be used to inform borough priorities; identify potential research opportunities; and inform service commissioning/development activities.
Recommendation	The Board of Members is asked to **NOTE** the NCL Outcomes Framework 2023/24 Annual Insights Report and **PROMOTE** its use to inform and enable delivery of NCL's Population Health and Integrated Care Strategy at system, place and neighbourhood level.
Identified Risks and Risk Management Actions	Not applicable.
Conflicts of Interest	Not applicable.
Resource Implications	Not applicable.
Engagement	To date the insights report has been presented to the following: • NCL Population Health and Inequalities Steering Group – owners of the NCL Outcomes Framework - involved in refresh of the NCL Outcomes Framework, as well as the format of the insights report • NCL ICB's Place and CMO Directorate DMT • NCL/UCLH Interface Meeting.

Equality Impact Analysis	Not applicable.
Report History and Key Decisions	The governance of the NCL outcomes framework sits with NCL's Population Health and Inequalities Committee and Steering Group and these groups have provided oversight of the development of the framework, the dashboard and the insights report.
Next Steps	Key next steps: • Use the outcomes framework in the development of a selection of core metrics • Refresh of the NCL outcomes framework online dashboard • Ensuring the NCL outcomes framework, aligns with, and is used alongside other population health management tools in NCL to inform decision making.
Appendices	Attachment 1 – North Central London Outcomes Framework: 2023/24 Annual Insights Report. Report to the NCL ICB Board of Members, November 2024. Attachment 2 – NCL Outcomes Framework 2023/24 Annual Insights Report (full report).

North Central London Outcomes Framework: 2023/24 Annual Insights Report

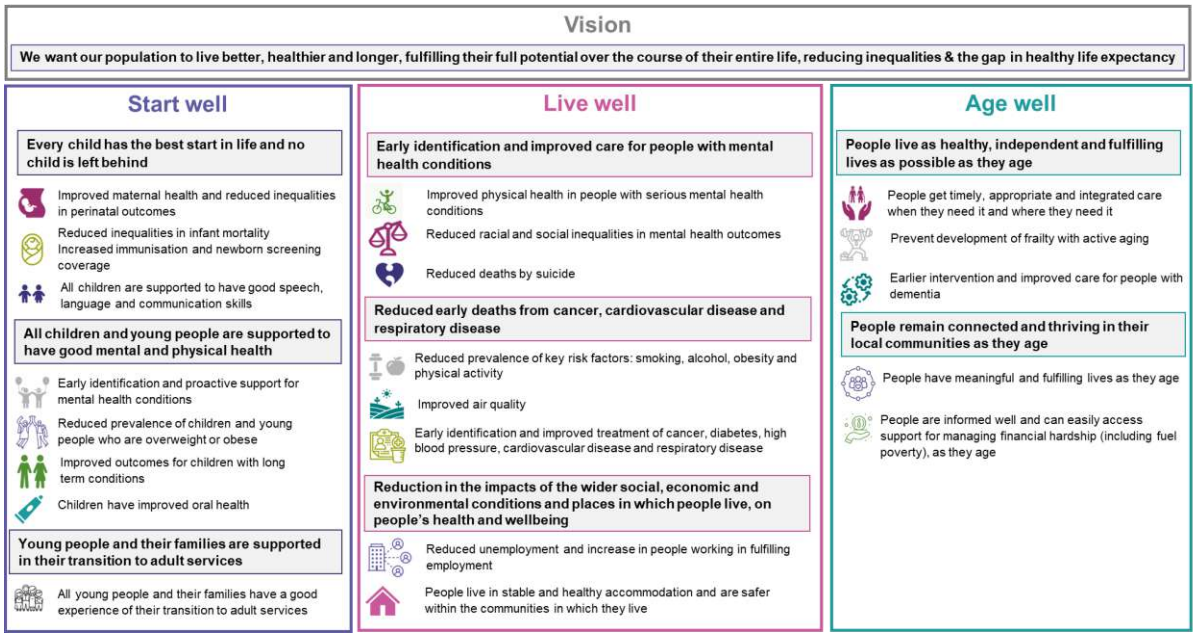
Report to the NCL ICB Board of Members, November 2024

1. Context: NCL Outcomes Framework overview

1.1 In North Central London (NCL) we have had an outcomes framework in place since 2022. It was developed by system partners to support us in understanding the health and needs of our population across the life course, and to highlight variation and disparities across our system.

1.2 The outcomes framework follows the life course and contains 9 overarching outcomes and 21 sub-outcomes. It is supported by a set of indicators, with data at borough and NCL level, benchmarked to London and England.

1.3 It provides a way to look at outcomes in a consistent way across NCL.



1.4 Early drafts of the outcomes framework informed the priorities outlined in NCL's Population Health and Integrated Care Strategy, and the framework now supports delivery through enabling us to monitor progress on delivering our ambitions for our population and helping to review and refine our system and local priorities within our Delivery Plan. The latter summarises those priorities in specific topic areas within the Population Health and Integrated Care Strategy the ICS will progress over the next 18 months and forms the ICB's Joint Forward Plan for 2024/25.

1.5 The Insight Report is one of the tools we will utilise to determine the progress we are making on realising the Strategy and the Delivery Plan over the next 18 months. Through our multi-agency Population Health and Inequalities Committee, we will monitor progress against the actions outlined in the Delivery Plan to assure progress. We will also utilise a set of 'core metrics' associated with these topic areas to determine whether these actions are having a positive impact on our health outcomes. This Plan and outcome monitoring will help partners determine if we are making sufficient progress or

need to make 'course corrections' to the projects and programmes underpinning the Plan during the year. This will enable us to monitor and make changes in real time, whilst also taking into account longer term trends that the Outcomes Framework will highlight. We will also provide more comprehensive research-led deeper dives on the underlying issues driving these measures, e.g. those associated with inequalities to inform future planning, including the next iteration of the NCL Outcomes Framework, Insights Report and Delivery Plan in 2025.

1.6 The outcomes framework has been used to frame the selection of 'core metrics' we will use to demonstrate the improvement we are making to population health in NCL. Refer to section 3.1 for more detail.

1.7 The NCL outcomes framework is not exhaustive, rather it provides an overarching framework to support partners and programmes to consider how they are contributing to our overarching ambitions as a system.

1.8 In 2023/24, we refined the draft outcomes and indicators within the framework, to align with the final NCL Population Health and Integrated Care Strategy. In addition we developed an online dashboard with benchmarked data for each of the indicators and trends over time (where historic data is available). The dashboard is accessible on the NCL ICS website.

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2. 2023/24 Annual Insights Report

Overview and purpose

2.1 The insights report provides an overview of key insights at borough and NCL Integrated Care System (ICS) level from the latest data across the NCL Outcomes Framework online dashboard. There are indicator-level insights arranged by life course as well as borough insights, focusing on areas where individual boroughs are performing worse than peers.

2.2 This 2023/24 report is the first outcomes framework insights report, which it is intended will become an annual report. The process is iterative and will evolve over time. The aim is for future reports to be produced around June of each year, following a full refresh of data on the dashboard, to inform the development of system intentions and the annual planning/operating plan cycle.

2.3 The report reviews the most recent data for each of the 81 indicators within the dashboard, as well as trends over time, comparing data across NCL boroughs and NCL as a whole to London and England (where data is available), to assess how we are doing at meeting our agreed ICS population health outcomes, particularly those which relate to delivery areas in NCL's Population Health and Integrated Care Strategy (PH&IC Strategy). London is used as a comparator as it will be recognised as a standard benchmark to many users of the dashboard familiar with the indicators and we do not have targets or other outcome based milestones such as 'herd immunity' for immunisations for many indicators. We will, however look to how we can incorporate other milestones for some key indicators in future reports.

2.4 As well as being used to inform the development of a smaller selection of 'core metrics' to monitor delivery of the strategy, the insights report will also be used to inform borough priorities; identify potential research opportunities; and inform service commissioning.

2.5 The data in the online dashboard is currently up to date as at February 2024 and it is this data which is reflected in the insights report. We are aware that there is more recent data available for some indicators and are working as part of the transition of the dashboard from Barnet Council (who did the initial development work) to the Integrated Care Board (ICB) to get the data in the dashboard updated during autumn 2024. Due to varied reporting cycles across different indicators the timing of the insights report will never be perfectly aligned for all indicators.

2.6 In the dashboard itself, we are looking to do quarterly refreshes of the data going forward. Whereas the annual insights report is intended to offer an annual commentary on the findings from the data, users are encouraged to review the dashboard more regularly throughout the year for the latest data on different indicators.

2.7 Trend data is not available for all indicators, and some metrics may not yet show performance since the creation of NCL ICS (1 July 2022). Further, due to the reporting lag for some metrics, progress made in the last year or two may not be reflected in the data. Tracking ICS progress across indicators is more likely to be possible from 2024/25, although it is important to note that the outcomes framework is not strictly designed as a performance framework – the majority of the outcomes are long-term in nature and as such change may only be evident over longer timeframes. Where there are notable or emerging trends in the data available to-date, these have been drawn out in narrative of the full insights report. In future iterations of the annual report we hope to be able to draw out more around trends and include some graphs – should users want to see existing trend data there is some data available in the online dashboard.

2.8 While the outcomes framework is comprehensive, it does not cover all health areas or populations – the focus is largely on outcomes across the whole population and demographic and geographical inequalities data is not reflected below the population-level borough statistics. We want to close the gap on inequalities as well as improve overall population health outcomes and as such, the insights presented in this report should be viewed in the context of broader data and insights at borough and system level, and as a starting point to initiate further conversations and deeper dives to inform local priorities. Some of this work for some of the indicators will be done as part of the work proposed around 'core metrics'.

Key messages: 2023/24 Insights

2.9 This next section provides a brief summary of some key findings from the 2023/24 Insights Report. Please refer to the appendix for the full report.

2.10 As indicated above, the June 2022 Outcomes Framework baseline report (unpublished) was used to inform the five population health risks and other delivery areas within the PH&IC Strategy. The latest data indicates that, despite some progress, these five population health risks remain relevant and require ongoing system focus, for instance:

- **Childhood immunisations** - Although there has been notable, steady improvement in the proportion of children who have been fully vaccinated by age five, 31% of children in NCL were not fully vaccinated by the end of 2022/23
- **Cancer** - Despite steady improvement in bowel cancer screening over recent years, overall cancer screening coverage is poor, with all boroughs except Enfield having lower coverage than London in at least one programme in 2023
- **Mental health and wellbeing** - The proportion of adults with SMI having a physical health check increased by 44% from 2020/21 to 2022/23, but we are not achieving our target of 0–18 year olds receiving at least one contact from an NHS-funded mental health service
- **Heart health -** With 73% of NCL patients with high blood pressure treated to within age-specific target range within the last 12 months, we are falling short of the national target (77% for 2023/24; now 80% for 2024/25)
- **Lung health -** Only 53% of NCL patients with chronic respiratory disease are vaccinated against flu, and only 69% of people aged 65+.

2.11 The data also highlights that there is there is more work to do across the breadth of the Delivery Plan to improve outcomes throughout the life course, a few examples of which are given here:

2.12 The data indicates there are many areas of good and improving performance at system and borough level, with examples of this drawn out throughout the report – and that where there is strong variation across the five boroughs, there may be learning from boroughs which are performing better. Below we have selected one example for each borough as an illustration of an area where the data suggests they are performing better than other boroughs in NCL; and an area where the reason for this may be less related to the demographics of their population:

- **Barnet -** At a rate of 45/100,000 Barnet had the lowest rates of Children and young people's hospital admissions for diabetes in NCL, and was the only NCL borough with rates significantly lower than London
- **Enfield**- Enfield has the highest cancer screening rates across NCL for all 3 cancer screening programmes and is the only borough to have higher rates than London for all programmes
- **Camden** - Camden has a greater proportion of physically active children and adults compared to other NCL boroughs (54% and 72% respectively) and for children, is the only borough with higher rates than London
- **Haringey –** Haringey has the lowest rate of babies born with low birth weight in NCL, a rate which is significantly below London
- **Islington**- Islington has had the highest rates of people with a physical or mental long term health condition who were employed for the last two reporting periods, and at 80% in 2022/23 was significantly higher than London.

3. Next steps for NCL Outcomes Framework

3.1 There are three main next steps for development of the NCL outcomes framework described. The governance associated with the Population Health and Integrated Care Committee includes sub-groups to help progress development and delivery of the tools described below. In the context of the Delivery Plan, the Strategic Intelligence Group will provide an opportunity for partners to pool expertise, resources and tools to progress an intelligence-driven approach to population health management. This will enable the ICB to identify and address variation in outcomes by population segments, alongside supporting the development of dashboards for reporting of core metrics. This will support the deeper dives into specific areas and building horizon scanning and scenario capabilities needed in population health management. In doing so, it will progress the ICB's Data Strategy.

1) Development of assurance and oversight tools to support and refine NCL's PH&IC Strategy and Delivery Plan

We are currently in the process of setting up robust assurance arrangements for the Delivery Plan. This includes a set of tools which support us to better understand progress against Delivery Plan actions and whether this progress in influencing outcomes in key topic areas:

- **Delivery Plan Monitoring and Alignment Framework:** Assure partners project and programme actions included in individual topic areas are progressing satisfactorily and are aligned with the wider strategic priorities across the ICS, including action to address inequalities in access, outcomes and experience amongst under-served communities and with individual organisational and partnership plans (e.g. individual Borough Health & Well-Being Strategies).

- **Core metrics –** Determine the extent to which the actions partners are taking in the Delivery Plan are changing realisable outcomes in key topic areas over the next 18 months. This will be through developing 'core metrics: as part of measuring the benefits realised by NCL's PH&IC Strategy and Delivery Plan, a small set (around 10-15) of 'core metrics' will be identified to monitor and demonstrate progress made in delivering improvements in key population health outcomes for our population. The NCL outcomes framework and insights report is one of several tools that will inform selection and prioritisation of our core metrics.

- **Deep dives -** The chosen core metrics, and the topic areas in the Delivery Plan on which they focus, will be supported by a benefit realisation deep dive, which will seek to understand how we can work differently across partners to improve our outcomes and that we are making a tangible difference to population health. The deep dives will, in turn, inform the refinement of the next iteration of the Delivery Plan in 2025. They will involve bringing together academic research, intelligence and insights and NHS/local authority/Voluntary and Community Sector partner delivery to ensure we are harnessing strengths of all partners.

2) Refinement of the NCL outcomes framework dashboard and annual report

- **Refining the NCL Outcomes Framework (OF) dashboard –** we are in the process of bringing the maintenance and further development of the NCL outcomes framework dashboard in-house within the ICB. As part of this we will be working out the process for, and appropriate interval to, update data on the dashboard on a regular basis. We will continue to review and refine the framework metrics to ensure they remain relevant and fit for purpose, as well as develop additional metrics to address feedback around gaps/improvements received to-date. Future refreshes of the Outcomes Framework dashboard will aim to add further RAG-ratings and historic data where possible, facilitating further benchmarking across a wider range of indicators and greater comparison over time.

- **Refine the annual insight reporting process** – this is the first annual insights report and the dashboard is itself relatively new. We are keen to receive feedback to ensure that both the dashboard and the insights report meet the needs of our system and borough partners.

3) Work with partners to shape the role of the NCL outcomes framework within our broader population health intelligence toolkit and its role in influencing priority setting at both borough and system level

- Ensure that the NCL outcomes framework is viewed as a key tool within the wider toolkit of emerging population health management tools offering insights to population health within NCL, including the development of the new London Data Service

- Understand how it aligns with other local data, priorities and broader work, such as borough Joint Health and Wellbeing Strategies and refreshes, to inform shaping of future priorities and any emerging systems for monitoring progress.

North Central London Health and Care
Integrated Care System

North Central London Outcomes Framework Annual Insights Report 2023/24

August 2024

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Strategy, Research and Communities Team

North Central London Integrated Care Board

Executive Summary

North Central London Health and Care
Integrated Care System

1. Overview

- This report provides **an overview of key insights** at borough and North Central London (NCL) Integrated Care System (ICS) level from the latest data in the NCL Outcomes Framework online dashboard.
- This 2023/24 report is the first Outcomes Framework insights report, which **will become an annual report**. This process is iterative and will evolve over time. The aim is for future reports to be produced around June of each year, following a full refresh of data on the dashboard, to inform the development of system intentions and the annual planning/operating plan cycle.
- The report reviews the **most recent data for each indicator within the dashboard, as well as trends over time**, comparing data across NCL boroughs and NCL as a whole to London and England (where data is available), to **assess how we are doing at meeting our agreed ICS population health outcomes,** particularly those which relate to delivery areas in NCL's Population Health and Integrated Care Strategy (PH&IC Strategy). **The report will also be used to inform the development of a smaller selection of 'sentinel metrics'** to monitor delivery of the strategy; to inform borough priorities; identify potential research opportunities; and inform service commissioning.
- **The data in the online dashboard is up to date as at February 2024** and it is this data which is reflected in the report. **We are aware that there is more recent data available for some indicators** and are working as part of the transition of the dashboard from Barnet Council to the Integrated Care Board (ICB) to get the data in the dashboard updated during summer 2024. Due to varied reporting cycles across different indicators the timing of the insights report will never be perfectly aligned for all indicators.
- We are **looking to do quarterly refreshes of the data in the dashboard going forward.** Whereas the annual insights report offers an annual commentary on the findings from the data, we encourage users to review the dashboard more regularly throughout the year for the latest data on different indicators.
- Trend data is not available for all indicators, and some metrics may not yet show performance since the creation of NCL ICS (1 July 2022). Further**, due to the reporting lag for some metrics, progress made in the last year or two may not be reflected**. Tracking ICS progress across indicators is more likely to be possible from 2024/25, although **it is important to note the long-term nature of many of these outcomes and that change may only be evident over longer timeframes.** Where there are notable or emerging trends in the data available to-date, these have been drawn out in narrative of the report.
- While **the Outcomes Framework is comprehensive, it is not exhaustive** – for instance, **the focus is largely on outcomes across the whole population** and demographic and geographical inequalities data is not reflected below the population-level borough statistics. **We want to close the gap on inequalities as well as improve overall population health outcomes** and as such, the insights presented in this report should be viewed in the context of broader data and insights at borough and system level, and as a starting point to initiate further conversations and deeper dives to inform local priorities. Some of this work for some of the indicators will be done as part of the work proposed around 'sentinel metrics'.

Executive Summary

North Central London Health and Care
Integrated Care System

2. Key messages

- The June 2022 Outcomes Framework baseline report (unpublished) was used to inform the five population health risks and other delivery areas within the PH&IC Strategy. The latest data indicates that, **despite some progress, these five population health risks remain relevant and require ongoing system focus**, for instance:

Childhood immunisations
Although there has been notable, steady improvement in the proportion of children who have been fully vaccinated by age five, 31% of children in NCL were not fully vaccinated by the end of 2022/23

Cancer
Despite steady improvement in bowel cancer screening over recent years, overall cancer screening coverage is poor, with all boroughs except Enfield having lower coverage than London in at least one programme in 2023

Mental health and wellbeing
The proportion of adults with SMI having a physical health check increased by 44% from 2020/21 to 2022/23, but we are not achieving our target of 0–18 year olds receiving at least one contact from an NHS-funded mental health service

Heart health
With 73% of NCL patients with high blood pressure treated to within age-specific target range within the last 12 months, we are falling short of the national target (77% for 2023/24; now 80% for 2024/25)

Lung health
Only 53% of NCL patients with chronic respiratory disease are vaccinated against flu, and only 69% of people aged 65+

- The data also highlights that there is there is **more work to do across the breadth of the Delivery Plan to improve outcomes throughout the life course**, a few examples of which are given here:

Start Well

Poverty - 17% children live in poverty (2021/22 data which is likely to have increased since)
Maternal smoking - More than one in 20 women giving birth in NCL smoke
Newborn hearing screening - NCL boroughs are within the 6 worst performing boroughs in London
Oral health - More than one in four 5-year-olds in NCL have experience of tooth decay
Healthy weight - 38% 11-year-olds are overweight or obese
Communication skills - One in five reception children do not achieve the expected communication and language skills

Live Well

Smoking - More NCL patients aged 15+ years smoke compared to London
Healthy weight - 55% of adults are overweight or obese
Alcohol - Admissions for alcohol-related conditions are higher in three of our boroughs (Islington, Haringey and Enfield) compared to London
Employment - 35% people with a long term physical or mental health condition of working age are not in employment
Diabetes - Only 31% patients with Type 1 diabetes and 43% of patients with Type 2 diabetes in NCL achieved all three treatment targets

Age Well

Loneliness – Only 36% older adult social care users have as much social contact as they would like
Dementia diagnosis - Although rates across NCL were similar to London, Camden, Haringey and Barnet did not meet the national benchmark for dementia diagnoses
Avoidable admissions – Unplanned admissions for older adults with certain long-term conditions have increased across all our boroughs since 2020/21
Intermediate care – On average more than one in ten of NCL's hospital beds per week are occupied by patients who did not meet Criteria to Reside but were not discharged
Carers - The average quality of life score for carers in NCL was 7 out of 12 which, although low, was comparable to London

Executive Summary

North Central London Health and Care
Integrated Care System

2. Key messages (continued)

- The data **indicates there are many areas of good and improving performance at system and borough level,** with examples of this drawn out throughout the report – and that where there is strong variation across the five boroughs, **there may be learning from boroughs which are performing better,** for instance:

Barnet	Enfield	Camden	Haringey	Islington
Children and young people's hospital admissions for diabetes - At a rate of 45/100,000 Barnet had the lowest rates in NCL and was the only NCL borough with rates significantly lower than London	**Cancer screening Coverage -** Enfield has the highest screening rates across NCL for all 3 cancer screening programmes and is the only borough to have higher rates than London for all programmes	**Physical activity levels in children and adults -** Camden has a greater proportion of physically active children and adults compared to other NCL boroughs (54% and 72% respectively) and for children, is the only borough with higher rates than London	**Low birth weight –** Haringey has the lowest rate of babies born with low birth weight in NCL, a rate which is significantly below London	**Employment among those with a physical or mental long term health condition –** Islington has had the highest proportion of people employed for the last two reporting periods and at 80% in 22/23 this was significantly higher than London

3. Next steps for the Outcomes Framework dashboard and insights report

- **Sentinel metrics and deep dives –** as part of measuring the benefits realised by NCL's PH&IC Strategy and Delivery Plan, a small set of 'sentinel metrics' will be identified to monitor and demonstrate progress made in delivering improvements in key population health outcomes for our population. This insights report is one of several tools that will inform selection and prioritisation of our sentinel metrics. Planned 'deep dives' for each of the chosen areas will provide more granular insights as to the key drivers and inequalities sitting beneath each metric, as well as informing potential opportunities for research collaboration and innovation in NCL.
- **Borough Partnership priority setting and dashboards** – work with Borough Partnerships and local partners to understand how these insights align with other local data, priorities and broader work, such as borough Joint Health and Wellbeing Strategies and refreshes, to inform shaping of future priorities and emerging dashboards for monitoring progress.

Executive Summary

North Central London Health and Care
Integrated Care System

3. Next steps (continued)

- **Refining the NCL Outcomes Framework (OF) dashboard –** we are in the process of **bringing the maintenance and further development of the NCL OF dashboard in-house within the ICB**. As part of this we will be working out the process for, and appropriate interval to, **update data on the dashboard on a regular basis.** We will continue to review and refine the framework metrics to ensure they remain relevant and fit for purpose, as well as develop additional metrics to address feedback around gaps/improvements received to-date. Future refreshes of the Outcomes Framework dashboard will aim to add further RAG-ratings and historic data where possible, facilitating further benchmarking across a wider range of indicators and greater comparison over time.
- **Refine the annual insight reporting process** – this is the first annual insights report and the NCL OF dashboard is itself relatively new. We are keen to receive feedback to ensure that both the dashboard and the insights report meet the needs of our system and borough partners.
- **Work with partners to shape the role of the NCL OF within our broader population health intelligence toolkit and its role in influencing priority setting** – ensure that the NCL OF is viewed as a key tool within the wider toolkit of emerging population health management tools offering insights to population health within NCL, including the development of HealtheIntent and the new London Data Service.
- **Share the report with the new NCL Impacts and Insights Group** - to discuss implications and shape next steps further, including how we might socialise the findings with communities.

North Central London Health and Care
Integrated Care System

Section 1: Introduction

Introduction

North Central London Health and Care
Integrated Care System

In North Central London (NCL), we have worked in consultation with partners across boroughs and the system to develop an NCL Outcomes Framework (NCL OF) to enable us to understand and monitor the health needs of our population across the life course. Supported by an indicator set, the outcomes framework:

- Provides an agreed set of key outcomes and indicators to highlight variation and need across our system to support setting of priorities and ambitions - with outcomes that cover physical and mental health, as well as health behaviours and wider determinants of health and wellbeing
- Enables us to look at outcomes in a consistent way across NCL and across the life course
- Underpins and supports delivery of the NCL Population Health and Integrated Care Strategy (NCL PH&IC Strategy) enabling us to monitor progress on delivering our ambitions for our population over time at borough and Integrated Care System (ICS) level
- Provides an overarching framework to support partners and programmes to consider how they are contributing to our ambitions as a system, recognising that some these are longer-term, and that progress may take several years.

Our NCL Outcomes Framework will continue to develop as we mature as a system, and evolve to reflect the changing needs and priorities within our population.

In 2023/24, we refreshed the Outcomes Framework to ensure that it aligns with our new NCL PH&IC Strategy. We also developed and published an online dashboard hosted on our ICS website to facilitate access by colleagues from across NCL. Moving into 2024/25 and beyond, further work is planned to ensure the Outcomes Framework fully reflects all areas of our Strategy Delivery Plan.

June 2022	Apr 2023	Sept 2023	Feb 2024	Beyond Feb 2024
Baseline NCL Outcomes Framework • 69 indicators • 3 placeholders for future measures	**NCL Population Health and Integrated Care Strategy** • With priority areas informed by NCL Outcomes Framework	**Endorsement of refreshed NCL Outcomes Framework. Updated to:** • Address feedback, gaps and placeholders from baseline framework • Assure alignment to PH&IC strategy • Expanded framework to 81 indicators with ~20 placeholders for future measures	**Launch of NCL Outcomes Framework online dashboard** • Facilitate use and engagement with the Outcomes Framework by a broader audience	**Next steps** • Annual Insights Report, linked to priority areas in NCL Delivery Plan • Dashboard /data refresh (interval to be confirmed) • Annual Outcomes Framework review to ensure it remains fit for purpose

NCL Outcomes Framework

North Central London Health and Care
Integrated Care System

Vision

We want our population to live better, healthier and longer, fulfilling their full potential over the course of their entire life, reducing inequalities & the gap in healthy life expectancy

Start well

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

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

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

- Early identification and proactive support for mental health conditions
- Reduced prevalence 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

Early identification and improved care for people with mental health conditions

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

Reduced early deaths from cancer, cardiovascular disease and respiratory disease

- Reduced prevalence of key risk factors: smoking, alcohol, obesity and physical activity
- Improved air quality
- Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease

Reduction in the impacts of the wider social, economic and environmental conditions and places in which people live, on people's health and wellbeing

- Reduced unemployment and increase in people working in fulfilling employment
- People live in stable and healthy accommodation and are safer within the communities in which they live

Age well

People live as healthy, independent and fulfilling lives as possible as they age

- People get timely, appropriate and integrated care when they need it and where they need it
- Prevent development of frailty with active aging
- Earlier intervention and improved care for people with dementia

People remain connected and thriving in their local communities as they age

- People have meaningful and fulfilling lives as they age
- People are informed well and can easily access support for managing financial hardship (including fuel poverty), as they age

Purpose of this insights report

North Central London Health and Care
Integrated Care System

This report summarises key insights from the latest data on the North Central London's Outcome Framework dashboard (as at February 2024).

- These focus on key insights from data at both borough and system (NCL-wide) level; and those aligned to delivery areas within NCL's Population Health and Integrated Care Strategy.
- The dashboard contains the latest data* for each indicator and for many indicators there is also historic data – geographical variation across NCL in the most recent time period and trends over time are both considered within the insights (as relevant).
- This insights report aims to:
    - *Celebrate success* - drawing out areas where boroughs/NCL are performing well compared to peers (within NCL and/or London/England) and/or performance is improving
    - *Highlight areas where further focus is needed* -drawing out areas where boroughs/NCL are performing worse compared to peers (within NCL and/or London/England) and/or performance is worsening
    - *Support priority-setting (alongside other data/insights)* – and assess whether we are focusing on the right things
    - *Support monitoring of performance in key areas of strategy delivery* - such as the 5 Key Population Health Risks
    - *Allow boroughs to see where they may be outliers within NCL/in London* and where there are boroughs which are performing well, where there may be cross-NCL learning
    - *Act as the starting point to initiative deeper dives into the findings* – to understand why performance is as it is; what the drivers and levers may be; and whether this is being driven by outcomes in particular communities/geographical areas – these may be at borough and/or NCL level
    - *Support selection of a small number of 'sentinel measures'* to monitor the benefits realised by our Strategy over the short-medium term.
- This report does not offer interpretation of why there is variation/ poorer performance or include data below borough level or for particular communities.
- The intention is to produce a similar insight report each year around June, to enable the findings to inform development of system intentions and the annual planning/operating plan cycle, following a full data refresh in the dashboard (with refreshes of the data itself, where available, at more frequent intervals throughout the year).
- The main report provides a narrative summary of the data, with the full data tables provided at the end of this report, in Section 5.

* The data in this report reflects the latest data in the online dashboard, which was inputted in February 2024. At the time of the publication of this insights reports more up to date data on a few of the indicators may be available.

North Central London Health and Care
Integrated Care System

Section 2: Outcomes Framework insights by domain

Vision

North Central London Health and Care
Integrated Care System

We want our population to live better, healthier and longer, fulfilling their full potential over the course of their entire life, reducing inequalities and the gap in healthy life expectancy

- **Life expectancy (2020/22) -** Residents in Barnet have the highest life expectancy in NCL and residents in Islington the lowest. Men and women in Barnet, and women in Camden and Enfield had a higher life expectancy than the London average. In contrast, men and women in Islington, and men in Haringey had lower life expectancies. Women across all our boroughs consistently have a higher life expectancy compared to men.
- The impacts of COVID are still being seen on life expectancy projections, with all boroughs having lower life expectancy for men and women in 2020/22 compared to 2017/19 (although the difference is not always statistically significant). These patterns mirror those seen in London and England, and for women in Haringey and Camden signs of improvement are evident.
- **Healthy life expectancy (2018/20) –** Men and women in NCL are expected to live 64 years and 65 years in good health, respectively. This is similar to London.
- **Inequality in life expectancy (2018/20) -** Life expectancy is lower in our most deprived areas compared to our least deprived areas across all our boroughs, with inequality in life expectancy particularly high in Camden where the slope of inequality in life expectancy from the most to least deprived is 14 years for men, and 10 years for women. Inequality in life expectancy for women in Enfield was also significantly greater than London.
- Borough averages mask differences in life expectancies for different communities and for inclusion health groups e.g. people experiencing homelessness.

Refer to Section 5 for data tables with supporting data across the 4 domains of the Outcomes Framework

Start Well

North Central London Health and Care
Integrated Care System

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

Improved maternal health and reduced inequalities in perinatal outcomes

- **Maternal smoking (2022/23) -** More than one in 20 women giving birth in NCL smoke, with all boroughs except Camden having significantly higher rates compared to London. Rates across NCL's boroughs have become more similar and remained stable over in recent years.
- **Low birth weight (2021) -** Barnet and Haringey have significantly lower rates of babies born at low birth weight compared to London, while all other boroughs were similar.
- **Premature births (2019/21) -** Enfield has significantly higher rates of premature births compared to London and was the third highest amongst London boroughs. In contrast, Barnet and Islington had lower rates compared to London.

Reduced inequalities in infant mortality

- **Infant mortality (2020/22) -** NCL has similar infant mortality rates compared to London.

Increased immunisation and newborn screening coverage

- **MMR vaccination (2022/23) -** NCL has some of the lowest rates of MMR vaccination uptake by age 2 (1 dose) in England, with all boroughs having significantly lower uptake compared to London. Within NCL, Camden and Enfield are particularly low. Completion of MMR vaccination by age 5 (2 doses) is also comparatively low, with one in three 5-year-olds not fully vaccinated for MMR in all boroughs but Barnet. Coverage for both vaccines remains lower than pre-COVID, a pattern common across London and England.
- **Vaccinations by age 5 (2023) -** Although there remain only 69% children in NCL who have been fully vaccinated by age 5, there has been a steady and marked improvement since 2018, when this stood at 54%. Improvement has been particularly noticeable across Camden, Enfield and Haringey during this time period.
- **Newborn hearing screening (2022/23) -** Newborn hearing screening coverage across all boroughs NCL is lower than London and England and lower than the national threshold of ≥ 98%. In fact, the five boroughs are amongst the worst six performers in London in 2022/23.

All children are supported to have good speech, language and communication skills

- **Communication and language by age 5 (2022/23) -** Whilst across NCL as a whole children's communication and language skills at the end of reception year are similar to the London and England averages, there is variation across boroughs with a higher proportion of children achieving the expected level in Barnet and Haringey, and a lower level in Enfield (where a quarter of children did not meet the expected level in 2022/23).

Children have improved oral health

- **Tooth decay (2021/22) -** More than one in four 5-year-olds in NCL have experience of visually obvious tooth decay, which is similar to London.

Start Well

North Central London Health and Care
Integrated Care System

Every child has the best start in life and no child is left behind (continued)

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

- **Low income families (2021/22) -** NCL has higher rates of children living in relative low income families compared to London. Rates are highest in Camden where nearly 1 in 5 children are living in relative low income families, shortly followed by Haringey and Islington. Barnet had the lowest proportion at 12%.

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

Early identification and proactive support for mental health conditions

- **Mental health access (2022/23) –** In 2022/23 , we fell short of our NCL target with nearly one third fewer children and young people aged 0-18 years receiving at least one contact from an NHS-funded mental health service compared to the target.
- **Self-harm (2021/22) -** Young people (aged 10-24 years) in Camden and Islington have higher rates of hospital admissions for self-harm compared to London, while the remaining NCL boroughs have similar rates. In 2021/22, Camden's self-harm rate was 50 percent higher than the rate in Enfield.

Reduced prevalence of children and young people who are overweight or obese

- **Overweight and obesity (2022/23) -** One in five reception children in NCL are overweight or obese, ranging from just under one in five (19%) in Barnet, to just under one in four in Enfield (23%). Rates in Enfield are the third highest amongst London boroughs.
- More than one in ten reception children in Enfield are obese, significantly higher than the London average. Camden, Haringey and Islington had similar levels to London. Although rates are better in Barnet, there are still more than one in 20 children in Reception who are obese (8%).
- While similar to London, just under two in five (38%) children in NCL leave primary school overweight or obese, rising to 43% in Enfield. Although rates are lower in Barnet and Camden, more than one in five Year 6 children are obese in these boroughs, rising to more than one in four in Enfield (28%). Obesity prevalence across NCL more than doubles from Reception to Year 6 highlighting opportunities to intervene during early years and primary school.
- **Physical activity (2022/23) -** While similar to London, fewer than half of children aged 5-16 years in all NCL boroughs aside from Camden are physically active. Just over half of children in Camden (54%) are physically active.

Improved outcomes for children with long term conditions

- **Admissions for long-term conditions (2021/22) –** Crude hospital admissions rates for young people (10-18 years) for asthma, diabetes and epilepsy in NCL are similar to London. There is variation across NCL, however, with higher rates in Islington for all conditions, and lower rates in Barnet for asthma and diabetes. Admission rates in 2021/22 for asthma in Islington were more than double rates in Haringey and Barnet and for diabetes, nearly triple rates in Haringey and Camden.

Live Well

North Central London Health and Care
Integrated Care System

Early identification and improved care for people with mental health conditions

Early identification and improved care for people with mental health conditions

- **Depression (2022/23) -** Depression incidence amongst people aged 18+ years is higher in Camden and Islington compared to the London average. Similar to London and England, rates in all NCL boroughs increased between 2020/21 and 2021/22, but have since returned to close to 2020/21 levels.
- **Common mental health disorders (2017) -** More than one in five people aged 16+ years in Haringey and Islington have common mental disorders (any type of depression or anxiety), higher than the London average. Rates of common mental disorders are lowest in Barnet (based on 2017 data, awaiting forthcoming Adult Psychiatric Morbidity Survey).
- **SMI care plans (2022/23) –** Three quarters (78%) of patients with severe mental health illness (SMI) in NCL have a comprehensive care plan, similar than the London average.
- **SMI premature mortality (2018/20) -** Premature mortality in adults with SMI is higher in Islington compared to the London average, and twice the rate in Barnet and nearly twice the rate in Enfield. The rate overall in NCL is similar to the London average.

Improved physical health in people with serious mental health conditions

- **SMI physical health check (2022/23) -** 62% of adults with SMI in NCL had a physical health check in the previous 12 months, although this has increased substantially compared to just 18% in 2020/21. Coverage decreased slightly between 2021/22 and 2022/23 in Haringey and Barnet, but increased in the other three boroughs, with coverage doubling in Enfield and Camden between the two years.

Reduced racial and social inequalities in mental health outcomes

- **Independent living (2021/22) -** The proportion of adults in contact with secondary mental health services living independently, with or without support varies considerably across NCL, from 16% in Camden to 39% in Enfield.

Reduced deaths by suicide

- **Suicide (2020/22) -** Camden's suicide rate amongst people aged 10+ years is the highest in NCL and significantly higher compared to London, although similar to England as a whole. Rates are comparatively lower in Barnet and Enfield.

Live Well

North Central London Health and Care
Integrated Care System

Reduced early deaths from cancer, cardiovascular disease and respiratory disease

Reduced prevalence of key risk factors: smoking, alcohol, obesity and physical activity

- **Smoking (2022/23) -** More NCL patients (aged 15+ years) smoke in NCL compared to London, with higher rates in Haringey (19%), Enfield and Islington. While rates are lower in Barnet and Camden, more than one in ten people aged over 15 years smoke. There has been a steady decline in smoking rates over the last three years across boroughs.
- **Smoking cessation support (2022/23) -** 97% of NCL GP patients who have certain conditions* and smoke were offered smoking cessation support and treatment in the last 12 months, with similar rates across each of our boroughs, and compared to London. NCL rates have increased since 2020/21 when only 73% patients had been offered support.
- **Alcohol admissions (2021/22) -** Admissions for alcohol-related conditions are higher in three of our boroughs (Islington, Haringey and Enfield) compared to London. Rates in Camden are similar, and in Barnet lower than London.
- **Overweight and obesity (2021/22) -** While adult overweight and obesity levels in NCL are similar to, or lower than, the London average, around one in two adults in Haringey, Camden and Islington are overweight or obese, rising to nearly 60% in Barnet and Enfield.
- **Physical activity (2021/22) -** While rates of physical activity are better or similar to London, only two thirds of adults in NCL are physically active.
- **Active travel (2022) -** There is a clear inner/outer borough pattern with active travel, with more than a third of adults in Islington, Haringey and Camden walking or cycling for travel at least three times per week, and around one in five in Barnet and Enfield.

Improved air quality

- **Air pollution (2021) and associated mortality (2022) -** The percentage of annual deaths from all causes attributable to air pollution in those aged 30 years and over in 2022 varied across NCL, with slightly higher rates in Camden and Islington and the lowest rates in Enfield. Concentrations of fine particular matter reduced in all boroughs between 2019 and 2021.
- There is correlation between the boroughs in NCL with higher concentrations of fine particulate matter and boroughs with a higher percentage of deaths attributable to air pollution.

*Conditions include any or any combination of: coronary heart disease, peripheral arterial disease (PAD), stroke or transient ischemic attack (TIA), hypertension, diabetes, chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD), asthma, schizophrenia, bipolar affective disorder or other psychoses.

Live Well

North Central London Health and Care
Integrated Care System

Reduced early deaths from cancer, cardiovascular disease and respiratory disease (continued)

Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease

Cancer

- **Bowel screening (2023) -** Bowel cancer screening uptake across NCL has increased from 49% in 2015 to 63% in 2023, with a noticeable increase across all boroughs since 2019, although there remains variation across NCL with screening rates in Camden, Haringey and Islington lower than the London average. For NCL as a whole, it is the cancer screening programme with the highest coverage, but still falls far short of full population coverage.
- **Breast screening (2023) -** Fewer than half of women in Camden and Islington were screened for breast cancer in 2023, while just over half (51%) were in Haringey, less than the London average. Whilst coverage in Barnet and Enfield is higher than the London average coverage is well below the England average (66%) and across all boroughs has not yet recovered from the decline during the pandemic.
- **Cervical screening (2023) -** Cervical cancer screening is lowest in Camden with fewer than half (45%) of 24-49 year olds and fewer than two-thirds (64%) of those aged 50-64 years taking up the offer. Rates are higher in all boroughs in those aged 50-64 years, and highest overall in Enfield. Across both age groups coverage has been on the downward trend in recent years, for the younger age group particularly since 2020, but starting earlier in the older age group, with a similar pattern across London and England.
- **Early diagnosis (2021) -** 58% of cancers in NCL are diagnosed at stages 1 or 2. This is higher compared to England (54%).
- **Emergency admissions (2022/23) -** The rate of emergency admissions with cancer is lower in NCL compared to London.
- **5-year survival (2016 diagnoses) -** 5-year survival from breast, lung and other cancers combined (excluding non-melanoma skin cancer and prostate cancer) in NCL is higher compared to the England average and has steadily increased from 52% of those diagnosed in 2010 to 58% of those diagnosed in 2016.
- **Premature mortality (2022) -** The premature (under 75 years) mortality rate from cancer in NCL is similar to London. Rates remain slightly higher in Islington, although rates in Islington have noticeably declined in recent years, and are no longer statistically significantly higher than London.

Live Well

North Central London Health and Care
Integrated Care System

Reduced early deaths from cancer, cardiovascular disease and respiratory disease (continued)

Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease

Diabetes, high blood pressure and cardiovascular disease

- **NHS health checks (2018/19 – 2022/23) –** Uptake of NHS Health Checks varies considerably across NCL, ranging from just under one in two of the eligible population in Islington receiving a check, and one in three in Camden, to fewer than one in 10 in Enfield. The impact of COVID on these cumulative three-year totals is still visible.
- **Diabetes 3 treatment targets (2022/23) –** Although higher than England, fewer than a third (31%) of patients with Type 1 diabetes and 43% of patients with Type 2 diabetes in NCL achieved all three treatment. Across all boroughs achievement rates are higher in patients with Type 2 compared to Type 1 Diabetes. Islington and Barnet were amongst the poorest performing boroughs in NCL for both indicators.
- **High blood pressure management (2022/23) –** 73% of patients with high blood pressure in NCL were treated to within the age-specific target range within the last 12 months, compared to the NHS national target of 77% (the target has since increased to 80%).*
- **Premature mortality (2022) –** Under 75 mortality from cardiovascular disease across all NCL boroughs is similar to London, except for Barnet which is lower.

Respiratory disease

- **Flu vaccination for people with chronic respiratory disease (2022/23) -** Only just over half of NCL patients (aged 6+ months) who have chronic respiratory disease, such as COPD, are vaccinated for flu, rising to 58% in Barnet
- **Emergency admissions (2019/20) -** Rates of emergency hospital admissions for COPD amongst people aged 35 years and over were higher in Islington compared to London, and lower in Barnet, Haringey and Enfield.
- **Premature mortality (2022) -** Under 75 mortality rate from respiratory disease is lower in Barnet compared to London, and similar in all other NCL boroughs

*80% target outlined in NHS Priorities and operational planning guidance 2024/25. Previous (2023/24) national target for was 77% by March 2024.

Live Well

North Central London Health and Care
Integrated Care System

Reduction in the impacts of the wider social, economic and environmental conditions and places in which people live, on people's health and wellbeing

Reduced unemployment and increase in people working in fulfilling employment

- **16-17 year olds NEET (2022/23) -** A lower proportion of 16-17 year olds in Barnet and Camden are not in education, employment or training (NEET) or have activity which is not known, compared to the London average, while rates in Enfield, Haringey and Islington are higher. Rates in Haringey have, however, significantly reduced in recent years (from 15% in 2018/19 to 5% in 2022/23).
- **Employment (2022/23) -** Around three quarters of the working age population aged 16 to 64 years in NCL are in employment, similar to London, rising to 83% in Islington.
- **Employment with physical/mental health condition (2022/23) -** A similar proportion of NCL's working age population who have a physical or mental long term health condition are in employment (65%), compared to London, with higher rates (80%) in Islington.
- **Employment with a learning disability (2021/22) -** In Enfield, Islington and Barnet, a higher percentage of the population aged 18 to 64 who are in receipt of long-term support for a learning disability are in paid employment compared to the London average (≥9%). By contrast the figure is just three percent in Haringey.
- **London living wage (2022) -** More than a third of employee jobs in Haringey have hourly pay below the living wage (34%) compared to only 6% in Camden and 7% in Islington. There has been an improvement across all boroughs since 2020, with the exception of Haringey where the proportion of low paid jobs has increased.
- **MSK conditions (2023) -** While similar or lower than the London average, more than one in ten (≥12%) people aged over 16 years across boroughs in NCL have a long-term musculoskeletal (MSK) problem.

People live in stable and healthy accommodation and are safer within the communities in which they live

- **Homelessness (2022/23) -** The rate of households in Haringey and Islington owed a duty under the Homelessness Reduction Act, is higher compared to the London average; with Haringey also having a higher rate of households in temporary accommodation (a rate double the NCL average).* Rates of homelessness (households owed a duty) increased significantly in Islington between 2021/22 and 2022/23.
- **Violent crime admissions (2018/19-2020/21) -** Rates of hospital admissions for violent crime are lower in Barnet, Camden, and Enfield compared to London, whereas rates in Islington and Haringey are similar.

* 2022/23 data was not available for Enfield

Age Well

North Central London Health and Care
Integrated Care System

People live as healthy, independent and fulfilling lives as possible as they age

People get timely, appropriate and integrated care when they need it and where they need it

- **GPs meeting patient needs (2023) -** Just under 90% of patients in NCL reported that their needs were met at their last GP appointment.
- **Adult social care user satisfaction (2021/22) -** 62% of older adult social care service users (aged 65+ years) in Islington are satisfied with care and support services, higher than the London average. Similar rates to London seen in other boroughs, ranging from 54% users in Barnet to 58% in Camden.
- **Avoidable admissions (2022/23) -** Rates of unplanned admissions for people aged 65+ years with certain long-term conditions*, such as diabetes, and high blood pressure, were highest in Islington and Enfield, with rates of 170 admissions and 166 admissions per 100,000 population, respectively. Avoidable admissions have increased across all our boroughs since 2020/21.
- **Delayed discharge (Q2 2023/24) -** On average by end of Quarter 2 2023/24, more than one in ten of NCL's hospital beds per week were occupied by patients who did not meet Criteria to Reside but were not discharged.
- **Long length of stay (2022/23) -** During 2022/23, 8% of patient discharges in NCL had a length of stay (LOS) of more than 21 days. The proportion of discharges with a LOS of 21+ days has increased across all our boroughs since 2020/21 and 2021/22.
- **Readmissions (2022/23) -** More than 90% of older people aged 65+ years in Enfield were still at home 91 days after discharge from hospital into reablement /rehabilitation services in 2022/23. By comparison, only half of patients in Haringey were still at home.
- **Discharge to usual place of residence (2022/23) -** 93% of NCL patients are discharged from hospital to their usual place of residence with similar rates across all our boroughs, and relatively constant trends over the last 2 years.
- **Support needs met by care home admission (2022/23) -** Rates of long-term support needs of older adults met by admission to council-funded residential and nursing care homes were highest in Camden, and lowest in Barnet.
- **End of life admissions (2022) -** One in 20 people aged 75+ years in NCL who died in 2022 had three or more admissions in their last 90 days of life, compared to 9% in 2019. This is lower than London.
- **Death in chosen place (2022/23) -** On average, two thirds of people in NCL who have universal care plans die in their chosen place of death each month (average of data from August 2022 to March 2023). However, this ranges from 58% in Haringey to 74% in Enfield, noting, however, that due to small numbers these data are likely to have a lot of variability.

*These include, for example diabetes, convulsions and epilepsy, COPD and asthma and high blood pressure

Age Well

North Central London Health and Care
Integrated Care System

People live as healthy, independent and fulfilling lives as possible as they age (continued)

Prevent development of frailty with active aging

- **Disability-free life expectancy at 65 (2018/20) -** Men and women aged 65 years across NCL as a whole are expected to live around another 10 years without a long lasting physical or mental health condition or disability that limits their ability to carry out day to day activities. This is similar to the London average. Men aged 65 years in Camden are expected to live to another 15 years without disability, higher than the London average.
- **Flu vaccination aged 65+ (2022/23) -** In three boroughs (Camden, Haringey and Islington) only two-thirds or fewer people aged 65+ years have been vaccinated for flu, lower than the London average. Only Barnet had higher rates (at 70%), with rates in Enfield and NCL as a whole similar to London (68%). Uptake was lower in 2022/23 compared to 2021/22 in all five boroughs.
- **Falls admissions (2021/22) -** Rates of emergency hospital admissions due to falls amongst those aged over 65 years are higher in Camden and Islington compared to the London average, and lower in Enfield and Haringey.

Earlier intervention and improved care for people with dementia

- **Dementia diagnosis (2023) -** Although rates across NCL were similar to London. Camden, Haringey and Barnet did not meet the 66.7% national benchmark for dementia diagnoses.
- **Dementia care plan (2022/23) -** Just under four in five (79%) patients with dementia in NCL have a dementia care plan that has been reviewed face to face in the last 12 months, which is similar to the proportion in London (78%). Borough figures vary from 76% in Enfield to 82% in Camden.

*National ambition for dementia, for at least two thirds (66.7%) of people with dementia to have received a formal diagnosis, was put in place in 2015.

Age Well

North Central London Health and Care
Integrated Care System

People remain connected and thriving in their local communities as they age

People have meaningful and fulfilling lives as they age

- **Carers quality of life (2021/22) -** The average quality of life score for carers in NCL was 7 out of 12, which was comparable to London.
- **Loneliness (2021/22) -** More than 70% of adults in all our boroughs reported feeling lonely never, rarely or just some of the time in 2021/22, with the best rates in Barnet (77%). Rates are similar across boroughs in 2021/22 compared to 2020/21.
- **Social contact for adult social care users (2022/23) -** Just over a quarter (27%) of older people (aged 65+ years) who use adult social care services in Islington reported that they have has much social contact as they would like, less than the NCL and London averages (36%). All other boroughs were similar to London, rising to 43% in Haringey.
- **Adult social care users control over daily life (2022/23) -** A similar proportion of older people who use adult social care services in NCL report having control over their daily life compared to London, but rates vary across boroughs – with around 63% of older people in Barnet and Camden reporting having control over their daily life, compared to 77% in Islington (a 14% difference).
- **Quality of life for adult social care users (2022/23) –** The average quality of life reported by older people (aged 65+ years) who use adult social care services across NCL was 18 out of 24, comparable to London.

Older people are informed well and can easily access support for managing financial hardship (including fuel poverty) as they age

- **Accessible information for adult social care users (2022/23) -** Around two-thirds of older people (aged 65+ years) in NCL who use adult social care services report finding it easy to find information about support, higher than London, with borough figures ranging from 61% in Barnet to 69% in Islington.
- **Fuel poverty (2021) -** 12% of households in NCL were in fuel poverty in 2021, ranging from 10% households in Islington to 16% of households in Haringey.

North Central London Health and Care
Integrated Care System

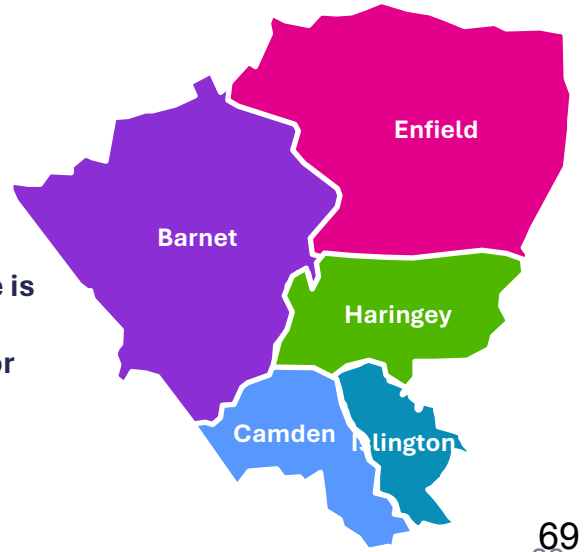
Section 3: Borough insights

Borough summaries

North Central London Health and Care
Integrated Care System

Whereas the last section of the report provided a whole-system focus, this section has a borough focus and highlights indicators where there are potential opportunities for population health improvement within each of our five boroughs (Barnet, Camden, Enfield, Haringey and Islington).

- The focus of this section is to draw attention to indicators where individual boroughs are performing worse than their peers and/or performance appears to be getting worse
- It overlooks the many areas where individual boroughs are doing better than their peers - other sections of this report draw attention to some of these and these can also be seen in the many indicators RAG-rated green in the full data tables in Section 5.
- These borough summaries are intended to signal areas which may warrant further investigation, in the context of what is known about each borough's population and work currently being delivered/current priorities. Within this, for example, as signalled in the executive summary and in Section 4, it is important to note within this that due to the reporting lag for some indicators, more recent work to drive improvement may not yet be reflected in the data
- In this section, indicators of note for each borough have been mapped to delivery areas of the NCL PH&IC Strategy, across the life course. As the insights are tailored to each borough's performance, individual boroughs may not have indicators in the same boxes as other boroughs, but they may include:
    - Our five population health risk areas, including Childhood immunisations, Cancer, Lung Health, Heart Health and Mental Health and Wellbeing at all ages
    - Common risk factors, including smoking and overweight/obesity
    - Health and care, including access, experience and integration
    - Wider determinants, for example loneliness and housing
    - Other including, newborn hearing screening.
- **Indicators have been selected where:**
    - **Boroughs are RAG-rated worse (red) compared to London in the latest time period**
    - **Boroughs are RAG-rated similar (amber) or better (green) compared to London in the latest time period but performance is getting worse**
    - **The indicator was not RAG-rated but the difference in performance is visually substantially different from London and/or other NCL boroughs and/or the NCL average (an assumed difference, not tested by statistical significance)**
- *Please note for space abbreviated titles for the indicators have been used.*



Refer to Section 4 for further technical guidance.

Barnet

North Central London Health and Care
Integrated Care System

	Vision		
PH&IC Strategy delivery area	Start well	Live well	Age well
Our five population health risk areas	**MMR vaccine uptake (22/23)** – worse than London	**SMI health checks (22/23)** – worse than NCL peers **Cervical cancer screening (2023)** – worse than London **NHS Health Check uptake (2018/19-22/23)** – worse than London **Type 1 diabetes treatment (22/23)** – similar to NCL peers, but getting worse	
Common risk factors	**Smoking at delivery (22/23)** – worse than London	**Active travel (2022)** – worse than London	
Health and care – access, experience and integration			**Length of stay 21+days (22/23)** – similar to NCL peers, but getting worse **Avoidable admissions (22/23)** – similar to NCL peers, but getting worse **Older adult social care users who have control over their daily lives (22/23)** – worse than London, and getting worse **Older adult social care users who find it easy to get information about support (22/23)** – worse than London, and getting worse
Wider determinants		**Jobs paid below the London Living Wage (2022)** – worse than London, but getting better	
Other	**Newborn hearing screening (22/23)** – worse than London		

*

Camden

North Central London Health and Care
Integrated Care System

	Vision		
	Inequality in life expectancy for men and women (2018/20) - worse than London		
Strategy delivery area	**Start well**	**Live well**	**Age well**
Our five population health risk areas	**MMR vaccine uptake (22/23)** – worse than London **Hospital admissions for self-harm (21/22)** - worse than London	**Suicide rate (20/22)** – worse than London **Depression incidence (22/23)** – worse than London **Bowel cancer screening (2023)** – worse than London, but getting better **Breast cancer screening (2023)** – worse than London **Cervical cancer screening (2023)** – worse than London	**Flu vaccine uptake (22/23)** – worse than London, and getting worse
Common risk factors			
Health and care – access, experience and integration			**Avoidable admissions (22/23)** – better than NCL peers, but getting worse **Length of stay 21+days (22/23)** – similar to NCL peers, but getting worse **Long-term support needs met by care home admissions (22/23) –** worse than London and getting worse **Emergency falls admissions amongst older people (21/22)** – worse than London **Older adult social care users who have control over their daily lives (22/23)** – worse than London, and getting worse
Wider determinants	**Children in low-income families (21/22)** – worse than London	**Air pollution (2021)** - worse than London **Mortality due to air pollution (2022)** –- worse than London **People with mental health conditions living independently (21/22)** - worse than London	
Other	**Newborn hearing screening (22/23)** - worse than London		

Enfield

North Central London Health and Care
Integrated Care System

	Vision		
	Inequality in life expectancy for women - worse than London, and getting worse		
Strategy delivery area	**Start well**	**Live well**	**Age well**
Our five population health risk areas	**MMR vaccine uptake (22/23)** – worse than London **Children fully vaccinated by age 5 (2023)** – worse than NCL peers, but getting better	**Cervical cancer screening (2023)** – better than London, but getting worse **NHS Health Check uptake (2018/19-22/23)** – worse than London, and getting worse **Treatment targets for Type 1 Diabetes (22/23) –** similar to NCL peers, but getting worse	
Common risk factors	**Smoking at delivery (22/23)**- worse than London **Childhood overweight and obesity (22/23)** - worse than London	**Smoking prevalence (22/23) –** worse than London, but getting better **Alcohol-related hospital admissions (21/22) -** worse than London **Active travel (2022)** – worse than London	
Health and care – access, experience and integration			**Avoidable admissions (22/23)** – worse than NCL peers, and getting worse **Length of stay 21+days (22/23)** – similar to NCL peers, but getting worse
Wider determinants	**Reception children's language and communication skills (22/23)** – worse than London	**16- and 17-year-olds NEET (22/23)** – worse than London **Jobs below the London Living Wage (2022)** – worse than London, but getting better	**Adults reporting loneliness (21/22) –** worse than London **Fuel poverty (2021)**– worse than London
Other	**Premature births (19/21)** - worse than London, but getting better **Newborn hearing screening (22/23)** - worse than London		

Haringey

North Central London Health and Care
Integrated Care System

Strategy delivery area	Start well	Live well	Age well
Vision	**Men's life expectancy -** worse than London		
Our five population health risk areas	**MMR vaccine uptake (22/23)** – worse than London	**Prevalence of common mental health disorders (2017)** –- worse than London **Bowel cancer screening (2023)** – worse than London, but getting better **Breast cancer screening (2023)** – worse than London, and getting worse **Cervical cancer screening (2023) -** better /similar* to London but getting worse **NHS Health Check uptake (2018/19-22/23)** – worse than London, and getting worse **Treatment targets for Type 1 Diabetes (22/23) –** similar to NCL peers, but getting worse **Flu vaccine uptake amongst those with chronic respiratory conditions (22/23)** – worse than NCL peers	**Flu vaccine uptake (65+) (22/23)** - worse than London, and getting worse
Common risk factors	**Smoking at delivery (22/23)** - worse than London	**Smoking prevalence (22/23) –** worse than London, but getting better **Alcohol-related hospital admissions (21/22) -** worse than London	
Health and care – access, experience and integration			**Avoidable admissions (22/23)** – similar to NCL peers, but getting worse **Length of stay 21+days (22/23)** – worse than NCL peers, and getting worse **Readmission of older people within 91 days (22/23)** – worse than London
Wider determinants	**Children in low-income families (21/22)** – worse than London	**16- and 17-year-olds NEET (22/23)** – worse than London, but getting better **Adults with a learning disability in employment (21/22)** – worse than London **Jobs below the London Living Wage (2022)** – worse than London, and getting worse **Homelessness (households owed a duty) (22/23) -** worse than London **Temporary accommodation (22/23)** - worse than London	**Adults reporting loneliness (21/22) –** worse than London **Social contact for older adult social care users (22/23) –** worse than London **Fuel poverty (2021)**– worse than London
Other	**Newborn hearing screening (22/23)** - worse than London		

*Cervical screening for 25-49 year olds better but for 50-64 year olds similar to London

Islington

North Central London Health and Care
Integrated Care System

	Vision		
	Life expectancy for men and women – worse than London		
Strategy delivery area	**Start well**	**Live well**	**Age well**
Our five population health risk areas	**MMR vaccine uptake (22/23)** – worse than London **Children fully vaccinated by age 5 (2023)** – worse than NCL peers **Hospital admissions self-harm (21/22)** – worse than London **Admissions for asthma (21/22) –** worse than London **Admissions for diabetes (21/22) –** worse than London **Admissions for epilepsy (21/22) -** worse than London	**Prevalence of common mental health disorders (2017)** -– worse than London **Premature morality for adults with SMI (18/20)** – worse than London **Bowel cancer screening (2023)** – worse than London, but getting better **Breast cancer screening (2023)** – worse than London, and getting worse **Cervical cancer screening (2023)** – similar/worse than London, and getting worse **NHS Health Check uptake (2018/19-22/23)** – better than London, but getting worse **Emergency admissions for COPD (19/20) -** worse than London	**Flu vaccine uptake (65+ years) (22/23)** - worse than London
Common risk factors	**Smoking at delivery (22/23)** - worse than London	**Smoking prevalence (22/23) –** worse than London, but getting better **Alcohol-related hospital admissions (21/22) -** worse than London	
Health and care – access, experience and integration			**Avoidable admissions (22/23)**– worse than peers, and getting worse **Length of day 21+ days (22/23)** – similar to NCL peers, but getting worse **Emergency falls admissions amongst older people (21/22) -** worse than London
Wider determinants	**Children in low-income families (21/22)** – worse than London	**Air pollution (2021) –** worse than London, but getting better **Mortality due to pollution (2022) –** worse than London **16- and 17-year-olds NEET (22/23)** – worse than London **People with mental health conditions living independently (21/22)** - worse than London **Homelessness (households owed a duty) (22/23) –** worse than London, and getting worse **Temporary accommodation (22/23)** - better than London, but getting worse	**Social contact for older adult social care users (22/23) -** worse than London
Other	**Newborn hearing screening (22/23)** - worse than London		

North Central London Health and Care
Integrated Care System

Section 4: Guidance and technical notes

Guidance and technical notes

North Central London Health and Care
Integrated Care System

Dates covered by the report and monitoring progress since the creation of the Integrated Care System (ICS)

- Whereas the latest available data* is provided in this report, there is some delay in reporting data for some indicators. Whereas there is data in the dashboard from 2022 or more recent for two-thirds of metrics, some metrics are not yet showing performance since the creation of the NCL ICS (1 July 2022) to establish a baseline position.
- In this report time trends have been reviewed (where historic data is available) and noticeable patterns reported, using data from the last few reporting periods for that indicator. Over time more metrics will have historic data and, as such, tracking progress across indicators since the creation of the ICS is more likely to be possible from 2024/25.

RAG-rating

- Within the NCL Outcomes Framework dashboard (reproduced in the tables in Section 5), where possible, indicator values are colour-coded to enable a quick visual interpretation. Colours red, amber and green (RAG-rating) show if a measure for an area is statistically worse (red) or better (green) than the London benchmark** or if it is similar (amber). For some indicators high figures are good (e.g. cancer screening coverage), and for others low figures are good (e.g. premature mortality).

- The RAG-rating is intended to support benchmarking of indicators. Focus on the RAG-rating should not be at the expense of reviewing the performance itself – i.e. all areas may have poor performance and even though for some indicators performance in NCL is no worse than London, performance may still need to be optimised to ensure we are doing all we can to improve population health in that area. Obesity is a good example of this.
- **It has not been possible to RAG-rate all indicators,** which is particularly noticeable for the 'Age Well' outcomes and for many of these indicators we do not have any data to tell if there is any statistical significance in any difference between boroughs. For indicators where we have confidence intervals/RAG-rated indicators we refer in the report to outliers being statistically significantly/significantly different to either other boroughs or London. For indicators where there are no confidence intervals, in order to draw out some insights, we have made some assumptions about variation based on where numbers are visually substantially different from each other, given the size of the cohort. This is not based on statistical significance and as such it is important to take these interpretations with a degree of caution.

* The data in this report reflects the latest data in the online dashboard at the time the report was produced, which was inputted in February 2024. At the time of the publication of this insights reports more up to date data on a few of the indicators may be available.
**London was chosen as the comparator as it is a recognised benchmark and NCL values were available for fewer metrics to use instead.

Guidance and technical notes

North Central London Health and Care
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Statistical significance and confidence intervals

- **Statistical significance** – in places the report refers to one data point being 'significantly' different to another. This is a reference to statistical significance. For the purpose of this report (and in the dashboard itself) statistical significance is taken to mean that the observed difference between the data points is unlikely to be due to random chance and has a degree of certainty. This has been concluded using the confidence intervals for each value - where the confidence intervals do not overlap, the difference is said to be significantly or statistically significantly different.
- For the RAG-rating, the methodology for determining significance is as follows:
  - **Higher -** the lower confidence interval value for an area does not overlap with, and is greater than, the upper confidence interval value for London
  - **Similar** – the upper or lower confidence interval value for an area overlaps with the upper or lower confidence interval value for London
  - **Lower –** the upper confidence interval value for an area does not overlap, and is less than, the lower confidence interval for London
- **Confidence intervals** – this is a statistical term describing the precision of statistical estimate or value. It describes a range within which a number (like an average) lies for the whole population, based on a sample of data. By comparing the 95% confidence intervals around estimates or a target we can say whether statistically there are differences or not in the estimates we are observing.

NCL average and borough figures

- For some indicators, where there was not an NCL value readily available, NCL specific values have been derived from averaging data from the five NCL boroughs. This was only done if there were data available for four or more of the boroughs. These are indicated in the data tables in the Section 5 by an asterix *.
- The data is presented here at borough and NCL level (where available). It is important to recognise, however, that there can also be a lot of variation within a place, which may be masked by the average.

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Integrated Care System

Section 5: Data tables – the latest data for the full set of outcome indicators

Vision

North Central London Health and Care
Integrated Care System

Domain	Outcome	OF ID	Indicator Name	Unit	Period	Barnet	Camden	Enfield	Haringey	Islington	NCL	London	England
Vision	We want our population to live better, healthier and longer, fulfilling their full potential over the course of their entire life, reducing inequalities and the gap in healthy life expectancy	1a	Life expectancy at birth (men) - 3 year*	Years	2020 - 22	80.8	79.2	79.3	78.5	78.0	79.1	79.1	78.9
		1b	Life expectancy at birth (women) - 3 year*	Years	2020 - 22	84.9	84.5	84.1	84.0	82.6	83.8	83.6	82.8
		2a	Healthy life expectancy at birth (men) - 3 year*	Years	2018 - 20	62.9	64.6	64.3	62.6	63.0	63.5	63.8	63.1
		2b	Healthy life expectancy at birth (women) - 3 year*	Years	2018 - 20	67.1	66.8	62.0	65.0	63.8	64.8	65.0	63.9
		3a	Inequality in life expectancy at birth (men) - 3 year*	Years	2018 - 20	6.7	13.5	7.4	8.1	11.3	9.2	7.5	9.7
		3b	Inequality in life expectancy at birth (women) - 3 year*	Years	2018 - 20	5.7	9.6	7.2	4.2	5.0	6.4	5.4	7.9

Statistically significantly better compared to London | Statistically similar compared to London | Statistically significantly worse compared to London

Start Well

North Central London Health and Care
Integrated Care System

Domain	Outcome	OF ID	Indicator Name	Unit	Period	Barnet	Camden	Enfield	Haringey	Islington	NCL	London	England
Start Well	Every child has the best start in life and no child is left behind	4	Proportion of women recorded as smokers at time of delivery	%	2022/23	5.5	5.4	5.4	5.4	5.5	5.8	4.6	8.8
		5	Rate of babies born at term with low birth weight*	%	2021	2.7	3.3	3.5	2.6	3.1	3.0	3.3	2.8
		6	Rate of premature births (less than 37 weeks gestation)*	per 1,000	2019 - 21	67.6	70.7	84.8	77.2	66.9	74.3	75.2	77.9
		7	Infant mortality rate (<1 yr)*	per 1,000	2020 - 22	3.0	3.8	3.9	2.9	2.4	3.4	3.6	4.0
		8a	Percentage coverage of 1 dose of MMR vaccination by age 2	%	2022/23	80.6	75.0	75.3	76.7	78.2	77.5	82.4	89.3
		8b	Percentage coverage of 2 doses of MMR vaccination by age 5	%	2022/23	70.6	63.6	64.8	65.9	66.3	66.8	74.0	84.5
		9	Percentage of children fully vaccinated by age 5	%	2023	72.5	68.6	65.9	70.2	66.4	69.2		
		10	Newborn hearing screening coverage*	%	2022/23	97.9	96.5	97.1	97.4	97.3	97.6	98.6	98.5
		11	Percentage of children achieving at least the expected level in communication and language skills at the end of reception*	%	2022/23	81.7	79.6	75.0	81.1	79.4	79.4	79.2	79.7
		12	Percentage of 5 year olds with experience of visually obvious tooth decay*	%	2021/22	30.2	31.8	28.8	27.5	24.7	27.5	25.8	23.7
		13	Proportion of children living in relative low income families (under 16 yrs)*	%	2021/22	11.9	19.8	15.6	18.0	18.5	17.2	16.4	19.9

Start Well

North Central London Health and Care
Integrated Care System

Domain	Outcome	OF ID	Indicator Name	Unit	Period	Barnet	Camden	Enfield	Haringey	Islington	NCL	London	England
Start Well	All children and young people are supported to have good mental and physical health	14	Proportion of 0-18 year olds receiving at least one contact from an NHS-funded mental health service against target	%	2022/23						69.9		
		15	Hospital admission rate for self harm (10-24 yrs)*	per 100,000	2021/22	254.6	317.0	210.0	220.5	288.6	278.2	229.7	427.3
		16a	Prevalence of overweight (including obesity) in reception children*	%	2022/23	18.7	19.1	23.1	19.7	21.6	20.5	20.0	21.3
		16b	Prevalence of obesity (including severe obesity) in reception children*	%	2022/23	7.7	8.7	10.8	9.5	9.1	9.2	9.3	9.2
		17a	Prevalence of overweight (including obesity) in year 6 children*	%	2022/23	34.2	36.0	42.9	38.6	38.1	37.9	38.8	36.6
		17b	Prevalence of obesity (including severe obesity) in year 6 children*	%	2022/23	21.2	22.3	28.0	24.4	23.4	23.8	24.8	22.7
		18	Percentage of physically active children and young people (5-16yrs)*	%	2022/23	43.0	54.4	43.2	42.1	39.0	44.9	45.7	47.0
		19	Crude rate of hospital admissions for asthma for young people (10-18 yrs)*	per 100,000	2021/22	67.4	129.3	117.5	72.5	170.1	107.5	108.3	87.6
		20	Crude rate of hospital admissions for diabetes for young people (10-18 yrs)*	per 100,000	2021/22	44.9	51.7	70.5	54.4	141.7	72.8	66.1	80.4
		21	Crude rate of hospital admissions for epilepsy for young people (10-18 yrs)*	per 100,000	2021/22	56.2	51.7	35.2	54.4	85.0	55.7	51.2	56.4

Live Well

North Central London Health and Care
Integrated Care System

Domain	Outcome	OF ID	Indicator Name	Unit	Period	Barnet	Camden	Enfield	Haringey	Islington	NCL	London	England
Live Well	Early identification and improved care for people with mental health conditions	22	Depression incidence (18+ years)	%	2022/23	1.2	1.7	1.2	1.2	1.6	1.3	1.1	1.4
		23	Estimated prevalence of common mental disorders (16+ yrs)	%	2017	16.2	19.4	19.2	22.3	22.7	19.4	19.3	16.9
		24	Proportion of patients with severe mental health issues having a comprehensive care plan	%	2022/23	78.8	80.0	80.8	78.1	71.0	77.8	77.1	68.5
		25	Premature mortality rate in adults with severe mental illness (18-74 yrs)*	per 100,000	2018 - 20	68.5	112.5	78.2	101.2	145.2	101.7	102.5	103.6
		26	Percentage of people with severe mental illness who had a health check in the previous 12 months	%	2022/23	55.8	62.8	69.7	62.8	60.0	62.1		
		27	Proportion of adults in contact with secondary mental health services living independently, with or without support*	per 100,000	2021/22	19.0	16.0	39.0	27.0	17.0	23.6	21.0	26.0
		28	Suicide rate (10+ yrs)	per 100,000	2020 - 22	4.2	10.6	4.9	5.2	9.7	7.4	6.9	10.3
	Reduced early death from cancer, cardiovascular disease and respiratory disease	29	Smoking prevalence (15+ yrs)	%	2022/23	12.4	13.7	16.2	18.8	16.2	15.4	14.2	14.7
		30	Proportion of patients in primary care with certain conditions offered smoking cessation support and treatment in the last 12 months	%	2022/23	97.4	96.1	96.4	96.6	96.3	96.6	95.7	94.1
		31	Standardised rate of hospital admission for alcohol-related conditions*	per 100,000	2021/22	335.7	447.3	452.7	463.4	542.7	451.6	425.2	494.0
		32	Percentage of adults classified as overweight or obese (18+ yrs)*	%	2021/22	57.5	50.1	59.7	49.0	51.0	55.3	55.9	63.8
		33	Percentage of physically active adults (19+ yrs)*	%	2021/22	66.1	72.4	62.7	68.3	71.8	67.9	66.8	67.3

Live Well

North Central London Health and Care
Integrated Care System

Domain	Outcome	OF ID	Indicator Name	Unit	Period	Barnet	Camden	Enfield	Haringey	Islington	NCL	London	England
Live Well	Reduced early death from cancer, cardiovascular disease and respiratory disease	34	Percentage of adults who walk or cycle for travel at least 3 times per week*	%	2022	24.0	34.7	22.0	36.0	36.8	30.7	30.7	19.6
		35	Fraction of mortality attributable to air pollution*	%	2022	7.2	7.7	7.1	7.4	7.9	7.2	7.1	5.8
		36	Fine particulate matter (concentrations of total PM2.5)*	µg/m3	2021	8.6	9.2	8.5	8.9	9.4	8.7	8.7	7.4
		37	Cancer screening coverage - bowel cancer (60-74 yrs)	%	2023	65.2	59.0	65.4	60.5	61.1	62.9	63.5	72.0
		38	Cancer screening coverage - breast cancer (53-70 yrs)	%	2023	58.4	45.8	60.3	51.4	45.9	54.0	55.8	66.2
		39a	Cancer screening coverage - cervical cancer (25-49 yrs)	%	2023	57.3	45.4	62.5	58.3	51.3	55.1	58.0	65.8
		39b	Cancer screening coverage - cervical cancer (50-64 yrs)	%	2023	69.7	64.0	73.1	70.6	69.7	69.9	70.7	74.4
		40	Percentage of staged cancers diagnosed at stages 1 & 2 (unadjusted, by diagnosis year)	per 100,000	2021						57.8		54.4
		41	Crude rate of emergency admissions with cancer	per 100,000	2022/23						249.3	304.5	420.8
		42	5-year survival from breast, bowel, lung and other cancers (excluding non-melanoma skin cancer and prostate cancer) by calendar year of diagnosis	%	2016						57.8		55.7
		43	Under 75 mortality rate from cancer*	per 100,000	2022	103.5	107.2	112.7	118.8	125.6	114.2	109.2	122.4
		44	Cumulative percentage of the eligible population aged 40 to 74 years who received an NHS Health check	%	2018/19 - 22/23	27.2	36.3	7.8	11.0	47.0	27.2	34.1	27.4

Live Well

North Central London Health and Care
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Domain	Outcome	OF ID	Indicator Name	Unit	Period	Barnet	Camden	Enfield	Haringey	Islington	NCL	London	England
Live Well	Reduced early death from cancer, cardiovascular disease and respiratory disease	45a	Percentage of patients with Type 1 Diabetes who achieved all three treatment targets	%	2022/23	31.1	41.7	32.9	35.8	32.7	31.4		23.9
		45b	Percentage of patients with Type 2 Diabetes who achieved all three treatment targets	%	2022/23	40.6	45.5	47.1	40.7	36.8	42.6		37.9
		46	Proportion of patients with hypertension, treated to age-specific blood pressure target in last 12 months	%	2022/23	70.3	75.1	74.3	73.4	71.8	72.7	69.6	68.6
		47	Under 75 mortality rate from all cardiovascular diseases*	per 100,000	2022	61.5	66.6	71.7	86.1	81.0	74.2	75.0	77.8
		48	Percentage uptake of flu vaccine in patients (aged 6 months+) with chronic respiratory disease	%	2022/23	58.3	51.6	52.5	50.3	50.5	52.9		
		49	Rate of emergency hospital admissions for COPD (35+ yrs)	per 100,000	2019/20	190.1	348.7	267.7	265.6	531.0	339.4	357.8	415.1
		50	Under 75 mortality rate from respiratory disease*	per 100,000	2022	16.8	31.4	22.0	25.1	29.6	26.0	26.1	30.7
	Reduction in the impacts of the wider social, economic and environmental conditions and places in which people live, on people's health and wellbeing	51	Percentage of 16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known*	%	2022/23	0.9	2.5	5.7	4.8	4.5	3.9	3.4	5.2
		52	Percentage of working age population in employment (16-64 yrs)*	%	2022/23	71.4	71.4	72.3	75.9	82.6	75.0	75.8	75.7
		53	Percentage of the population with a physical or mental long-term health condition in employment (16-64 yrs)*	%	2022/23	55.9	59.6	65.4	64.1	80.0	65.1	65.6	65.3
		54	Proportion of working age adults who are in receipt of long term support for a learning disability in paid employment (18-64 yrs)*	%	2021/22	8.9	3.1	14.7	2.5	9.2	6.9	5.2	4.8

Live Well

North Central London Health and Care
Integrated Care System

Domain	Outcome	OF ID	Indicator Name	Unit	Period	Barnet	Camden	Enfield	Haringey	Islington	NCL	London	England
Live Well	Reduction in the impacts of the wider social, economic and environmental conditions and places in which people live, on people's health and wellbeing	55	Proportion of employee jobs with hourly pay below the London Living London wage	%	2022	22.6	6.2	25.0	34.2	7.2		13.6	12.5
		56	Percentage population reporting a long-term Musculoskeletal (MSK) problem (16+ yrs)*	%	2023	13.7	12.0	13.8	13.5	14.0	14.1	13.4	18.4
		57	Households owed a duty under the Homelessness Reduction Act (rate)*	per 1,000	2022/23	14.1	6.6		20.2	21.9	15.2	15.7	12.4
		58	Households in temporary accommodation (rate)*	per 1,000	2022/23	13.1	4.8		22.7	8.6	11.6	15.9	4.2
		59	Rate of hospital admissions for violent crime*	per 1,000	2018/19 - 20/21	31.4	33.3	38.1	47.1	47.4	40.5	44.3	41.9

Age Well

North Central London Health and Care
Integrated Care System

Domain	Outcome	OF ID	Indicator Name	Unit	Period	Barnet	Camden	Enfield	Haringey	Islington	NCL	London	England
Age Well	People live as healthy, independent and fulfilling lives as long as possible as they age	60	Percentage of patients who say their needs were met at their last GP appointment	%	2023	92.3	93.4	91.9	92.2	89.9	89.3		91.0
		61	Percentage of adult social care service users satisfied with care and support services (65+ yrs)*	%	2021/22	53.7	57.9	57.7	55.0	62.4	57.6	54.9	61.8
		62	Rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions for those aged 65+ years (avoidable admissions)	per 100,000	2022/23	123.7	112.9	165.5	152.6	170.2	138.0		
		63	Percentage of hospital bed base occupied by patients who do not meet the criteria to reside and were not discharged (weekly average)	%	2023/24 YTD						12.1	11.5	
		64	Percentage of patient discharges with a length of stay of 21+ days	%	2022/23	6.9	6.9	7.7	8.5	8.5	7.6		
		65	Proportion of older people (aged 65+ yrs) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services*	%	2022/23	88.3	85.6	91.3	50.5	81.2	79.4	86.2	82.3
		66	Percentage of patient discharges from hospital to usual place of residence	%	2022/23	92.0	92.8	92.3	93.0	92.9	92.5		
		67	Long-term support needs of older adults (aged 65+ yrs) met by admission to residential and nursing care homes, per 100,000 population*	per 100,000	2022/23	380.2	668.3	490.1	407.7	435.3	481.4	433.1	560.8
		68	Percentage of deaths with three or more emergency admissions in the last three months of life (aged 75+ yrs)	%	2022						4.8	6.2	5.1
		69	Percentage of people with universal care plans who died in their chosen place of death (monthly average)	%	2022/23	68.5	67.0	74.1	58.2	67.9	67.9	67.1	

Age Well

North Central London Health and Care
Integrated Care System

Domain	Outcome	OF ID	Indicator Name	Unit	Period	Barnet	Camden	Enfield	Haringey	Islington	NCL	London	England
		70a	Disability-free life expectancy at 65 (Men)*	Years	2018 - 20	9.1	15.5	8.8	12.3	9.2	10.7	10.2	9.9
		70b	Disability-free life expectancy at 65 (Women)*	Years	2018 - 20	10.0	12.5	11.7	8.5	10.4	10.4	10.3	9.8
		71	Flu vaccination coverage (aged 65+)*	%	2022/23	70.0	66.9	68.0	61.3	65.1	68.5	68.3	79.9
		72	Rate of emergency hospital admissions due to falls (aged 65+ yrs)*	per 100,000	2021/22	2,217.9	2,484.1	1,595.4	1,857.4	2,619.5	2,151.7	2,187.5	2,099.9
		73	Estimated dementia diagnosis rate (65+ yrs)	per 100,000	2023	61.8	49.8	66.8	60.0	73.6	66.3	65.6	63.0
		74	Percentage of patients with dementia whose care plan has been reviewed face to face in the last 12 months	%	2022/23	78.1	82.3	75.6	80.5	76.0	78.5	77.7	73.6
	People are connected and thriving in their local communities as they age	75	Carer-reported quality of life score*	Score out of 12	2021/22	6.6	6.8	7.4	6.7	7.1	6.9	7.1	7.3
		76	Percentage of adults who report feeling lonely never, rarely or just occasionally*	%	2021/22	77.3	73.5	70.2	70.8	71.9	72.7	73.3	75.2
		77	Proportion of older people who use adult social care services who reported that they had as much social contact as they would like (65+ yrs)*	%	2022/23	32.5	38.6	37.6	43.1	27.0	35.8	35.7	41.5
		78	Proportion of older people who use adult social care services who have control over their daily life (65+ yrs)*	%	2022/23	62.6	62.8	68.8	71.9	76.7	68.6	66.6	73.7
		79	Social care-related quality of life score (65+ yrs)*	Score out of 24	2022/23	17.6	17.7	18.4	18.0	18.5	18.0	17.8	18.6
		80	Proportion of older people who use adult social care services who find it easy to find information about support (65+ yrs)*	%	2022/23	60.9	68.3	66.7	66.3	68.8	66.2	63.8	68.6
		81	Percentage of households in fuel poverty*	%	2021	11.5	11.2	13.8	15.5	10.0	12.4	11.9	13.1

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
12 November 2024

Report Title	Recovering Primary Care Access: Autumn 2024 update	**Date of report**	24 October 2024	**Agenda Item**	2.2
Lead Director / Manager	Sarah McIlwaine, Director of Primary Care	**Email / Tel**		Sarah.mcilwaine@nhs.net	
Board Member Sponsor	Sarah McDonnell-Davies, Executive Director of Place				
Report Author	Rebecca Kingsnorth, Adam Backhouse	**Email / Tel**		rebeccakingsnorth@nhs.net	
Name of Authorising Finance Lead	Sarah Rothenberg, Director of Finance, Primary Care	**Summary of Financial Implications** Three sources of national funding support delivery: • System Development Funding (held by the ICB) • PCN Capacity and Access funding (administered by NHSE and the ICB jointly) • Practice Transition and Transformation funding (administered by the ICB) Investment of each line is on track against plan.			
Report Summary	The ICB is 18-months into a programme to deliver the requirements of the National Delivery Plan for Recovering Primary Care Access. Activity in general practice has increased year on year since the pandemic and this plan is focused on improving patient experience of access to General Practice. The key intervention at Practice level is the implementation of the *Modern General Practice* operating model (described in the paper). Work is also required to support patient direct access to wider services (for example Community Pharmacy and Community Services) and to reduce workload for practices by smoothing the interface with other parts of the NHS. Our work to improve access for patients whilst addressing workload in General Practice started before – and will continue beyond – this programme. In NCL General Practice delivers an average of 680,000 appointments, 100,000 online consultations and 30,000 out-of-hours appointments monthly. This represents ~800,000 documented patient contacts a month, or 90% of all patient contacts with the NHS. General Practice is focused on access but also – in the context of the ICS Population Health Strategy - proactivity and prevention. This programme has interdependencies with other key programmes being run by the Primary Care team in NCL, including implementation of our long term conditions model, delivery of our screening and vaccination programmes and our work to look at the gap				

	between demand and resource through the *NHSE Test Sites programme* (outlined in the CEO report to Board). This paper describes progress since the Board report in March 2024. Our PCARP programme interventions go beyond National requirements and respond to feedback from the NCL Board and Primary Care Committee. Work since the last report has included approval of a Protected Learning Time scheme for Practices and work to support reception and administration roles. Access is a key priority but we are clear that: • Improving access and managing same day demand is one aspect of general practice provision and must be balanced with provision of proactive care to patients with more complex and long term health needs. Our Long Term Conditions model and work across the ICS is designed to support this. We are also building on the vaccination programme delivered with General Practice to ensure we are addressing prevention. • North Central London ICB has launched a public communications campaign "Your Local Health Team" that highlights the different ways in which General Practice can be accessed, the breadth of the primary care team and different skilled health professionals now available and how patients can access self-care advice. • To complement our local campaign, London ICBs and NHSE have recently undertaken deliberative engagement with patients and the public to explore public opinion on changes that may be necessary to enable general practice to meet rising demand. • General Practice is not sufficiently resourced to meet population demand and need and demand. In NCL we have seen a 15% growth in the registered patient list in 5 years, but a 15-30% growth across most practices in appointment numbers. We are working to quantify the gap between demand and resource with NHS England and our PCN Test Sites to inform changes to policy and GP contracts. Overall, NCL ICB is on track to deliver the requirements of the national plan by March 2025. Our goal is to improve patient experience of contacting their GP practice, patient satisfaction and the operating model and workload (by supporting all practices to move to a version of the *modern general practice* model which is right for them). 2024 GP: Patient survey questions were updated for 2024 to reflect the introduction of Modern General Practice, so while a direct comparison between this and previous years' results is not possible, NCL headlines from the most recent survey include: • 7 /10 respondents report an overall good experience of General Practice locally • Several practices have made significant improvements in overall patient satisfaction • We have above national average levels of satisfaction with telephone access • We have reduced the gap between local and national averages in a number of domains (noting London results are typically behind National) • Variation in satisfaction persists between Practices - further analysis and targeted change management support is being provided to practices. We are monitoring this and a wider range of outcomes as described in previous papers to Board.
Recommendation	The Board of Members is asked to **APPROVE** this report.

Identified Risks and Risk Management Actions	Delivering the Access Recovery Plan will contribute to mitigation of the ICB's Corporate risks: • PERF15 - failure to address variation in primary care quality and performance across NCL • PERF28 - failure of primary care patient access Specifically in relation to PERF 28 the risk of failure of primary care patient access, delivery of the national Access Recovery Plan is one of the agreed controls, as is the delivery of the communications campaign described in this paper. These controls are further supported by analysis of data related to primary care access as reported to the Primary Care Committee within Quality and Performance reports and more detailed analysis described in this report.
Conflicts of Interest	The Clinical Director for Primary Care for North Central London ICB is an employee of Islington GP Federation and Board member of the General Practice Provider Alliance. This is managed in line with the ICB Conflicts of Interest Policy.
Resource Implications	Delivery of this plan requires allocation of national funding as described above, and allocation of ICB staff time and resources, as well as engagement from practices and PCNs. It takes place in the context of wider pressures on General Practice and national GP Collective Action in response to the 2024/5 GP contract.
Engagement	Engagement with practices and PCNs via regular forums and communication channels, including with Londonwide Local Medical Committees. Practice communications ongoing through the delivery period. Engagement and communication with patients and the public: • Forms part of our local change support offer for practices to help ensure operational changes are communicated effectively and shaped with patients. • A full communications plan on primary care access has been launched including our local campaign. • We have commissioned, with NHSE (London) and other London ICBs, Deliberative Engagement with patients and the public about primary care, exploring areas like access, which will inform current work and future ambitions. • Our actions reflect feedback received in wider forums (for example Primary Care Committee) and our engagement over the years with organisations like Healthwatch.
Equality Impact Analysis	A national Equality and Health Impact Assessment was produced in relation to the national Plan. A local Equality Impact Initial Screening Assessment has been produced to supplement, focusing on our local implementation approach. Both are available on request. Neither document has identified equality concerns related to this work, but they do underline the importance of the interdependency between this programme and the ICB's digital inclusion programme which is being led by the Digital and Communities teams. Both pieces of work will inform our developing Ambitions for General Practice.
Report History and Key Decisions	ICB Executive Management Team received reports on this work in August 2023, October 2023, and February 2024. The Primary Care Committee approved reports on this work in October 2023, February 2024 and October 2024. The ICB Board approved reports on this work November 2023 and March 2024.
Next Steps	Implementation against this plan will continue to March 2025.

Appendices	1: Patient journey under Modern General Practice 2: Delivery of structural and process change to enable access improvement 3: NCL progress against the national delivery checklist

Recovering Primary Care Access - Autumn 2024 update to Board

1 Introduction

1.1 Background

The National Delivery Plan for Recovering Primary Care Access was published in May 2023 initiating a two-year programme for GP Practices, Primary Care Networks (PCNs) and ICBs. The aim is to improve patient experience of access to General Practice. The key action is transition to the *Modern General Practice* operating model. Work includes improved contact routes (telephone, digital, in person), telephony systems and practice websites. It also includes use of online consultation tools, structured information gathering, triage and care navigation, workflow and process improvement and making full use of a multi-professional primary care team. Outside the Practice, work includes mobilisation of Pharmacy First, working with Community Services on patient self-referral routes and improving the 'interface' between Practices and Trusts.

There is an emphasis on building infrastructure and capability – enabling teams to work together, to access, understand and use data and to sustain change. Alongside key metrics around improved patient / public satisfaction with access, the programme seeks to improve key indicators of digital maturity. The patient journey will change and this is shown in appendix 1. Appendix 2 describes our key activities and appendix 3 captures performance against NHSE key metrics for the programme.

The national update in April set ambitious national targets to increase use of the NHS App, increase self-referral into community services and Pharmacy First and sought faster progress implementing commitments at the primary-secondary care interface. The paper describes overall progress since the last board report in March 2024. NHSE are monitoring delivery through Board reports so appendix 2 and 3 outline our performance after 18 months.

A national update to the plan published in April 2024 reports record numbers of GP appointments nationally and celebrates successful expansion of Pharmacy First and community self-referral services. Nationally 360 million appointments (excluding Covid vaccinations) were delivered by General Practice in the 12 months to February 2024 – this is 57.5 million appointments more than would have been delivered over the same period before the Covid-19 pandemic[1].

In North Central London, General Practice now delivers ~800,000 documented patient contacts per month via 680,000 appointments, 100,000 online consultations and 30,000 out-of-hours appointments (through Primary Care Networks and GP Hubs) [2]. Practice list sizes have grown by ~15% over the last 5 years but appointment volumes are up 15-30% (2023/24 compared to 2019/20), meaning appointment demand and provider capacity has outstripped population growth. General Practice delivers 90% of all patient contacts with the NHS[3].

[1] Source: NHS England: Pressure on NHS services remains high
[2] Source: NHS England: Appointments in General Practice; Submissions via Online Consultation Systems in General Practice
[3] Source: UK Government: The future of general practice

Given this, wider development of local care models and infrastructure is important. Building capability at PCN level, and supporting partners (statutory, VCSE) to work together and integrate at Neighbourhood and Place, will help General Practice to deliver its broad role - from universal primary prevention to support for high risk and complex patients.

NCL is out to engage with practices at present aiming to shape a set of *General Practice Ambitions* which will be co-owned with the GP Provider Alliance and describe the direction of travel in NCL and developments we want to see. The Ambitions will reflect feedback from patients – received to date, from our communications campaign, from our deliberative enquiry and as we engage to inform the Long Term Health Plan.

1.2 Our wider priorities for General Practice

Whilst the national Delivery Plan for Recovering Access to Primary Care focuses on access and same day demand, this is only one aspect of the role of general practice. General practice also has a vital role in identifying and offering proactive care to patients with ongoing health needs and in prevention. Both must be balanced with the focus on access. In North Central London we are working to ensure our most complex patients are proactively and effectively supported.

We have invested in a Locally Commissioned Service (LCS) provided by all Practices to ensure the offer for patients with long term conditions is consistent way. We also recognise the need for resilient infrastructure – good quality premises, effective technology and a well-trained and supported workforce. This requires sustained investment over time. We are one of the first ICS in the country to start allocating 5% of system Capital to the General Practice estate and have recently supported a Protected Learning Time scheme for practices so the whole practice team can engage in learning, improvement and transformation opportunities.

The nationally commissioned ‘core contract’ for general practice needs to evolve and it is accepted that general practice is not sufficiently resourced to meet population need and demand. In response NHS England is working with 7 ICBs (including North Central London) and a cohort of Primary Care Networks from each area to quantify the gap between resource and demand trial and evaluate new ways of working. As an ICB we also need to consider our approach as part of the ‘left shift’ of resources to support delivery of the Population Health Strategy.

It should be noted our work is taking place in the context of Collective Action by General Practice coordinated by the British Medical Association (BMA) following the 2024/25 national GP contract settlement. To date, the level of risk to the programme and our wider work as a result of this is low.

Change beyond the access recovery programme will be required. London has recently undertaken a programme of deliberative engagement with patients and the public - gathering opinion from a small representative group on changes that may be necessary to enable general practice to meet rising demand. The deliberative format facilitated genuine conversation with participants who shared their experiences, exchanged ideas and reflected on the potential trade-offs in a real-world context. The report from this work is expected November 2024 and this will inform our next steps.

Locally, we have launched a public communications campaign “Your Local Health Team” that highlights the different ways in chich general practice can be accessed currently – online, by phone and in person, the breadth of the primary care team and different skilled health professionals that are available, and how patients can access self-care advice (see section 2.2). Feedback received via this and other routes will inform local plans.

2 Current progress: primary care access

We are 18 months into the two-year national plan. Primary Care Committee and ICB Board have previously noted two papers describing our overall approach to delivery, support offers made to practices and our work with system partners to implement wider changes in support of General Practice. Overall we are on track to deliver requirements by March 2025. Our goal is to realise improvement in patient experience by supporting all practices to move to a version of modern general practice which is right for them. Appendices 2 and 3 outline our actions and delivery against National requirements.

2.1 Delivering the requirements of the plan

In appendix 2 we provide detail of delivery activity to date. In improving access routes the intention is all on the day requests from patients are seen and responded to. Below we outline the key progress for Board:

The structural change required has been largely completed and we are working with remaining practices to ensure 100% achievement of key requirements

- 100% practices are using modern, cloud-based telephony systems and we are working with them to optimise functionality such as call-back.
- 99% have enabled ordering of repeat prescriptions via the NHS App and 90% have enabled booking and cancelling appointments. Patient use of the App has increased in NCL since the programme began. In June 2024 there were ~676,000 logins to the NHS App by NCL patients.
- 85% percent of practices offer online registration for new patients
- 98% have submitted their plans and taken up funding
- We have completed 58 / 60 initial diagnostic conversations with practices identified as a priority.
- 97% of community pharmacies are delivering the Pharmacy First service.
- 56% of residents are now registered with the NHS App and patient activity in the App continues to increase.
- Secondary care trusts have all committed to implementing the four national commitments to reduce bureaucracy at the primary / secondary care interface.

We are beginning to see impact against key metrics and will monitor progress

- Primary Care Network have described improvement and innovation to date in their (nationally specified and funded) *Capacity and Access Improvement Plans* for 23/24. NHS England are asking practices to self-declare completion of the transition to modern general practice over the 24/25 financial year.
- We are tracking use of digital tools including online consultations, two-way SMS and use of NHS App features. Increasing activity in all areas shows that digital access routes are becoming embedded across NCL.
- Early data shows promising signs that Pharmacy First activity is increasing across NCL – from ~6,000 per month on launch to ~9,000 per month by September. We have change support in place and will continue to work in areas where take up of the service is lower.
- Community self-referral activity has increased and we are now meeting national targets across most eligible pathways.
- A dataset to monitor implementation of the interface commitments between primary care and trusts is in development.

Practices are beginning to see results from efforts to improve patient experience.

- The 2024 GP Patient Survey gives insight into where patient experience is already improving, and where more support will be required to help practices realise key benefits. See section 3 for more detail.
- A more detailed analysis of survey trends is helping us refine our hypotheses about what drives patient satisfaction with General Practice.
- Good primary care access - that includes urgent, planned and proactive care - is essential to population health improvement. This work, and wider commitments to general practice, will enable better access local services, greater personal control and more timely and integrated approaches for patients with complex needs.

As we enter Winter additional investment is in place to support general and paediatric appointment capacity alongside resources at PCN level to help manage telephone and online consultation demand. One of the most significant opportunities this Winter is to increase use of Community Pharmacy services. Pharmacies can now support urgent medication supply, referrals for minor illness and consult on seven clinical pathways (including sinusitis, sore throat and simple UTIs). We are raising public awareness via our communications campaign and working to increase direction and referral (from 111 and Practices and over time from UTC and ED).

2.2 Communicating with patients & residents

To ensure we take patients on the journey as General Practice changes the ICB has launched *"Your Local Health Team"* - a local communications and engagement campaign focussed on General Practice and wider primary care.

Key messages about changes in primary care are couched in a wider, unified, health and care campaign that will help patients understand what is available to them (during Winter & beyond) and how to access it. This includes a push on the services directly available at Community Pharmacy. The campaign is supported by partners including GP Practices, local authorities and the voluntary sector. It will run for 18 months across social media, local magazines, outdoor advertising and other channels.

The campaign covers key messages about ways to access General Practice, the different skilled professionals working in primary care, self-care, staying well and vaccination. The campaign will help patients and residents take an active role in their wellbeing and healthcare by promoting services such as the NHS App, Pharmacy First and NHS 111. It will also direct to local support relevant to cost of living, housing and wider priorities.

The campaign will feature both universal and targeted messaging, including information on services specific to particular boroughs. Key audiences for the campaign include young people, parents of young children and working age adults – groups who have not been previously targeted for information about changes to GP access. There is an aligned engagement and outreach plan using a community connector model to reach underserved communities.

We will measure the reach and impact of the campaign through a variety of metrics and adjust our approach throughout the campaign. We will be surveying our new Community Voices Panel made up of 1,000 NCL residents representing the area's populations demographics on their awareness and likelihood to follow up on our calls to action at key intervals.

3 Impact

3.1 Intended impact

The primary outcome measure Nationally is patient satisfaction with experience of access measured through the national GP Patient Survey with specific new questions about experience of contacting the practice via telephone, NHS App and practice websites. The national expectation is that improvements will be seen in the 2025 survey results - however, it is important to note overall patient satisfaction is driven by many factors including patient expectations, satisfaction with waiting times for onward referrals and long-term condition support.

The aim is to see practices with historically lower levels of patient satisfaction demonstrating clear improvements, the majority seeing some benefit as a result of implementing the *modern general practice* model and a reduction in variation between the highest and lowest scoring practices in NCL. We see the work to deliver the national plan as the foundation of a longer-term approach to improving patient satisfaction.

3.2 Headlines from the 2024 Survey

The 2024 GP : Patient survey collected responses from patients in Jan-Feb 2024 and results were published in July. The survey questions and methodology have changed such that we cannot make direct comparisons with previous years in most cases. We did not expect to see significant changes this year but there are some positive early signs:

- Over 50 practices have improved overall patient satisfaction by 10% or more.
- 6 practices have increased overall satisfaction by 20% or more.
- Conversely 14 practices have seen overall patient satisfaction drop by 10% or more.

We are above the national average for satisfaction with telephone access and have closed the gap between NCL and national averages in some areas e.g. patient satisfaction with practice websites. Overall 7/10 respondents report a good experience of General Practice in NCL. We are at or just below averages for key access questions.

	NCL average 2024	National average 2024	London average 2025	NCL practice range 2024
% patients who had a **good overall experience of contacting their practice**	67%	67%	67%	23% - 100%
% patients reporting a **good overall experience of their GP practice**	72%	74%	73%	30% – 98%
% patients who find it easy to contact their GP practice ***on the phone***	52%	50%	53%	11% – 97%
% patients who find it easy to contact their GP practice ***using their website***	46%	48%	48%	8% – 96%

% patients who find it easy to contact their practice ***via the NHS App***	42%	45%	45%	7% – 82%
% patients who find the **reception and admin team at their practice helpful**	79%	83%	81%	42% – 99%
% patients who **knew what the next step would be** when they last contacted their practice	80%	83%	81%	52% - 100%

Addressing variation between practices is a key focus and we are offering more intensive change management support where it appears to be most needed:

- There is a 34% difference in levels of patient satisfaction with access between the highest and lowest scoring PCNs
- Camden is well represented in the highest scoring practices
- Barnet is overrepresented in the lower scoring practices. We have recently undertaken a deep dive with the Barnet Lead Member for Health to identify opportunities to improve this.

The ICB Primary Care Committee receives a broader Quality & Performance Report. This covers a range of metrics including access, patient satisfaction, workforce data, clinical and quality indicators, Health Check and Vaccination data and data on utilisation of acute and other services by the practice population.

3.3 Analysing patient satisfaction

Joint work between the ICB analytics and primary care teams is underway to explore the full potential of the survey dataset as part of a 'data-driven' approach to supporting General Practice in NCL. Nationally it is well documented that - despite significant increases in appointment capacity - patients report lower levels of satisfaction with access. Locally appointment numbers are up and the number of face-to-face appointments have recovered to pre-Covid levels, but we still hear people struggle to access General Practice when they need to.

Initial analysis shows a positive overall experience of general practice is most strongly positively correlated with a positive overall experience of *contacting the practice* and where the *reception / admin team were found to be helpful*. This adds weight to our previous assessment that investing in training, development and wellbeing of non-clinical practice staff will help achieve key programme outcomes. It also correlates with historic data on complaints which shows admin and reception teams are most likely to be the subject of escalated complaints.

Overall experience is also moderately negatively correlated with the proportion of respondents whose last appointment was remote however this is not universally the case - some practices have maintained high levels of overall satisfaction whilst offering more remote appointments, other practices see poor overall satisfaction regardless of appointment type. More work will be required to fully understand why this is happening, including learning from practices who are using a more blended appointment model whilst maintaining high levels of satisfaction.

Overall experience is also moderately negatively correlated with the proportion of respondents who report conditions or illnesses reduce their ability to carry out day-to-day activities – strengthening the case for proactive and preventative care.

4 Conclusion

We can report positively against national measures of success for this programme, but have also ensured priorities identified locally – like patient communications and the development of non-clinical staff – are factored in. The programme should help standardise the model of delivery and reduce variation in experience of access. Most practical actions are complete. There is a strong digital transformation element and data suggests some increase in patients making use of digital access routes and the features of the NHS App. We have seen examples of excellent improvement work led by PCNs and their progress is reflected in the overall trends in key datasets.

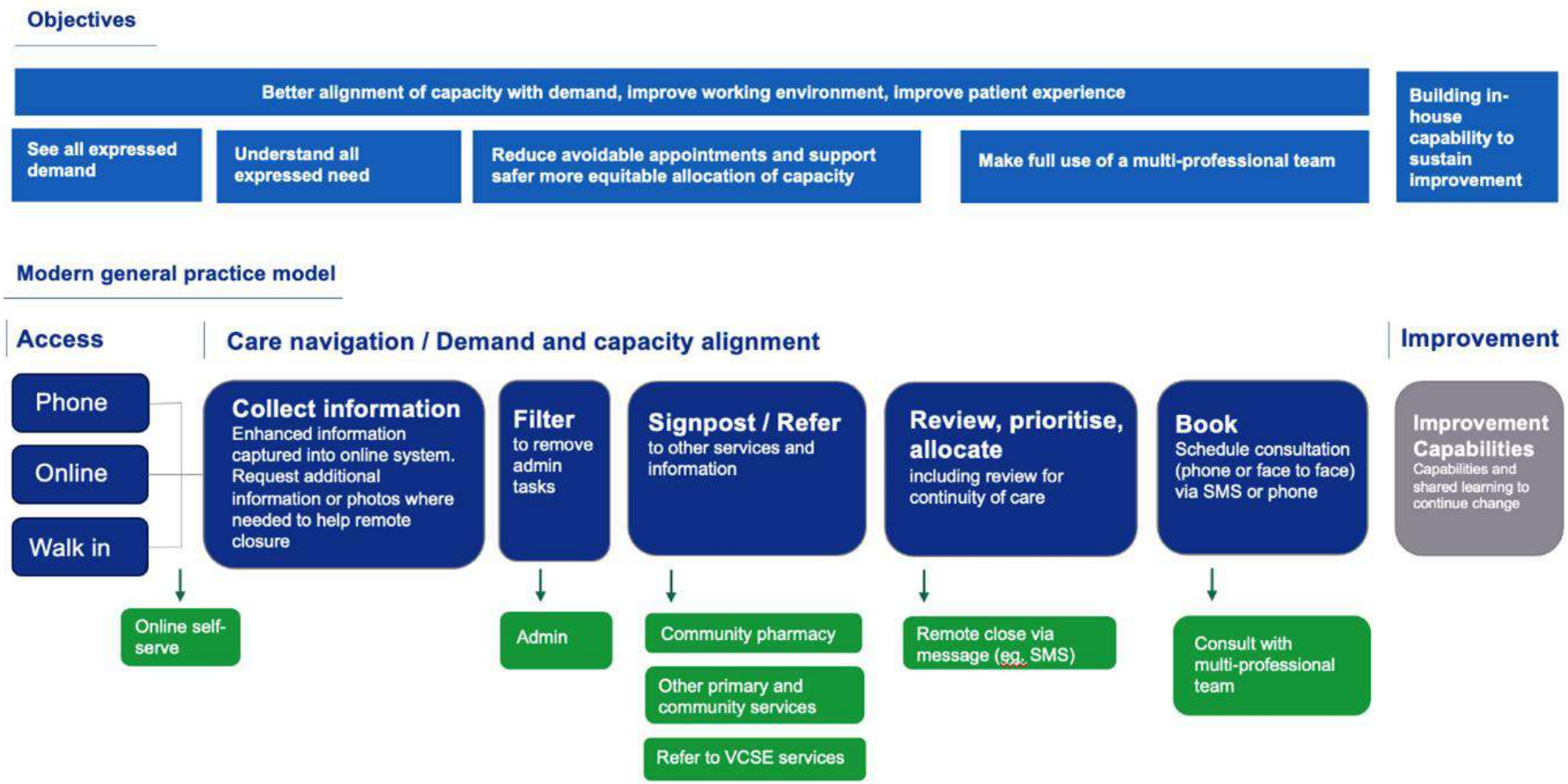
This is a significant programme of work which requires an overall strategic vision coupled with detailed and practical intervention and support right down to practice level. All 180 practices are engaged and NCL is delivering the programme effectively. NCL needs to drive towards London and National averages and is gaining ground. Variation is a key challenge with work needed in the North of NCL in particular.

Our work with Community Pharmacy is expanding and this is an important new approach to supporting patient access and primary care delivery of clinical services. Now services are live and accessible for all, we must optimise their use. The operational and clinical interface with other services is also critical and will take clinical leadership and practical effort beyond the life of this programme to minimise workload for General Practice, smooth patient journeys and improve patient satisfaction.

PCNs provide a strong foundation for Neighbourhood models where partners can come together to proactively support our most complex patients, deliver a shift from sickness to prevention and develop partnerships with the VCSE which have reach and optimise individual and community power. Development of integrated and local care models will benefit General Practice and this agenda must be progressed alongside efforts to sustain, reinforce and improve core services. The NCL People Strategy, Digital Strategy and Estates Strategy all emphasise Primary Care needs and priorities. As an ICS we have been bold in this regard and will need to continue to make difficult choices about where we prioritise investment to support key system outcomes.

We will continue to support practices to deliver changes and improvements to March 2025 - the official end of the programme. We believe realising the benefits of new ways of working is a longer-term goal that will require ongoing support. Learning from this programme and patient engagement will shape our longer-term access priorities, General Practice Ambitions and broader approach to supporting primary care transformation.

Appendix 1: Patient journey under modern general practice



Appendix 2: Programme detail

Supporting practices to adopt modern general practice

The majority of the work to deliver the national plan has been to create the right conditions for practices to make the transition to modern general practice. 98% percent of practices have taken up their modern general practice *transition and transformation support* funding and created local plans to use the funding to make the transition. Funding creates capacity for internal change and investment in staff development. We are working with the remaining handful of practices to help develop plans and begin the work.

We have completed 58 Support Level Framework (SLF) diagnostic conversations with practices against an original target of 60. The outputs of SLF conversation for practices include agreed improvement priorities, at least one of which will be about improving access. Practices tell us they have found SLF conversations valuable to focus their work. Facilitators value the opportunity to connect with practice teams. We will offer the opportunity to a new cohort of ~30 practices this financial year. We have used themes from completed SLFs to inform our commissioned change management support and test intentions for future transformation funding.

A locally commissioned change management programme, commissioned from and delivered by Islington GP Federation has engaged 53 practices on additional support for the change work. In August 2024, 13 practices started on bespoke change support with the remainder scheduled over the next 6 months. We intend all 56 will have completed an intervention by March 2025.

Implementing the digital tools that enable modern general practice

One hundred percent of practices have made the transition from analogue to cloud-based telephony systems. The majority of PCNs now have common telephony suppliers, facilitating at-scale working between practices to manage demand. One hundred percent of practices report they have activated the call-back function of their telephony system in line with national best practice. The ICB is now supporting practices to realise the benefits of cloud-based systems through hands-on support sessions including using data from telephony systems to inform improvement work.

Fifty-six percent of NCL residents are now registered with the NHS App. There has been a steady increase in registrations through 2024. The ICB has commissioned pilots from GP Federations and voluntary sector partners to test approaches to increasing signups, including working with residents considered digitally excluded. We are on track to ensure 100% availability of app features for residents:

- 100% practices have configured the app to allow prospective records access
- 99.4% practices have enabled ordering of repeat prescriptions via the app. The only practice that does not offer this feature is our Special Allocation Scheme (SAS) practice, who have chosen to do this because of the importance to their patient cohort of fostering positive staff-patient interactions
- 86.9% practices have enabled booking and cancelling appointments via the app. Here we are an outlier compared to the national average of 94.8%. The ICB's digital first team are prioritising work with remaining practices to make the necessary changes in the app and bring NCL in line with the national position by March 2025

One hundred percent of NCL practices have configured the systems to allow patients prospective access to their medical records. However, as of July 2024, 36% of practices have not yet enabled access for >10% of registered patients due to "need for enhanced review" (London average 27%). Providing patients with prospective records access is a contractual requirement for practices as of 2023/24. ICB digital first are in contact with all 63 of these practices to develop plans and timescales for completing enhanced reviews by March 2025.

85% percent of practices offer online registration for new patients. Thirty-nine percent use the national online registration tool, whilst 46% use third-party tools. NHS England aspire to >90% practices using the national tool by 31st December 2024. Our priority is supporting the 15% practices not offering online registration to take up the offer of the national tool, but we are also encouraging practices using third-party suppliers to consider the benefits of switching.

Structural changes in the wider health system

For the wider health system structural change that will enable improved GP access includes increasing the alternative options to General Practice e.g. through community pharmacy and self-referral to community providers and streamlining care at the primary / secondary care interface.

Ninety-seven percent of NCL Community Pharmacies are offering Pharmacy First services. Where sites have chosen not to participate, this is due to not meeting the requirements to deliver the service (e.g. lack of sufficient space or a dedicated consultation room). Overall there is sufficient coverage of the service across NCL to ensure all patients can benefit.

Availability of community self-referral for the 7 services selected by NHS England continues to improve. All NCL community providers offer self-referral into musculoskeletal services, podiatry, equipment services and tier 2 weight management services. Self-referral into falls services will be in place across NCL by March 2025. Introducing self-referral into the remaining services (wheelchair services and audiology) requires contract work and so these changes will be incorporated into the ICB's *core offer transformation programme* for community services. Quality is a key element of this transformation and further expansion of self-referral pathways must be scaled in proportion to increasing demand so as not to create bottlenecks. Acknowledging the spirit of the national and local direction of travel to achieve our ambition of taking a population-based approach to commissioning, we will continue the expansion of referral pathways beyond the NHSE target date of March 2025.

All four NCL acute providers have signed up to implement the four Academy of Medical Royal College recommendations to improve work at the primary / secondary care interface, as outlined in the NCL interface consensus document. Baseline assessments from our four acute providers show:

- 2/4 have implemented a consultant-to-consultant referral protocol to prevent onwards referrals being sent back to the GP to action
- 2/4 are working towards the ability to issue fit notes without GP input and three trusts are working to improve quality of their discharge summaries to make these easier for GPs to action
- 2/4 trusts have implemented a process for call and recall that does not require GP input
- 2/4 trusts are confident that patients have access to clear points of contact to avoid people relying on their GP practice to contact their secondary care team

Although all trusts report they have implemented one or more interface commitments, there is a need to optimise and standardise in areas such as IT connectivity and staff awareness. There is a dedicated

programme of work led by the ICB's Deputy Medical Director; there are jointly chaired Clinical interface groups (CIGs), chaired by ICB clinical lead with trust medical directors for each acute trust, and there is a focus on support with implementation and strengthening place-based relationships.

4.1 Process change – expected shifts in activity

Understanding changes in practice activity

At practice level our planned activity measures include:

- Monitoring practice spend of transition and transition funding and the impact this has had. NHS England estimate the work to implement modern general practice takes 9-12 months for an average practice, so we will begin to check in with practices from November 2024. Practices have committed to proactively communicating the changes they make to patients as a condition of accessing funding.
- The work practices undertake (beyond sign-up) as part of local and national change support offers, which we will work with practices and providers to measure quantitatively (ongoing participation) and qualitatively (practice experience, improvement themes and early successes).

From a digital perspective we have access to national datasets that allow us to see how practices are adopting and making use of the digital tools they have put in place. In June 2024:

- 95,174 online consultations were submitted to practices. This number has remained consistent for many months and represents significant additional work our practices undertake to provide good access. However, not all practices are making equal use of this tool. The practice range in June was between 1 and 6,189. PCNs will be asked to review this data as part of their capacity and access improvement plans for 2024-25.
- 504,856 two-way SMS messages and 958,525 batch / reminder messages were sent to patients. Two-way messages can be used to manage appointments but are also integral to engaging patients with proactive care and supporting long-term condition management.
- There were 675,811 logins to the NHS App by NCL residents – a number that has remained consistent for some time. More specifically, we saw:
    - 54,269 repeat prescriptions ordered
    - 283,694 instances of patients viewing their own health records. This is the fastest growing area of NHS App activity in NCL though as 36% practices have not yet enabled access to records for >10% of patients (see above) this option is not yet available to a large proportion of NCL residents
    - are currently withholding access to records (see above) this option is not yet available to a large proportion of NCL residents
    - 2,005 appointments booked, and 5,398 cancelled – we anticipate this number will increase as the number of practices offering this app function increases

One of the benefits of transitioning to cloud-based telephony is that practices can review detailed data on their telephony activity including call volumes, dropped calls and average patient wait times. In future, this will allow us to demonstrate the telephone demand our practices experience and provide valuable insight into how practices are managing their telephone activity.

PCN capacity and access and improvement plans

In 2023/24 PCNs were incentivised through a national scheme to collaborate in making improvements in patient experience of access. In July 2023 the ICB worked with PCNs to write and sign-off local

improvement plans. At the end of the financial year, PCNs submitted evidence of achievement of their plans which were reviewed by an ICB panel to determine whether the improvement demonstrated met the national criteria to make the improvement payments. Where this was not achieved, PCNs were given feedback and invited to resubmit with more detail. This process has now concluded.

Final achievement of practice-level actions in the plans :

- 93% practices achieved an improvement in the quality of their appointment data as published in the national General Practice Appointment Dataset (GPAD). This will give us much greater confidence in the data, which can be used to plan services and demonstrate the volume of activity NCL practices are delivering.
- All practices report that they have now restarted regular data collection for the GP Friends and Family Test (FFT). National FFT reporting has been suspended since April 2024; when this data becomes available again in future, we will revisit the NCL position.
- All practices tell us they have implemented the call-back feature in their telephone systems to allow patients to maintain their place in the queue when they wish to speak with their practice, without having to remain on hold.

Final achievement of PCN-level improvement priorities in the plans:

- Many PCNs reviewed patient feedback including FFT scores and online reviews at network meetings to discuss feedback and act on common themes. Several have been able to demonstrate sustained improvements in FFT scores, or a reduction in variation between member practices' FFT scores as a result of this approach.
- PCNs have been taking advantage of live data from telephone providers to improve how they manage incoming calls and reduce call waits. This data allows practices to work together to understand patterns in call volumes and change staffing accordingly. Some have taken advantage of the ability to work together to manage telephones to allow practices to support each other during busy periods.
- Where patient feedback has shown greater desire for patients to manage their own care, some PCNs have invested in new avenues of support. This includes increasing the range of self-booking options available via the NHS app, investing in care navigation training for reception teams and promoting use of online General Practice via websites, in-practice and social media.

Learning from the 2023/24 cycle has been incorporated into the approach for the 2024/25 capacity and access improvement payments. This financial year, PCNs can claim improvement payments at any point in year. The payment is available in three sections, each linked to confirming all practices have implemented an aspect of modern general practice (better digital telephony, simpler online requests, faster care navigation, assessment and response). We have streamlined our claims process and produced clear guidance about the evidence required to demonstrate achievement. The claims process will launch in October 2024.

Changes in wider health system activity

Of the 280 Community Pharmacy sites who have signed up to offer the Pharmacy First service, 278 have delivered at least one consultation since launch (data from 31st Jan – 30th Sept), 210 have delivered 100+ consultations and 28 have delivered 500+ consultations. Publication of practice-level data on Pharmacy First activity has been delayed nationally, but an early cut of London data shows a steady increase in activity. The ICB has commissioned outreach work from Local Pharmaceutical Committees (LPCs) to work with Pharmacy and GP teams to raise awareness of the service and support local

relationship building. Feedback from LPC pharmacists to date has been positive, with training for non-clinical staff and support with digital tools providing the most valuable interventions to increase Pharmacy First activity.

In May 2024, 2,486 NCL residents referred themselves to a community service. We are aware of variation in activity between providers and boroughs due to lack of availability of all self-referral routes and differences in how the option to self-refer is communicated to patients. To continue to increase self-referral activity our community providers will engage in a communications campaign through our local Borough Partnership forums to promote the self-referral pathways through primary care, local authority and voluntary sector partners. The challenge in increasing self-referral activity is being felt across the region, including in NCL; only 2/5 London ICS achieved the nationally set 2023/24 target of increasing self-referrals by 50% over the course of the year. In 2024 we have closed the gap between monthly self-referrals and the NHS target, and in May 2024 we exceeded the target for the first time. Our self-referral activity numbers remain the highest in London.

We do not yet have activity data on implementation of the primary / secondary care interface commitments but are developing this for future reporting.

Appendix 3: NCL progress against the national delivery checklist

The main body of this report describes the overall ICB approach to delivering the access recovery plan. There is also a national checklist of actions against which we must provide assurance of progress. For ease of assurance progress against that checklist is set out below. There is some repetition within the list as it identifies actions for the national team, practices / PCNs and ICBs.

4.2 National actions

#	Detail	Deadline	Met	Position September 2024	Next steps
Theme: modern General Practice					
1	Financial and procurement support to any practice that indicates to its ICB that it wants to move from analogue to digital telephony. The Better Purchasing Framework is live with qualifying suppliers.	01/07/23	Yes	Complete – there are no NCL practices using analogue telephony	Continue to offer further phases of telephony upgrades to support practices who wish to align providers across a PCN to facilitate joint working.
2	Funding of tools for online consultation, messaging, self-monitoring and appointment booking tools. Online consultation tool pre-guidance published by June (complete). Digital Pathway Framework lot on Digital Services for Integrated Care (DSIC) Summer – Autumn 2023 and fully launched in December 2023 with supplier contracts awarded.	31/12/24	Yes	Complete (DSIC was stood down nationally, but NCL has completed its local spending plans with NHS England).	N/A
3	The National General Practice Improvement Programme (GPIP): nationally funded support 23/24-24/25 for practices and PCNs.	31/07/24	Yes	Complete – we have supported 9 NCL practices to join the final wave of the GPIP programme. 13 practices participated in 2023/24.	N/A
4	Transition cover and transformation support funding where practices/PCNs are transitioning to Modern General Practice Access Model and require additional support (e.g. extra practice shifts, locums, or peer support) utilise an average of	31/03/25	Not due	Currently 98% NCL practices have received their funding.	Work with practices 12 months on from receiving their funding to understand how they have used it.

#	Detail	Deadline	Met	Position September 2024	Next steps
	£13.5k per qualifying practice of flexible funding through capacity fund reimbursements. Available 23/24 and 24/25.				
5	Care navigation training: every practice to nominate one member of staff to undertake training. Digital and transformation lead training: designed to equip individuals in the Digital and Transformation Lead ARRS role with the core skills to be able to lead transformational change. Every PCN can nominate one lead to undertake training.	31/03/24	Yes	Complete – this training is no longer being offered.	Acknowledging that further training may be needed, we have asked NCL Training Hub to scope need in more detail.
6	Repurposed £246 million(nationally) of IIF to support improving access and provide capacity for transformation. Capacity and Access Support payments to be paid monthly to PCNs. Local Capacity and Access Improvement Payment to be awarded based on commissioner assessment of improvement in access performance, specifically patient experience of contact, ease of access and demand management, and accuracy of reporting in appointment books	31/08/24	Yes	We have completed the assurance of 2023/24 capacity and access plans – see main body of paper for more detail.	Work with PCNs to support their delivery of their 2024/25 capacity and access plans.
7	Increase in ARRS flexibility and ARRS numbers: Increase ARRS funding by £385 million (nationally); Increase flexibility by including apprentice physician associates and advanced clinical practitioner nurses Guidance and calculator available	31/03/24	Yes	We have supported PCNs to maximise the use of their ARRS funding through 2023/24 and will continue to do so as long as the scheme runs.	Continued support to PCNs acknowledging uncertainty as to the future of the scheme.
8	Communication materials available for all practices to support patients to understand digital access to practice, NHS App for repeat prescriptions, multidisciplinary General Practice teams and wider care available (Pharmacy & 111) There are also other materials that practices may find useful (Enhanced access, looking after you coaching and staff respect)	31/03/24	Yes	We supported practices to access these materials.	A locally funded and produced communications and engagement campaign on General Practice will launch in autumn 2024.

4.3 Actions for Practices / Primary Care Networks

#	Detail	Deadline	Met	Position September 2024	Next steps
Theme: empowering patients					
1	Apply system changes or manually update patient settings to provide prospective record access to all patients.	31-Oct-23	Partially met	Significant work has gone in to ensuring 100% practices have correctly configured EMIS to enable online records access and 64% now offer full prospective records access to their patients. 36% practices have not yet enabled access for >10% patients - enhanced reviews required before making this available.	Targeted work with practices yet to enable access to all patients to establish timelines and processes for completing the enhanced reviews by March 2025.
2	Ensure directly bookable appointments are available online following bookable online appointment guidance	31-Jul-23	Partially met	87% practices have configured the NHS App to offer their patients directly bookable appointments online – typically used to schedule planned and preventative care (June 2024)	The Digital First team will provide further support to practices. Due to high level of triage taking place as part of General Practice access models the no. of appointments made available for direct booking is likely to be low.
3	Offer secure NHS App messaging to patients where practices have the technology to do so in place	Ongoing	Yes	All practices have access to the ICB patient messaging contracts that fulfil this requirement.	N/A
4	Encourage patients to order repeat medications via app supported by comms toolkit	Ongoing	Yes	99.4% practices offer patients the ability to order repeat prescriptions online. The 1 outlier practice is the special allocation scheme practice (see above)	

#	Detail	Deadline	Met	Position September 2024	Next steps
5	Use messaging software to support patients to communicate with practice including for self-monitoring (where not in place see 12 below)	Ongoing	Yes	All practices have access to the ICB patient messaging contracts that fulfil this requirement.	N/A
Theme: modern General Practice					
6	IIF CAIP baselining and recovery planning: Complete prework and fill in template to baseline existing position	30/06/23	Yes	Complete	Our support for PCNs with the 2024/25 capacity and access fund described in the main body of the paper
7	IIF CAIP baselining and recovery planning: Confirm to ICB request to move from analogue to digital telephony	01/07/23	Yes	Complete	As above
8	IIF CAIP baselining and recovery planning: Confirm requested support offers to ICB (e.g. care navigator / digital and transformation lead training, GPIP transformation support, capacity backfill support, online consultation tools etc)	15/07/23	Yes	Complete – we have supported 9 NCL practices to join the final wave of the GPIP programme. 13 practices participated in 2023/24.	N/A
9	IIF CAIP baselining and recovery planning: Complete PCN/practice access improvement plan with committed offers	31/07/23	Yes	Complete	As above
10	IIF CAIP baselining and recovery planning: Self-certification of accurate recording of all appointments and compliance with GPAD guidance	31/03/24	Yes	Complete	As above
11	IIF CAIP baselining and recovery planning: Make improvements identified in practice/PCN access improvement plan and report to ICBs	31/03/24	Yes	Complete	As above
12	Digital tools and implementation: If already on digital telephony, ensure call-back functionality and queuing is enabled, where the functionality is included in the current contract costs	31/03/24	Yes	All practices in NCL report that they have switched these functions on.	N/A
13	Digital tools and implementation: Work with ICB to identify digital tools to procure in preparation for framework launch. Further purchasing guidance to be developed through procurement exercise. Implement tools once acquired	30/11/23	Yes	Complete (DSIC was stood down nationally, but NCL has completed its local spending plans with NHS England).	N/A

#	Detail	Deadline	Met	Position September 2024	Next steps
14	Digital tools and implementation: Use website guidance to update and ensure improved user experience with online tools correctly displayed. Ensure online tools are maximised	31/03/25	Yes	Support provided where indicated via our commissioned change offer.	N/A
15	Digital tools and implementation: Training all practices in the PCN to understand and use local DoS including self- referral, community pharmacy and other services	31/03/24	Yes	DoS available via the NCL GP website.	N/A
Theme: capacity					
16	Submit ARRS and workforce plan to ICB	31/08/23	Yes	Complete	Ongoing support to PCNs from the ICB on an annual cycle.
17	Review and take up local offers for retention, see System Development Funding (SDF) guidance for 2023/24.	Ongoing	Yes	A recruitment drive in 2023/24 led to increased numbers on the National Fellowships programme with committed funds for 2 years participation.	The broadened Local Retention offer funded for 2023/24 is continuing into 2024/25. Support Level Framework discussions will continue to identify workforce retention needs
Theme: reducing bureaucracy					
18	Opportunity to feed back to ICB on progress against primary and secondary care interface difficulties, ensuring a system-wide approach.	Ongoing	Yes	Available forums include Clinical Interface Groups for each Trust, NCL GP webinar, Primary Care Operations Group.	Will remain on the agenda for Clinical Interface Groups, with a focus on improving effectiveness of GP liaison roles in acute trusts.

4.4 Actions for the ICB

#	Detail	Deadline	Met	Position September 2024	Next steps
Theme: empowering patients					
1	Expand self-referral routes (falls services, musculoskeletal services, audiology for older people including loss of hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services) as set out in 2023/24 operational planning guidance. ICBs	30/09/23	Partially met	Self-referral is consistently available in 4/7 services.	Falls services to launch by March 2025 with remaining services to launch in 2025/26.

#	Detail	Deadline	Met	Position September 2024	Next steps
	should also note operational planning action to expand direct access where GP involvement is not clinically necessary				
2	Support expansion of community pharmacy (inc. oral contraception and blood pressure services). Coordinate local communications.	Ongoing	Yes	On track to deliver ICB actions, whilst acknowledging there is further work to complete to continue to embed the service.	Ongoing work with providers to embed the service and increase activity across NCL.
Theme: modern General Practice access					
3	Sign up practices ready to move from analogue to digital telephony, and co-ordinate access to specialist procurement support through NHS England's commercial hub to achieve and track the transition of the majority of practices from analogue to CBT by 31/12/23 and the remainder by 31/03/24.	01/07/23	Yes	Complete – there are no NCL practices using analogue telephony	Continue to offer further phases of telephony upgrades to support practices who wish to align providers across a PCN to facilitate joint working.
4	Select digital tools from the Digital Pathway Framework lot on Digital Services Integrated Care (DSIC) product catalogue. Determine at what scale the procurement approach would align with local need. Use peer networks, user research and demonstrations with practices/Practice Participation Groups/PCNs to help practices and PCNs identify and adopt the most usable software	Dec 23	Yes	Complete (DSIC was stood down nationally, but NCL has completed its local spending plans with NHS England).	N/A
5	Nominate practices and PCNs for national intensive and intermediate transformation support and encourage uptake and participation in GPIP hands-on support. Use the Support Level Framework during 23/24 to understand need. Establish and/or build on current local peer to peer learning infrastructure to develop local communities of practice to support shared learning and data driven improvement which includes enabling Modern General Practice	Dec 23	Yes	Complete – we have supported 9 NCL practices to join the final wave of the GPIP programme. 13 practices participated in 2023/24.	N/A

#	Detail	Deadline	Met	Position September 2024	Next steps
6	Fund or provide local hands-on support to at least 850 practices nationally (ICBs should work with regions to determine population appropriate share of target). Level of support to be similar to the national GPIP intermediate offer, and offered alongside wider and/or ongoing support for practices and PCNs where required	31/03/25	Yes	We have commissioned a provider to deliver hands-on change support to all practices we believe would benefit.	Joint working with the provider through 2024/24 to support successful delivery.
7	Agree and distribute transition cover and transformation support funding (an average of £13.5k / qualifying practice) to support practice teams seeking to implement Modern General Practice.	31/03/25	Yes	Complete – all NCL practices have received their funding.	Work with practices 12 months on from receiving their funding to understand how they have used it.
8	Encourage uptake and co-ordinate nominations and allocations to care navigator training, and digital and transformation PCN leads training and QI capability improvement training. ICBs should work with regions to determine population appropriate share of nominations	50% 23/24 nominations by 31/07/23	Yes	Complete – this training is no longer being offered.	Acknowledging that further training may be needed, we have asked NCL Training Hub to scope need in more detail.
9	Understand and sign off PCN/practice capacity and access IIF CAIP baseline	30/06/23	Yes	Complete	Our support for PCNs with the 2024/25 capacity and access fund described in the main body of the paper
10	Agree with practice/PCN support needs (digital telephony, online tools, training, capacity backfill, intensive support, etc) Support practice/ PCN to secure and put support needs into place	15/07/23	Yes	Complete	See above
11	Co-develop and sign off PCN/practice access improvement plans Oversee and support Practices/ PCNs in implementation of access improvement plans	31/0/23	Yes	Complete	See above
12	Assess improvement and pay 30% CAP IIF funding at the end of year using progress against baseline and access improvement plans, as well as improvement activity across all three areas over the year as per template in guidance & further guidance to be issued by 30 June	31/08/24	Not due	Complete	See above

#	Detail	Deadline	Met	Position September 2024	Next steps
13	Set up process for practices to inform of diversion to 111 and monitor exceptional use when over capacity	Ongoing 2023/24	Yes	Practices have a range of routes available to them to contact the ICB, however in the absence of an agreed definition of exceptional circumstances we have not communicated specific escalation criteria.	N/A
14	Develop system level access improvement plans to include summary of practice/PCN improvement plans, challenges, wider support needs and barriers and ICB actions.	31/11/23	Yes	Complete	N/A
15	Support PCNs to use their full ARRS budget and report accurate complement of staff using NWRS portal	Ongoing 2023/24	Yes		
Theme: reducing bureaucracy					
16	ICB Chief Medical Officers to establish local mechanism to allow both General Practice and consultant led teams to raise local issues to improve the primary- secondary interface; jointly prioritise working with LMCs; tackle the high priority issues including those in the AoMRC report, and address the four priorities in the Recovery Plan.	Nov 23	Yes	Each trust has an established Clinical Interface Group (CIG), we have a NCL system wide Interface Steering Group as well as regular GP webinars, the Primary Care Operations Group and clinical leads meetings.	Work will continue through the Clinical Interface Groups.
17	Report in public board updates and plans for improving the primary–secondary care interface (four focus areas highlighted in the recovery plan) ensuring a system-wide approach to actions	Nov 23	Yes	Update in the body of this, and previous, board reports on GP access.	N/A
18	Support practices to sign up to our Register with a GP surgery service, either on an individual practice basis or via bulk ICB enrolment and track uptake of the service using regional and ICB data	Deadline moved to Dec 24	Not due	85% practices currently offering online registration – aim to reach 90% target by December 2024.	Support already in place via webinars and outreach to practices.
Theme: enablers					
19	Co-ordinate system comms to support patient understanding of the new ways of working in General Practice. Messaging	Ongoing	Yes	This is ongoing work	A locally funded and produced comms and engagement

#	Detail	Deadline	Met	Position September 2024	Next steps
	should include system specific services and DoS (Directory of local services)				campaign on General Practice will launch in autumn 2024.
20	Maintain an up-to-date DoS and deliver training to all practices/PCNs on DoS	Ongoing 2023/24	Yes	DoS available via the NCL GP website with engagement and instructions for use via our usual NCL GP comms channels.	N/A

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
12 November 2024

Report Title	Update to Constitution and Committee Terms of Reference	**Date of report**	25 October 2024	**Agenda Item**	2.3
Lead Director / Manager	Ian Porter, Executive Director of Corporate Affairs	**Email / Tel**		Ian.porter3@nhs.net	
Board Member Sponsor	Paul Najsarek, ICB Chair (ICB Chair) Liz Sayce, Non-Executive Member (Chair of NCL ICS People Board) Kay Boycott, Non-Executive Member (Chair of Audit Committee) Dr Jonathan Levy, Partner Member- Provider of Primary Medical Services (Chair of Integrated Medicines Optimisation Committee)				
Report Author	Andrew Spicer, Assistant Director of Governance, Risk and Legal Services	**Email / Tel**		Andrew.spicer1@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** This paper supports the Integrated Care Board ('ICB') to effectively discharge its financial duties.			

Report Summary

This paper sets out proposed amendments to the ICB's governance arrangements as follows:

Constitution

On 26 July 2024 NHS England published revised statutory guidance on ICB Constitutions and governance. The guidance requires ICBs to make a number of amendments to their Constitutions which, for NCL ICB, fall within 2 categories.

The first category is changes which are substantive and/or impose a new or modified requirement on NCL ICB, and are as follows:

Requirement	Clause
A new stipulation that the Audit Committee Chair may not be the Deputy Chair of the ICB (the prohibition on the Audit Committee Chair also being the ICB Chair was already in place);	Constitution clause 28.8, Standing Orders clause 28.1
A new stipulation that the Senior Independent Non-Executive Member (otherwise known as a 'Senior Independent Director') must be one of the Non-Executive Members. NCL ICB already has the provision for a Senior Non-Executive Member in its Constitution but this role was	Standing Orders clauses 33.1 and 33.2

not previously limited to being a Non-Executive Member only	
Revised wording on the requirements of the Joint Forward Plan to include references to: • Setting out any steps that the ICB proposes to take to implement the joint health and wellbeing strategy; • Setting out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25; • Setting out any steps that the ICB proposes to take the address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether or children or adults).	Constitution clause 37.8

The second is non-substantive changes. This reflects:

- Updates to legislation;
- Removing references to the ICB pre-establishment period;
- The addition of wording to complement and strengthen additional national requirements (but which have no impact on NCL ICB as we already have them in place);
- The resolution of some minor typographical imperfections inherent in the mandated sections of the national ICB model Constitution;
- Changes which are substantive and/or impose a new requirement.

The proposed Constitution is here.

The Board is asked to **APPROVE** the revised Constitution.

Committee Terms of Reference

A review was recently undertaken on committee membership to:

- Better focus Board member capacity and time;
- Strengthen committee roles and oversight where appropriate;
- Continue to ensure suitable arrangements are in place to assist the Board to effectively discharge its duties.

Consequently, the following amendments are requested:

NCL ICS People Board ('People Board')

The proposed amendments to the Terms of Reference are:

- To remove the NCL ICB Chief Executive and the Partner Member as members of the People Board in section 4.1.

The Board of Members is asked to **APPROVE** the Terms of Reference for the NCL ICS People Board.

Audit Committee

The proposed amendments to the Terms of Reference are:

- To remove one of the Non-Executive Members as a member of the Audit Committee in section 13.1;
- To remove reference to 'Community Participants' as standing participants in section 14.1.

The Board of Members is asked to **APPROVE** the Terms of Reference for the Audit Committee.

Integrated Medicines Optimisation Committee ('IMOC')

The proposed amendments to the Terms of Reference are:

- To update section 3.2(j) to reflect key groups and forums that feed into IMOC;

	• To remove the Non-Executive Member as a member of the IMOC in section 4.1; • To clarify in section 6 the current Chairing arrangements being the Chair of IMOC is a clinical member of the Board of Members other than the Chief Medical Officer or the Chief Nursing Officer. The Board of Members is asked to **APPROVE** the Terms of Reference for the Integrated Medicines Optimisation Committee. <u>Quality and Safety Committee</u> The proposed amendments to the Terms of Reference are: • To remove the Chief People Officer as a member of the Quality and Safety Committee in section 4.1. The Board of Members is asked to **APPROVE** the Terms of Reference for the Quality and Safety Committee. <u>Functions and Decisions Map and other governance documentation</u> Any approved amendments to committee Terms of Reference will need to be reflected, as appropriate, in the ICB's Functions and Decisions Map and in other relevant governance documentation. In addition, to better reflect the governance arrangements supporting the delegation of Specialist Services by NHS England to London the references to the NCL Specialist Commissioning Steering Group needs to be updated with references to the NCL Delegated Services Board The Board of Members is asked to **APPROVE** the amendments to the Functions and Decisions Map and the amendments to other governance documentation.
Recommendation	The Board of Members is asked to: • **APPROVE** the revised Constitution; • **APPROVE** the NCL ICS People Board Terms of Reference; • **APPROVE** the Audit Committee Terms of Reference; • **APPROVE** the Integrated Medicines Optimisation Committee Terms of Reference; • **APPROVE** the Quality and Safety Committee Terms of Reference; • **APPROVE** the amendments to the Functions and Decisions Map and to other governance documentation.
Identified Risks and Risk Management Actions	The proposed amendments to the Constitution and to the Terms of Reference will strengthen the Board and its committees' ability to discharge their functions.
Conflicts of Interest	Conflicts of interest are managed in accordance with the ICB's Conflicts of Interest Policy.
Resource Implications	The proposed amendments to the Constitution and the Committee Terms of Reference will support the ICB is better using its resources.
Engagement	The ICB Chair, Chief Executive and Audit Committee Chair were engaged on the proposed changes to the Constitution prior to submission to the Board of Members. In addition, the Board of Members contains Non-Executive, Executive and Partner Members which bring a wide range of stakeholder perspectives.

	The draft Terms of Reference were shared with the respective committee Chairs and lead Executive Directors.
Equality Impact Analysis	This paper has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	The following governance papers have been presented to the Board of Members: • Supporting Documents to the Constitution- 4 July 2022; • Committee Terms of Reference- 4 July 2022; • Committee Terms of Reference, Standing Financial Instructions and Chair's Action Report- 27 September 2022; • Amendments to ICB Governance Arrangements- 20 November 2022; • Amendments to the ICB's Governance Arrangements- 7 February 2023; • Governance Review- 25 July 2023; • Update to Governance Arrangements- 7 November 2023 • Update to Committee Terms of Reference- 7 May 2024.
Next Steps	If the ICB Board approve the recommendations the next step is to implement them.
Appendices	• Draft Constitution; • Draft NCL ICS People Board Terms of Reference; • Draft Audit Committee Terms of Reference; • Draft Integrated Medicines Optimisation Committee Terms of Reference; • Draft Quality and Safety Committee Terms of Reference.

North Central London ICS People Board
Terms of Reference

1. Introduction

1.1 The North Central London Integrated Care System People Board ('People Board') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a committee of the ICB's Board of Members which will oversee the development and delivery of the Integrated Care System's strategic approach to people.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the People Board.

2. Purpose

2.1 The purpose of the People Board is to:

a. Provide strategic leadership and oversight of the delivery against people priorities including those within NCL strategic transformation programmes;

b. Work together to co-design, promote and deliver the strategic vision for workforce across the ICS and amongst its member organisations and staff;

c. Agree key priorities, programmes, and projects for developing and improving the experience, recruitment, and retention of staff;

d. Optimise the current workforce and build the future workforce required within health and social care in NCL to continue to deliver sustainable high-quality care for the populations that NCL serve;

e. Ensure that NCL ICS leverages the research, education, data and technology assets within the sector to drive innovative and future-focussed workforce transformation;

f. Champion equality and diversity, and challenge inequalities;

g. Identify and mitigate against strategic and programme risks;

h. Ensure interdependencies with other programmes and projects are understood, managed and communicated;

i. Promote engagement in programmes, projects and initiatives and progress on people matters within the ICS;

j. Feedback and act on new priorities and challenges across the NCL workforce;

k. Utilise Board members' influence to champion the NCL workforce programme, acting as advocates for innovation and change;

l. Enhance and accelerate programme benefits and outcomes across the health and care sector;

m. Challenge NCL organisations and the ICS effectively and constructively;

n. Support NCL workforce programme delivery, ensuring quality and tracking of benefits and resource prioritisation;

o. Ensure effective utilisation of available resources and funding for people development to ensure effective deployment (recognising that statutory accountability may lie elsewhere);

p. Adhere to the NHS's 'people promise' and principles of public life (Nolan principles) and uphold the values of the NHS and public sector.

3. Role

3.1 The People Board will:

a. Oversee the development and delivery of the NCL ICS People Strategy and associated plan;

b. Recommend the NCL ICS People Strategy to the ICB's Board of Members for approval and ongoing reviews of the strategy;

c. Commit NCL to action, to deliver against the People Strategy;

d. Ensure the People Strategy is delivering against the objectives of the ICS;

e. Communicate and engage with NCL workforce, promoting NCL People Strategy, workforce programmes and priorities;

f. Identify and act on opportunities for cooperation and delivery of priorities;

g. Support retention and recruitment of staff across NCL, and act as enablers and champions of system change;

h. Agreeing reprioritisation of appropriate ICS People funds within existing budgets.

4. Membership

4.1 The People Board shall comprise of the following voting members:

<u>ICB</u>

a. Non-Executive Member, NCL ICB;
b. Chief People Officer, NCL ICB;
c. Chief Nursing Officer, NCL ICB;

<u>Integrated Care System Partners</u>

a) The following sector members who bring sector experience and perspective to the People Board's deliberations:
    i. Three from HR/People;
    ii. Three from Nursing;
    iii. Two from Medical;
    iv. One from Pharmacy;
    v. Two from Higher Education institutions;
    vi. One from the NCL Training Hubs;
    vii. One from Adult Social Care;
    viii. One from a Local Authority (non-Adult Social Care);
b) One representative from the North Central London GP Provider Alliance;

c) Two representatives from the North Central London Voluntary, Community and Social Enterprise ('VCSE') Alliance;
d) One representative from Skills for Care;
e) Two representatives from the Workforce, Training & Education Directorate of NHS England (previously Health Education England) one of whom shall be a Dean;
f) One ICS representative for Equality, Diversity and Inclusion;
g) One Academic Health Science Network representative;
h) Two representatives from the Allied Health Professionals Council or Faculty.

4.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

4.3 In accordance with the ICB's Constitution all voting members of the People Board must be approved by the ICB's Chair.

4.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

4.5 Voting members may nominate deputies to represent them in their absence.

5. Participants and Observers

5.1 The list of standing participants is contained in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

5.2 Participants at People Board meetings are non-voting.

5.3 The roles referred to in the list of standing participants describe the representation/roles and any equivalent successor representation / roles and not the individual title or titles.

5.4 Standing participants are not permitted to nominate deputies to represent them in their absence unless prior agreement is permitted by the People Board Chair.

5.5 The People Board may invite or allow additional people to attend meetings as participants. Participants may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.6 The People Board may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.7 The People Board may call additional experts to attend meetings on a case by case basis to inform discussion.

6. Chair

6.1 The People Board Chair shall be an NCL ICB Non-Executive Member. The Chair may nominate a deputy to represent them in their absence.

7. Voting

7.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes

working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 7.2 below.

7.2 Each voting member of the People Board shall have one vote with resolutions passing by simple majority. In the event of a tied vote the People Board Chair shall have the casting vote.

8. Quorum

8.1 The People Board will be considered quorate when at least 30% of the voting members are present including the Chair (or the Deputy Chair if the Chair is unable to attend or is excluded due to conflicts of interest) and one ICB officer member.

8.2 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted onto the People Board to satisfy the quorum requirements

8.3 If a meeting is not quorate the People Board Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

9. Secretariat

9.1 The Secretariat to the People Board shall be provided by the Corporate Affairs Directorate.

10. Frequency of People Board Meetings

10.1 People Board meetings will be held quarterly but may hold additional meetings as and when necessary. The People Board Chair may call additional meetings or cancel meetings as necessary.

11. Notice of Meetings

11.1 Notice of a People Board meeting shall be sent to all People Board members no less than 7 days in advance of the meeting.

12. Agendas and Circulation of Papers

12.1 Before each People Board meeting an agenda setting out the business of the meeting will be sent to every People Board member no less than 7 days in advance of the meeting.

12.2 Before each People Board meeting the papers of the meeting will be sent to every People Board member no less than 7 days in advance of the meeting.

12.3 If a People Board member wishes to include an item on the agenda they must notify the People Board Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the People Board Chair.

13. Minutes of Meetings

13.1 The minutes of the proceedings of a meeting shall be prepared by Secretariat and submitted for agreement at the following meeting.

14. Authority

14.1 The Committee is accountable to the Board of Members and will operate as one of its committees.

14.2 The People Board must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

15. Reporting Responsibilities

15.1 The People Board will report to the ICB Board of Members on all matters within its duties and responsibilities.

15.2 The People Board may make recommendations to the ICB Board of Members or any other forum across the Integrated Care System it considers appropriate on any area within its remit.

16. Delegated Authority

16.1 The People Board may agree to delegate its authority to a People Board member or members to make decisions on the People Board's behalf outside of a People Board meeting at its absolute discretion on a case by case basis.

17. Virtual Meetings and Decision Making

17.1 It is a principle of the People Board and an expectation that the People Board will meet in person. However, from time to time the People Board meetings may be held virtually if circumstances require.

17.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

18. Sub-Boards, Working Groups and Task and Finish Groups

18.1 The People Board may appoint sub-board, working groups and task and finish groups to advise the People Board and assist it in carrying out its duties. The People Board may not delegate any of its functions, powers or decision making authority to a sub-board, working group or a task and finish group.

19. Conflicts of Interest

19.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

19.2 The People Board shall have a Conflicts of Interest Register that will be presented as a standing item on the People Board's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the People Board's agenda.

20. Gifts and Hospitality

20.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

20.2 The People Board shall have a Gifts and Hospitality Register and People Board members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the People Board's agenda

21. Standards of Business Conduct

21.1 People Board members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:

21.1.1 The law of England and Wales;
21.2.2 The NHS Constitution;
21.1.3 The Nolan Principles;
21.1.4 The standards of behaviour set out in the ICB's Constitution;
21.1.5 The Standards of Business Conduct Policy;
21.1.6 The Conflicts of Interest Policy;
21.1.7 The Counter Fraud, Bribery and Corruption Policy;
21.1.8 Any additional regulations or codes of practice relevant to the People Board.

22 Review of Terms of Reference

22.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the People Board in fulfilling its functions and the wider experience of the ICB.

22.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the ICB's Board of Members.

Date Approved by the Board of Members:
Date of Next Review:

Schedule 1
List of Members

The voting members of the People Board are:

ICB Members

Position	Name
NCL ICB Non-Executive Member	
NCL ICB Chief People Officer	
NCL ICB Chief Nursing Officer	

Integrated Care System Partners Members

Position	Name
Three sector members- HR/People	
Three sector members- Nursing	
Two sector members- Medical	
One sector member- Pharmacy	
Two sector members- Higher Education institutions	
One sector member- NCL Training Hubs	
One sector member- Adult Social Care	
One sector member- Local Authority (non-Adult Social Care)	
One representative from the North Central London GP Provider Alliance	
Two representatives from the North Central London VCSE Alliance	
One representative from Skills for Care	
One representative from the Workforce, Training & Education Directorate of NHS England one of whom shall be a Dean;	
One ICS representative for Equality, Diversity and Inclusion;	
One Academic Health Science Network representative.	
Two representatives from the Allied Health Professionals Council or Faculty.	

People Board Chair (voting member):

Position	Name
NCL ICB Non-Executive Member	

NHS North Central London
Integrated Care Board
Audit Committee
Terms of Reference

1. Introduction

1.1 The Audit Committee ('Committee') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a committee of the ICB's Board of Members.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2. Purpose

2.1 The purpose of the Committee is to carry out the duties listed in sections 3 to 12 below:

3. Integrated Governance, Risk Management and Internal Control

3.1 The Committee will:

a) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the ICB's activities that support the achievement of the organisational objectives and priorities;
b) Approve the ICB's risk management framework, corporate governance and information governance policies;
c) Seek assurance on the operation of the control environment, corporate governance framework, risk management framework. This includes for risk management reviewing the overall completeness of, and confidence in, the sources of assurance;
d) Review the adequacy and effectiveness of:
    - All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances;
    - The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
    - The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications;
    - The policies and procedures for all work related to counter fraud and security as required by NHS Counter Fraud Authority;
    - The policies and procedures for managing conflicts of interest;
    - The policies and procedures for managing gifts and hospitality.

3.2 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit, counter fraud and other assurance functions, but it will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management an internal control, together with an indication of their effectiveness.

3.3 These will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it. As part of its integrated

approach the Committee will have effective relationships with other key ICB Board of Member committees so that it underpins processes and linkages. However, these other committees must not usurp the Committee's role.

4. Internal Audit

4.1 The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2013 and provides appropriate independent assurance to the Committee, Chief Executive and ICB Board of Members. This will be achieved by:

a) Supporting the provision of the internal audit service and the costs involved;
b) Reviewing and approving the audit strategy, annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
c) Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources;
d) Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation;
e) Monitoring the effectiveness of internal audit and carrying out an annual review.

5. External Audit

5.1 The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

a) Supporting the appointment and performance of the external auditors;
b) Discussing and agreeing with the external auditors before the audit commences the nature and scope of the audit as set out in the annual plan;
c) Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact of the audit fee;
d) Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Board of Members as appropriate) and any work undertaken outside of the annual audit plan, together with the appropriateness of management responses;
e) Ensuring that there is in place a clear policy for the engagement of external auditors when supplying non-audit services.

6. Information Governance

6.1 The Committee shall:

a) Receive regular updates on Information Governance ('IG') compliance (including uptake & completion of data security training), data breaches and any related issues and risks;
b) Review the annual Senior Information Risk Owner ('SIRO') report and the submission for the Data Security & Protection Toolkit audit;
c) Provide assurance to the Board of Members that there is an effective framework in place for the management of risks associated with Information Governance.

7. Other Assurance Functions

7.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the ICB, and consider the implications for the governance of the ICB.

7.2 These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Litigation Authority etc) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies etc).

7.3 In addition, where required the Committee will review the work of other committees within the ICB, whose work can provide relevant assurance to the Committee's own areas of responsibility.

8. Counter Fraud

8.1 The Committee shall satisfy itself that the ICB has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority's standards and shall review the outcomes of work in these areas. This will be achieved by:

a) Considering the provision of the counter fraud service and the costs involved;
b) Reviewing and approving the counter fraud strategy, annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the needs of the organisation;
c) Considering the major findings of internal audit work and management's response;
d) Ensuring that the counter fraud function is adequately resourced and has appropriate standing within the organisation;
e) Monitoring the effectiveness of counter fraud and carrying out an annual review.

9. Management

9.1 The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

9.2 The Committee may also request specific reports from individual functions within the organisation.

10. Financial Reporting

10.1 The Committee shall monitor the integrity of the financial statements of its organisation and any formal announcements relating to its financial performance.

10.2 The Committee should ensure that the systems for financial reporting to the Board of Members, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

10.3 The Committee shall review the annual report and financial statements focussing particularly on:

a) The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee;
b) Changes in, and compliance with, accounting policies, practices and estimation techniques;
c) Unadjusted misstatements in the financial statements;
d) Significant judgments in preparation of the financial statements;
e) Significant adjustments resulting from the audit;
f) Letters of representation;
g) Explanations for significant variances;
h) Ease of understanding of the contents for patients and the public.

11. Whistleblowing

11.1 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

12. Reporting

12.1 The Committee shall report to the Board of Members on how it discharges its responsibilities;

12.2 The minutes of the Committee's meetings shall be formally recorded by the Secretariat and submitted to the Board of Members as required. The Committee Chair shall draw to the attention of the Board of Members any issues that require disclosure to the full Board of Members, or require executive action.

12.3 The Committee will report to the Board of Members at least annually on its work in support of the annual governance statement, specifically commenting on:

a) The fitness for purpose of the assurance framework;
b) The completeness and 'embeddedness' of risk management in the organisation;
c) The integration of governance arrangements;
d) The appropriateness of evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business;
e) The robustness of the processes behind the quality accounts.

12.4 The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

13. Membership

13.1 The Committee shall comprise of the following voting members:

a) The Non-Executive Member who is the Chair of the Audit Committee;
b) One additional Non-Executive Member;
c) A clinician.

13.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

13.3 In accordance with the ICB's Constitution all voting members of the Committee must be approved by the ICB's Chair.

13.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

13.5 Voting members may nominate deputies to represent them in their absence.

14. Participants and Observers

14.1 The following people shall attend Committee meetings as standing participants:

a) Chief Finance Officer
b) Executive Director of Corporate Affairs;
c) Internal Auditors;
d) External Auditors;

e) Counter Fraud.

14.2 Participants at Committee meetings are non-voting.

14.3 The roles referred to in the list of standing participants above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

14.4 The Chief Executive will be invited to attend an audit committee meeting at least once per year to discuss the process for assurance that supports the annual governance statement and the annual report and accounts. The list of standing participants is contained in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

14.5 Standing participants may nominate deputies to represent them in their absence.

14.6 The Committee may invite or allow additional people to attend meetings as participants. Participants may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

14.7 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

14.8 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

15. Chair

15.1 The Committee Chair shall be the Non-Executive Member who is the Audit Committee Chair**.** The Chair may nominate a deputy to represent them in their absence.

16. Voting

16.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 16.2 below.

16.2 Each voting member of the Committee shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Committee Chair shall have the casting vote.

17. Quorum

17.1 The Committee will be considered quorate when at least 3 voting members are present.

17.2 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted onto the Committee to satisfy the quorum requirements.

17.3 If a meeting is not quorate the Committee Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

18. Secretariat

18.1 The Secretariat to the Committee shall be provided by the Corporate Affairs Directorate.

19. Frequency of Committee Meetings

19.1 The Committee will meet up to five times a year. However, the Committee Chair may call additional meetings or cancel meetings as necessary.

20. Notice of Meetings

20.1 Notice of a Committee meeting shall be sent to all Committee members no less than 7 days in advance of the meeting.

20.2 The meeting shall contain the date, time and location of the meeting.

21. Agendas and Circulation of Papers

21.1 Before each Committee meeting an agenda setting out the business of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

21.2 Before each Committee meeting the papers of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

21.3 If a Committee member wishes to include an item on the agenda they must notify the Committee Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Committee Chair.

22. Minutes of Meetings

22.1 The minutes of the proceedings of a meeting shall be prepared by the Corporate Services Directorate and submitted for agreement at the following meeting.

23. Authority

23.1 The Committee is accountable to the Board of Members and will operate as one of its committees. The Committee must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

23.2 The Committee is authorised by the Board of Members to obtain at the ICB's expense outside legal or other professional advice on any matters within the Committee's Terms of Reference. They are authorised to seek any information they require from any employees or officers and all employees and officers are directed to co-operate with any request made in this regard.

23.3 The Committee is authorised by the Board of Members to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if they consider this necessary.

23.4 The Committee may meet privately with the internal and external auditors at their absolute discretion.

23.5 The Head of Internal Audit, representatives of external audit and counter fraud specialists have a right of access to the Committee Chair.

24. Reporting Responsibilities

24.1 The Committee will report to the Board of Members on all matters within its duties and responsibilities.

24.2 The Committee may make recommendations to the Board of Members it considers appropriate on any area within its remit.

25. Delegated Authority

25.1 The Committee may agree to delegate its authority to a Committee member or members to make decisions on the Committee's behalf outside of a Committee meeting at its absolute discretion on a case by case basis.

26. Virtual Meetings and Decision Making

26.1 Committee meetings may be held in person or virtually.

26.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

27. Sub-Committees

27.1 The Committee may appoint sub-committees to advise the Committee and assist it in carrying out its duties. The Committee may not delegate any of its functions, powers or decision making authority to a sub-committee.

28. Conflicts of Interest

28.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

28.2 The Committee shall have a Conflicts of Interest Register that will be presented as a standing item on the Committee's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Committee's agenda

29. Gifts and Hospitality

29.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

29.2 The Committee shall have a Gifts and Hospitality Register and Committee members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the Committee's agenda

30. Standards of Business Conduct

30.1 Committee members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:

30.1.1 The law of England and Wales;
30.1.2 The NHS Constitution;
30.1.3 The Nolan Principles;
30.1.4 The standards of behaviour set out in the ICB's Constitution;
30.1.5 The Standards of Business Conduct Policy;
30.1.6 The Conflicts of Interest Policy
30.1.7 The Counter Fraud, Bribery and Corruption Policy,
30.1.8 Any additional regulations or codes of practice relevant to the Committee.

30.2 The Committee will have access to sufficient resources to carry out its duties and Committee members will be provided with appropriate and timely training.

31. Review of Terms of Reference

31.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the Committee in fulfilling its functions and the wider experience of the ICB.

31.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the Board of Members.

Date Approved by the Board of Members:
Date of Next Review:

Schedule 1
List of Members

The voting members of the Committee are:

Position	Name

Committee Chair:

Position	Name

The standing participants are:

Position	Name

NHS North Central London
Integrated Care Board
Integrated Medicines Optimisation Committee
Terms of Reference

1. Introduction

1.1 The Integrated Medicines Optimisation Committee ('Committee') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a sub-committee of the ICB Quality and Safety Committee.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2. Purpose

2.1 The purpose of the Committee is to:

a) Provide oversight and assurance on the ICB's statutory functions on medicines;
b) Provide oversight and assurance on medicines to ensure:
   - Safe and clinically effective use of medicines;
   - Improved clinical outcomes;
   - Best value of medicines use;
   - The promotion of proper use of medicines;
   - Safe and consistent access to medicines in the context of care pathways which cross multiple providers;
c) Oversee the development and implementation of the ICB's medicines management strategy and procedures;
d) Provide clinical leadership for the system and ensure co-operation and consistency of approach to medicines optimisation across the NCL Integrated Care System;
d) Oversee the arrangements for sponsorship and/or joint working with the pharmaceutical industry.

3. Role

3.1 The Committee has two key areas of focus:

a) The ICB's internal medicines functions;
b) The ICB's wider system leadership.

3.2 In relation to the ICB's internal medicines functions the Committee shall:

a) Oversee and monitor implementation of the ICB's medicines management strategy, policies and procedures;
b) Ensure the ICB meets its constitutional requirements in making treatments available to patients and has the appropriate governance and systems in place to support treatment decision-making;
c) Provide advice, guidance and/or instructions to the ICB on medicines optimisation, medicines safety, medicines related quality improvements, medicine management and pharmaceutical and prescribing matters;
d) Approve medicines investments in line with the Committee's delegated financial authority limits;
e) Provide advice and support on cost effective, evidence based, best value prescribing to the ICB;

f) Monitor prescribing spend and efficiencies, inform and provide advice to the ICB on budget pressures, budget setting and financial forward planning in relation to medicines and prescribing;
g) Identify cost improvement opportunities and form solutions to enable CIP initiatives to be successful;
h) Approve ICB medicines policies, prescribing guidelines, clinical pathways and any other information, including information for patients, involving medicines. Engage relevant clinical opinion from stakeholder organisations in the development of proposals and recommendations on the management of medicines;
i) Oversee and advise on the impact and implementation of relevant medicines related national, regional and system policies and guidance;
j) Consider recommendations from the NCL Joint Formulary ('JFC'), the NCL Pharmacy Leadership Forum (PLF), the Medicines Clinical Reference Group ('CRG') and the Medicines Finance and Value Group;
k) Approve the NCL ICB prescribing recommendations list for GP practices and relevant commissioned services as appropriate;
l) Consider and make recommendations on the introduction and impact of new medicines as appropriate and their impact on ICB policies, resources, services and commissioning. This includes the implications for services arising from the managed introduction of a new medicines or the use of an established medicine for a new indication;
m) Advise on the management of entry of new medicines, or new indications for existing medicines, into the health and social care economy. Make prescribing recommendations for the use of medicines incorporating recommendations from NICE and commissioning decisions for drugs and advise on medicines use in order to ensure the best use of medicines and associated resources across the healthcare system locally, resulting in a clear commissioning framework for medicines use;
n) Ensure that processes underpinning local decision-making about medicines and treatments are consistent with the NHS Constitution and in accordance with common law, and that NICE recommendations and good practice guidance are taken in to consideration;
o) Review reports on assurance and performance against the NHS Oversights Framework and the results of controlled drugs prescribing monitoring, investigation, and actions to prevent inappropriate or fraudulent prescribing;
p) Contribute to the development of solutions to medicines or prescribing issues identified;
q) Provide support on medicines management issues to all relevant directorates, teams, and groups within the ICB;
r) Ensure that medicines management issues are fed into the wider clinical and corporate governance of the ICB as appropriate;
s) Review and make decisions on sponsorship and/or joint working with the pharmaceutical industry as per the ICB's Sponsorship and Joint Working With The Pharmaceutical Industry Policy (the policy is approved by the Audit Committee);
t) Oversee and monitor the arrangements agreed under the Sponsorship and Joint Working With The Pharmaceutical Industry Policy;
u) Make recommendations for amendments to the Sponsorship and Joint Working With The Pharmaceutical Industry Policy to the Audit Committee.

3.3 In relation to the ICB's wider system leadership the Committee shall:

a) Ensure the ICB works collaboratively with partner organisations across the North Central London Integrated Care System ('ICS') and Borough Partnerships ('BPs') as appropriate and particularly in regards to:
    - Population health and prevention, reducing variation and optimising outcomes for our populations;
    - Advising on pharmacy and prescribing related workforce developments, including within GP practices and Primary Care Networks ('PCNs') and ensuring

collaboration with the North Central London workforce programme regarding integration and modernisation of the workforce to deliver new care models, educating and training;
- Ensuring the provision of care in respect of medicines is delivered within the most appropriate care setting to meet the pharmaceutical and medicines optimisation needs of the local population;
- Supporting the reduction in avoidable medication waste to ensure NHS resources are used efficiently;

b) Consider NICE recommendations, impact for the ICB as a commissioner and the ICS system and advise on implementation;
c) Ensure principles of medicines optimisation are embedded in to practice, ensuring medicines deliver value, are clinically-effective and cost-effective and ensure people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team;
d) Promote prescribing practice standardisation and reduce variation to ensure optimal outcomes for patients and reduce risk and support patient safety with regard to medicines;
e) Monitor inappropriate prescribing and, where appropriate, advise on steps to manage this;
f) Advise on strategies to support self-care and prevention of ill health;
g) Have an overview of implementation of MHRA, National and local drug / patient safety alerts within the local health economy;
h) Support risk management, assurance, audit and research relevant to medicines-related issues;
i) Ensure the development / transformation of community pharmacy is embedded in local Pharmacy and Medicines Optimisation Strategy;
j) Make decisions relating to the commissioning of community pharmacy services in a timely way in compliance with the ICB Governance. Framework, engaging appropriately with other ICBs via the Pharmacy, Optometry and Dental Commissioning Oversight Group, where such decisions impact across ICB borders;
k) Support implementation and delivery of all responsibilities retained by each individual ICB for Community Pharmacy described in the MoU with NEL ICB following delegation to ICBs of pharmacy, optometry and dental commissioning under the NHS England Delegation Agreement;
l) Escalate as appropriate to the ICB Strategy & Development Committee ('SDC') and the Board who retain overall authority for delegated pharmacy, optometry and dental services and the MoU with NEL ICB and Delegation Agreement with NHS England.

3.4 In relation to its ICB internal medicines functions and wider system leadership (as appropriate), the Committee shall:
a) Oversee and approve Medicines investments within the Committee's delegated financial authority limits;
b) Provide oversight and scrutiny of medicines risks regarding the ICB and wider system;
c) Provide reports to the Board of Members, the Quality and Safety Committee and/or the Strategy and Development Committee as required.

3.5 The Committee will also ensure that the committee is patient focussed and that patients have been engaged in the development of relevant proposals.

4. Membership

4.1 The Committee shall comprise of the following voting members:
a) A clinical member of the Board of Members other than the Chief Medical Officer or Chief Nursing Officer;
b) Chief Medical Officer;

c) ICS Chief Pharmacist;
d) Chief Nursing Officer;
e) Executive Director of Place;
f) A director of finance.

4.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

4.3 In accordance with the ICB's Constitution all voting members of the Committee must be approved by the ICB's Chair.

4.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

4.5 Voting members may nominate deputies to represent them in their absence.

5. Participants and Observers

5.1 The following people shall attend Committee meetings as standing participants:
a) Clinical and Care Director (prescriber)
b) Assistant Director of Medicines Optimisation;
c) Director of Public Health or Consultant in Public Health;
d) Lead for the High Cost Drugs function;
e) 2 Community Participants;
f) 5 Sector members who bring sector experience and perspective to Committee's deliberations.

5.2 Participants at Committee meetings are non-voting.

5.3 The roles referred to in the list of standing participants above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

5.4 The list of standing participants is contained in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

5.5 Standing participants may nominate deputies to represent them in their absence.

5.6 The Committee may invite or allow additional people to attend meetings as participants. Participants may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.7 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.8 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

6. Chair

6.1 The Committee Chair shall be the clinical member of the Board of Members other than the Chief Medical Officer or Chief Nursing Officer. The Chair may nominate a deputy to represent them in their absence.

7. Voting

7.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 7.2 below.

7.2 Each voting member of the Committee shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Committee Chair shall have the casting vote.

8. Quorum

8.1 The Committee will be considered quorate when at least the following voting members are present:

a) The Chair;
b) A Clinician; and,
c) An Executive Director.

8.2 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted onto the Committee to satisfy the quorum requirements.

8.3 If a meeting is not quorate the Committee Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

9. Secretariat

9.1 The Secretariat to the Committee shall be provided by Corporate Affairs Directorate.

10. Frequency of Committee Meetings

10.1 Committee meetings will be held bi-monthly but may hold additional meetings as and when necessary. The Committee Chair may call additional meetings or cancel meetings as necessary.

11. Notice of Meetings

11.1 Notice of a Committee meeting shall be sent to all Committee members no less 7 days in advance of the meeting.

11.2 The meeting shall contain the date, time and location of the meeting.

12. Agendas and Circulation of Papers

12.1 Before each Committee meeting an agenda setting out the business of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.2 Before each Committee meeting the papers of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.3 If a Committee member wishes to include an item on the agenda they must notify the Committee Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Committee Chair.

13. Minutes of Meetings

13.1 The minutes of the proceedings of a meeting shall be prepared by the Secretariat and submitted for agreement at the following meeting.

14. Authority

14.1 The Committee is accountable to the ICB Quality and Safety Committee and will operate as one of its sub-committees. The Committee must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

14.2 The Committee is authorised by the Board of Members to obtain at the ICB's expense outside legal or other professional advice on any matters within the Committee's Terms of Reference.

15. Reporting Responsibilities

15.1 The Committee will report to Board of Members, ICB Quality and Safety Committee and/or the Strategy and Development Committee where appropriate on all matters within its duties and responsibilities as required.

15.2 The Committee may make recommendations to the ICB Board of Members, the Quality and Safety Committee and/or the Strategy and Development Committee and/or any other committee it considers appropriate on any area within its remit.

16. Delegated Authority

16.1 The Committee may agree to delegate its authority to a Committee member or members to make decisions on the Committee's behalf outside of a Committee meeting at its absolute discretion on a case by case basis.

17. Virtual Meetings and Decision Making

17.1 Committee meetings may be held in person or virtually.

17.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

17.3 In addition to the general authority set out in clause 17.2 above, due to the nature of its remit the Committee recognises that some urgent and immediate decisions may need to be made outside of Committee meetings and that the use of the protocol for virtual decision making is not appropriate. The Committee may therefore delegate urgent and immediate decisions that need to be made outside of Committee timescales in accordance with clauses 17.4 – 17.5 and 17.8 below.

17.4 Urgent decisions requiring a response within 24 hours will be made collectively by the following people or their nominated deputies:

a) The Committee Chair;
b) A Clinical member of the Committee;
c) Executive Director of Place.

17.5 Immediate decisions requiring a response within 2 weeks will be made at a Committee meeting where practicable or by the protocol for virtual decision making. Where this is not practicable the following people or their nominated deputies will collectively make the decision:
a) The Committee Chair;
b) A Clinical member of the Committee;
c) Executive Director of Place.

17.6 Due to the nature of its remit the Committee recognises that non-contentious, low risk, decisions may be made outside of Committee meetings by those listed in clause 17.7 below. The Committee shall agree a list of those decision that fall within the remit of this clause 17.6.

17.7 The following people or their nominated deputies may collectively make the non-contentious, low risk decisions set out in clause 17.6 above:
a) The Committee Chair;
b) A Clinical member of the Committee;
c) Executive Director of Place.

17.8 Decisions made outside of Committee meetings will be reported to the Committee at the next Committee meeting.

18. Sub-Committees

18.1 The Committee may not appoint sub-committees but may appoint working groups to advise the Committee and assist it in carrying out its duties. The Committee may not delegate any of its functions, powers or decision making authority to a sub-committee.

19. Conflicts of Interest

19.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

19.2 The Committee shall have a Conflicts of Interest Register that will be presented as a standing item on the Committee's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Committee's agenda

20. Gifts and Hospitality

20.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

20.2 The Committee shall have a Gifts and Hospitality Register and Committee members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the Committee's agenda

21. Standards of Business Conduct

21.1 Committee members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:
a) The law of England and Wales;
b) The NHS Constitution;
c) The Nolan Principles;
d) The standards of behaviour set out in the ICB's Constitution;
e) The Standards of Business Conduct Policy;
f) The Conflicts of Interest Policy
g) The Counter Fraud, Bribery and Corruption Policy,

h) Any additional regulations or codes of practice relevant to the Committee.

21.2 The Committee will have access to sufficient resources to carry out its duties and Committee members will be provided with appropriate and timely training.

22. Review of Terms of Reference

22.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the Committee in fulfilling its functions and the wider experience of the ICB.

22.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the Board of Members.

Date Approved by the Board of Members:
Date of Next Review:

Schedule 1
List of Members

The voting members of the Committee are:

Position	Name
A clinical member of the Board of Members other than the Chief Medical Officer or Chief Nursing Officer	
Chief Medical Officer	
Deputy Chief Clinical Officer and ICS Chief Pharmacist	
Chief Nursing Officer	
Executive Director of Place	
A director of finance	

Committee Chair:

Position	Name
A clinical member of the Board of Members other than the Chief Medical Officer or Chief Nursing Officer	

The standing participants are:

Position	Name
Clinical and Care Director (prescriber)	
Assistant Director of Medicines Optimisation	
Director of Public Health or Consultant in Public Health	
Lead for the High Cost Drugs function	
2 Community Participants	
5 Sector members who bring sector experience and perspective to Committee's deliberations	

NHS North Central London
Integrated Care Board
Quality and Safety Committee
Terms of Reference

1. Introduction

1.1 The Quality and Safety Committee ('Committee') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a committee of the ICB's Board of Members.

1.2 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2. Purpose

2.1 The purpose of the Committee is to provide oversight, scrutiny and assurance of the following areas on behalf of the Board of Members and to provide robust recommendations and/or directions for actions:

a) The quality and safety of commissioned services;
b) Reducing inequalities in outcomes, experience and access;
c) The effectiveness of patient care and high quality patient experience;
d) Provider service quality performance and quality improvement initiatives;
e) Continuous quality improvement and shared learning across the system;
f) Safeguarding and complaints.

3. Role

3.1 The Committee will:

a) Oversee and monitor delivery of the ICB key statutory requirements in relation to quality, safety, clinical effectiveness, professional and clinical standards;
b) Ensure that the ICB vision for quality care underpins the work of the ICB Population Health and Integrated Care Strategy;
c) Ensure that quality, patient safety and patient experience are at the core of the ICB's approach to commissioning and oversee the development and embedding of a culture within the ICB which supports this approach;
d) Understand quality from the perspective of people drawing on services, to include co-ordination/integration of care, and promote a culture of learning and improvement across the ICS;
e) Ensure that there are robust processes in place for the effective management of quality and safety across commissioned health and care services in North Central London;
f) Explore structures in place to support quality, clinical effectiveness, and safety; planning, control, and improvement programmes, to be assured that the structures operate effectively, and timely action is taken to address areas of concern;
g) Devise and agree the key quality priorities in terms of access, experience and outcomes drawing on the agreed 'I' statements within the population health improvement strategy, including priorities to address variation and inequalities in care;
h) Review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care;
i) Ensure the ICB is kept informed of significant risks and mitigation plans;
j) Review Patient Group Directions to ensure appropriate governance is in place (before approval by the ICB Chief Medical Officer);

k) Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standards, policies, reports, reviews and best practice as issued by the DHSC, NHSE and other regulatory bodies/external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained;
l) Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes;
m) Seek assurance, including through the Patient Safety Incident Response Framework, that the ICB identifies lessons learned from all relevant sources, including, serious untoward incidents requiring investigation, never events, safety alerts, complaints and claims and ensures that learning is disseminated and embedded;
n) Seek assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and associated metrics, including Learning from Deaths ('LFD') reports (including coronial inquests and LFD reports);
o) Have oversight of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children;
p) Have oversight of the arrangements for and assure compliance with the ICB's statutory responsibilities for Infection Prevention and Control;
q) Have oversight of approaches taken by our system partners to reduce health inequalities and inequities in care oversee the robustness of these arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services;
r) Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines safety and controlled drugs.
s) Approve quality, safety and clinical effectiveness policies on behalf of the Board of Members;
t) Scrutinise research proposals to ensure that there are robust processes in place for the effective management of quality and safety;
u) Provide oversight of the Integrated Medicines Optimisation Committee and receive and scrutinise reports from the Integrated Medicines Optimisation Committee as appropriate;
v) Oversee and approve the Terms of Reference for the System Quality Group.

4. Membership

4.1 The Committee shall comprise of the following voting members:

a) Two Non-Executive Members, one will have the remit and responsibility for Quality;
b) Chief Nursing Officer;
c) Chief Medical Officer;
d) Executive Director of Transformation and Performance;
e) Three Sector Representatives who bring sector experience and perspective to Committee's deliberation from:
    - Primary and/or community care;
    - Mental health or Acute;
    - Local Authority
f) Director of Quality.
g) Director of Safeguarding.
h) Place based safety representative

4.2 The roles referred to in the list of voting members above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

4.3 In accordance with the ICB's Constitution all voting members of the Committee must be approved by the ICB's Chair.

4.4 The list of voting members is set out in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

4.5 Voting members may nominate deputies to represent them in their absence.

5. Participants and Observers

5.1 The following people shall attend Committee meetings as standing participants:
a) Two Community Participants;
b) A Healthwatch representative.

5.2 Participants at Committee meetings are non-voting.

5.3 The roles referred to in the list of standing participants above describe the substantive roles and any equivalent successor roles and not the individual title or titles.

5.4 The list of standing participants is contained in Schedule 1. Schedule 1 does not form part of the Terms of Reference and may be amended without the need to formally amend these Terms of Reference.

5.5 Standing participants may nominate deputies to represent them in their absence.

5.6 The Committee may invite or allow additional people to attend meetings as participants. Participants may present at meetings and contribute to the relevant discussions but are not allowed to participate in any formal vote.

5.7 The Committee may invite or allow people to attend meetings as observers. Observers may not present at meetings, contribute to any discussion or participate in any formal vote.

5.8 The Committee may call additional experts to attend meetings on a case by case basis to inform discussion.

6. Chair

6.1 The Committee Chair shall be the Non-Executive Member with the remit and responsibility for Quality. The Chair may nominate a deputy to represent them in their absence.

7. Voting

7.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 7.2 below.

7.2 Each voting member of the Committee shall have one vote with resolutions passing by simple majority. In the event of a tied vote the Committee Chair shall have the casting vote.

8. Quorum

8.1 The Committee will be considered quorate when at least the following voting members are present:
a) The Chair;
b) ICB Chief Nurse or ICB Chief Medical Officer; and,

c) A Sector Representative.

8.2 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting inquorate a non-conflicted person may be temporarily appointed or co-opted onto the Committee to satisfy the quorum requirements.

8.3 If a meeting is not quorate the Committee Chair may adjourn the meeting to permit the appointment or co-option of additional members if necessary.

9. Secretariat

9.1 The Secretariat to the Committee shall be provided by Corporate Affairs Directorate.

10. Frequency of Committee Meetings

10.1 The Committee will meet at least five times a year but may hold additional meetings as and when necessary. The Committee Chair may call additional meetings or cancel meetings as necessary.

11. Notice of Meetings

11.1 Notice of a Committee meeting shall be sent to all Committee members no less than 7 days in advance of the meeting.

11.2 The meeting shall contain the date, time and location of the meeting.

12. Agendas and Circulation of Papers

12.1 Before each Committee meeting an agenda, agreed by the Chair and Executive Lead, setting out the business of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.2 Before each Committee meeting the papers of the meeting will be sent to every Committee member no less than 7 days in advance of the meeting.

12.3 If a Committee member wishes to include an item on the agenda they must notify the Committee Chair via the Secretariat no later than 7 days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Committee Chair.

13. Minutes of Meetings

13.1 The minutes of the proceedings of a meeting, including the agreed action points, shall be prepared by the Secretariat and submitted for agreement at the following meeting.

14. Authority

14.1 The Committee is accountable to the Board of Members and will operate as one of its committees. The Committee must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

14.2 The Committee is authorised by the Board of Members to obtain at the ICB's expense outside legal or other professional advice on any matters within the Committee's Terms of Reference.

15. Reporting Responsibilities

15.1 The Committee will report to the Board of Members on all matters within its duties and responsibilities.

15.2 The Committee may make recommendations to the Board of Members and/or any other committee or sub-committee it considers appropriate on any area within its remit.

16. Delegated Authority

16.1 The Committee may agree to delegate its authority to a Committee member or members to make decisions on the Committee's behalf outside of a Committee meeting at its absolute discretion on a case by case basis.

17. Virtual Meetings and Decision Making

17.1 Committee meetings may be held in person or virtually.

17.2 There are circumstances where time-critical decisions need to be made and it is not possible and/or reasonably practicable and/or a good use of resources to hold a physical meeting (either in person or virtually) in sufficient time. In these circumstances decisions may be made virtually using the protocol for virtual decision making.

18. Sub-Committees

18.1 The Committee has a sub-committee with delegated functions and authorities which is:
a) Integrated Medicines Optimisation Committee.

18.2 The Committee may appoint additional sub-committees to advise the Committee and assist it in carrying out its duties. The Committee may not delegate any of its functions, powers or decision making authority to any of its additional sub-committees.

19. Conflicts of Interest

19.1 Conflicts of Interest shall be dealt with in accordance with the Conflicts of Interest Policy and NHS England statutory guidance for managing conflicts of interest.

19.2 The Committee shall have a Conflicts of Interest Register that will be presented as a standing item on the Committee's agenda. In addition, an opportunity to declare any new or relevant declarations of interest will be listed as a standing item on the Committee's agenda

20. Gifts and Hospitality

20.1 Gifts and Hospitality shall be dealt with in accordance with the Conflicts of Interest Policy, and NHS England statutory guidance for managing conflicts of interest.

20.2 The Committee shall have a Gifts and Hospitality Register and Committee members will have an opportunity to declare any new or relevant declarations of relevant gifts and hospitality as a standing item on the Committee's agenda

21. Standards of Business Conduct

21.1 Committee members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:
a) The law of England and Wales;
b) The NHS Constitution;

c) The Nolan Principles;
d) The standards of behaviour set out in the ICB's Constitution;
e) The Standards of Business Conduct Policy;
f) The Conflicts of Interest Policy
g) The Counter Fraud, Bribery and Corruption Policy,
h) Any additional regulations or codes of practice relevant to the Committee.

21.2 The Committee will have access to sufficient resources to carry out its duties and Committee members will be provided with appropriate and timelchy training.

22. Review of Terms of Reference

22.1 These Terms of Reference will be reviewed from time to time, reflecting the experience of the Committee in fulfilling its functions and the wider experience of the ICB.

22.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the Board of Members.

Date Approved by the Board of Members:
Date of Next Review:

Schedule 1
List of Members

The voting members of the Committee are:

Position	Name
Non-Executive Member	
Non-Executive Member	
ICB Chief Nurse	
ICB Chief Medical Officer	
Executive Director of Transformation and Performance	
Sector Representative - community care	
Sector Representative - Mental health or Acute	
Sector Representative - Local Authority	
Director of Quality	
Director of Safeguarding	
Place based safety representative	

Committee Chair:

Position	Name
Non-Executive Member	

The standing participants are:

Position	Name
Community Participant	
Community Participant	
A Healthwatch representative	

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
12 November 2024

Report Title	NCL ICB Integrated Performance and Quality Report	**Date of report**	22 October 2024	**Agenda Item**	3.1
Lead Director / Manager	Richard Dale, Executive Director of Performance and Transformation Dr Chris Caldwell, Chief Nurse	**Email / Tel**		richard.dale@nhs.net chris.caldwell@nhs.net	
Board Member Sponsor	Dr Chris Caldwell, Chief Nurse				
Report Author	Alex Cox, Director of Performance Jenny Goodridge, Director of Quality & Clinical Standards	**Email / Tel**		alex.cox2@nhs.net jenny.goodridge2@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** The report does not set out specific financial requests, but some of the improvement programmes do have financial implications. Within the System Oversight Framework, finance is a key aspect of oversight. The detail of this is contained in the separate finance report.			
Report Summary	The NCL ICB Integrated Performance and Quality Report presents the latest analyses of key system operational performance indicators against national and locally agreed targets relating to primary care, mental health, community and acute services. Areas of progress: • NCL practices consistently exceed the national aspiration of providing 90% of appointments within 2 weeks of booking and offer a higher-than-average percentage of same day appointments. • As of September 2024, NCL is meeting all 2024/25 Operating Plan measures relating to Learning Disability and Autism (LDA). The LDA Programme has established an annual health check working group to				

	ensure an NCL System approach towards service provision, and has harmonised processes and administration across learning difficulties and mental health for the individualised aspects of the LDA programme • NCL A&E 4-hour performance is tracking above the 2024/25 Operating Plan trajectory for September 2024, with the target having been met for the previous 3 months too. NCL Providers are actively implementing local improvement plans aligned with national priorities set out by NHSE, with the primary goal of reducing time people spend in A&E or waiting for ambulances in the community: • Overall, the levels of elective activity continue to be above the 2024/25 Operating Plan trajectory. This is supporting not only the reduction in the backlog, but continued progress on reducing long waiting patients. Ongoing challenges and further work: • The national ambition to eliminate 65 week waits by September 2024 will not be met by the NCL System, and in line with other systems regionally and nationally, NCL ICB has worked with NHSE London, GOSH, RFL and UCLH to develop refreshed trajectories for clearance. NCL Trusts are currently delivering the revised plans • Performance for Talking Therapies (TT) remains varied across the 2024/25 Operating Plan metrics, as while the August 2024 plan was met for Reliable Recovery, Reliable Improvement and the 2+ contacts and discharge measure were not achieved. The North London Mental Health Partnership have developed and are implementing a recovery plan to bring performance back on track. • For cancer measures, NCL's Faster Diagnosis Standard (FDS) achievement and 62-day performance remains challenged. Recognising the Trusts' FDS and 62-day performance challenges, RFL was moved into Tier 1 and NMUH to Tier 2, in September 2024. • At NMUH, performance against agreed SOF exit criteria remains challenged. A&E 4-hour performance have been met for 2 of the first 6 months of 2024/25, but cancer metrics continue to track below plan in year. Ambulance handovers remain a key focus in 2024/25, and performance has shown improvements month on month up to September 2024. NCL ICB is actively supporting NMUH with implementation of its UEC improvement programme and maintains regular touchpoints, alongside the monthly and quarterly System Oversight Framework meetings. This report provides an overview of key quality issues/developments and/or any new national/regional guidance/regulations that will impact on quality across the ICS, including: • Concerns about a neurological centre provider • NHSE National Paediatric Audiology Improvement work • Review into operational effectiveness of the Care Quality Commission • National review of adult gender services by NHSE. The above items were discussed at Quality and Safety Committee on October 29th, 2024, and are being presented as a summary to the Board.
Recommendation	The Board of Members is asked to **NOTE** the key issues set out in the paper for escalation and the actions in place to support improvement.

Identified Risks and Risk Management Actions	Key risks identified are detailed in the BAF and listed below: • PERF5: Failure to deliver Cancer 62-day waiting time standard (Threat). • PERF8: Failure to Deliver Referral-To-Treatment ('RTT') Waiting Time Standard (Threat). • PERF29: Failure to deliver timely urgent and emergency care for the residents of NCL (Threat).
Conflicts of Interest	Not applicable.
Resource Implications	The report does not set out specific resource requests, but some of the improvement programmes do have resourcing implications.
Engagement	Not applicable.
Equality Impact Analysis	Not applicable – although quality processes do take account of equity when reviewing specific incidents.
Report History and Key Decisions	This report is underpinned by the Quality Report to the Quality and Safety Committee and the Performance Report shared across the organisation and system.
Next Steps	The report will continue to iterate based on board and stakeholder feedback, as well as develop alongside the NCL Outcomes Framework.
Appendices	Full dashboards for measures are set out in the appendix for reference.

North Central London
Integrated Care Board

NCL ICB Integrated Performance and Quality Report

October 2024

Author: NCL ICB Performance and Quality Teams

Overview of this Report

North Central London
Integrated Care Board

The NCL ICB Integrated Performance and Quality Report presents the latest analyses of key system operational performance and quality indicators against national and locally agreed targets relating to primary care, mental health, community and acute services.

The report focusses on the following key areas:

- Quality overview (slides 3 and 4)
- Primary Care (slide 5)
- Mental Health Services (slides 6 and 7)
- Community Health Services (slide 8)
- Urgent and Emergency Care (UEC) (slides 9 and 10)
- Electives (slide 11)
- Diagnostics (slide 12)
- Cancer Services (slide 13)

Progress updates are also provided for the following organisations in Segment 3 of the national System Oversight Framework (SOF), where improvement support is mandated by the regulator:

- Royal Free London (slide 14)
- North Middlesex Hospital (slide 14)
- Tavistock and Portman (slide 15)

The report includes a high-level overview of actions being taken to address key challenges and mitigations against identified key risks. NCL ICB has systems and processes in place to ensure all performance measures across different frameworks are closely monitored, prioritised and escalated where appropriate. This includes the SOF, Operational Plans, the Long-Term Plan and NHS Constitutional Standards.

The report incorporates aspects of the 2024/25 NHS Priorities and Operational Plan - NCL ICB are monitoring activity against trajectories taking into account all known risks. This includes the further collaborative work with providers to work towards elective activity targets, improve bed capacity to enhance A&E performance trajectories, and the efficient use of mental health beds to reduce the reliance on out of area placements.

Dashboards for performance are included in the appendix for reference, alongside the NCL System Balanced Scorecard. These are used alongside regular performance reports to track and support improvement through ICB committees and system forums.

The ICB's approach to performance management is designed to complement the NCL ICS Population Health Strategy, which focuses on improving the health of our population by improving outcomes and reducing health inequalities. The operational and process measures set out in the report are therefore aligned and underpin the delivery of the outcome measures set out in the NHS ICS Population Health Strategy.

This report will continue to evolve as we develop measures and metrics in line with our population health and integration delivery plan, and a future focus on inequalities in care.

Overview of Quality (1/2)

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Jacobs and Gardens Neurological Centres

NCL ICB currently commissions specialist inpatient beds with Jacobs Neuro Centre and Gardens Neuro Centre, providing specialist inpatient rehabilitation and complex disability management services for those who have complex neurological conditions including acquired brain injury, spinal injury and neuro-progressive conditions. Jacobs and Gardens, situated on the same site in Hertfordshire, are both owned by Elysium and between them provide 112 beds for complex patients.

NCL ICB Continuing Healthcare (CHC) teams have a small number of patients currently placed at Jacobs and Gardens with a range of complex needs including tracheotomy care and some in Persistent Disorders of Consciousness (PDoC).

Hertfordshire Local Authority holds lead safeguarding responsibilities for this provider, whilst Herts and West Essex (HWE) ICB has quality oversight responsibility on behalf of health.

NCL ICB has raised concerns regarding safeguarding and quality issues with this provider and have significantly stepped up our surveillance to ensure our patients' needs are being met safely. Placements to this provider have been suspended whilst lead commissioners work with the provider to improvement quality and safety.

The national NHSE quality and safety team has been informed of the concerns with these sites because ICBs from around the country have placed patients there. The CQC is also sighted on the issues.

We continue to work with patients/relatives to ensure the safety of our patients residing with this provider and are working with Herts ICB and Elysium to support significant improvements in care and service delivery.

NHSE National Paediatric Audiology Improvement work

Following an independent review of Paediatric Audiology at NHS Lothian, which identified systemic failings leading to some babies and children being undiagnosed or receiving late diagnosis, a national audit was instigated to understand the scale of the problem. Recognising the system wide nature of the issues identified, a National Paediatric Hearing Improvement Programme was established by NHS England to support providers and ICBs to improve the quality of paediatric audiology services.

Across NCL, Paediatric Hearing Services are provided by University College London Hospital University NHS Foundation Trust (UCLH), Whittington Health NHS Trust (WH) and Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH).

The national Chief Scientific Officer wrote to all ICB Chief Executives, Medical Directors, and Directors of Nursing to request immediate action on reviewing the quality of paediatric hearing services. https://www.england.nhs.uk/publication/paediatric-hearing-services-improvement-programme-system-recommendations-for-immediate-action/

A stage 1 & 2 review of our three NCL providers was undertaken from September – December 2023, with feedback provided to each of the teams in January 2024 by NHSE. ICBs were informed at the end of September that the national team will be undertaking a stage 3 peer review of these providers, which the ICB will need to co-ordinate.. A full briefing and plan are currently in development.

Overview of Quality (2/2)

North Central London Integrated Care Board

Review into operational effectiveness of the Care Quality Commission (CQC) – Dr Penny Dash, Chair of North-West London Integrated Care Board

In May 2024, the Department of Health and Social Care asked Dr Penny Dash to carry out a review of the Care Quality Commission (CQC). An interim report was published in July 2024, providing a high-level summary of the findings to date and to allow the CQC to start thinking about the systematic changes that they would need to make as an organisation. The final report was published on 15 October 2024.

The CQC had embarked on a major organisational change programme in 2021, that aimed at making the assessment process for health and social care providers easier and more streamlined. The aim was to use both qualitative and quantitative data to assess the quality of care and experience of those using health and social care services, and to provide a 'single assessment framework' for inspections. The CQC were without a Chief Executive since July, and Sir Julian Hartley has now been appointed into this role.

A new online portal was developed, allowing registered health and social care providers to manage their registration details and submit notifications, transforming how information is gathered and used to inform assessments of the quality of care within any registered provider.

The Health and Care Act 2022 gave the CQC legislative powers to assess Local Authorities (LA) and Integrated Care Systems (ICS). Assessment of local authorities commenced in December 2023 following a national pilot. Assessments of Integrated Care Systems (ICS) had not commenced and have been formally paused for six months.

The review found that there were significant failings internally within the CQC, resulting in a loss of credibility of the CQC across health and social care. The vision set out by the CQC, as part of the re-organisational programme to move away from 'specialist inspectors' and create a group of 'generalist inspectors', resulted in inspections carried out by individuals that were not familiar with the specific area of health and social care that they were inspecting.

National review of adult gender services by NHSE

NHS England has taken the decision to conduct a review of the operation and delivery of the adult Gender Dysphoria Clinics, following a recommendation set out in the Cass Review earlier this year.

Dr David Levy, Medical Director of Lancashire and South Cumbria Integrated Care Board, and previously NHS England's North-West Regional Medical Director will lead the review.

This review will examine the operating procedures in each service; the appropriateness of the service model for the presenting population; areas of concern, and any action being taken to improve quality. It will identify areas for improvement in relation to service quality, good practice that could be shared with other clinics, and any support that should be made available to services to assist improvement.

The adult gender services at the Tavistock and Portman NHS Foundation Trust are scheduled to be inspected at the beginning of November 2024.

Overview of Primary Care

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General Practice activity levels remain significantly higher than pre-pandemic levels, and currently average over 670,000 appointments per month during 2024/25. NCL practices consistently exceed the national aspiration of providing 90% of appointments within 2 weeks of booking and offer a higher-than-average percentage of same day appointments. Practices are currently signing up to a data provision notice which will make their telephone activity data available to NCL ICB, which will enhance our understanding of access.

Digital tools play an important role in improving patient access to General Practice, and the use of online consultations, two-way text messaging and NHS app usage continues to increase (though this activity does not count towards appointment numbers). On average, NCL practices receive 100,000 online consultations a month. NCL ICB monitors the uptake of digital tools, and supports practices with switch-on, and the embedding of these new ways of working as required. This offers patients more ways to contact their practices, though traditional access routes are maintained to support digital inclusion.

Through delivery of the requirements of the national Primary Care Access Recovery Plan (PCARP), practices are actively working on reducing variation in patient experience of accessing General Practice, noting that whilst practices are providing more appointments than ever before, there is a small overall drop in satisfaction with access, alongside variation in national GP Patient Survey results. Practices are in the process of transitioning to the "modern general practice" operating model as described in PCARP, which underlines the importance of balancing digital, telephone and in-person access to meet patient need.

This work is taking place alongside the development of local GP ambitions by NCL ICB and provider leaders. These ambitions will underpin future decisions and articulate shared aims to frontline teams and patients. For example setting out how a balance can be struck between episodic and same day access with capacity for planned and proactive care, and the delivery of population health improvement at neighbourhood level, as described in the Fuller Stocktake.

The NCL-wide locally commissioned service focuses on the identification and management of long-term conditions and launched in October 2023. The service has an emphasis on personalised care planning and continuity of care for those who will most benefit. This new service will ensure that the focus on access to general practice is balanced by a commitment to protecting capacity for planned work, and proactive care for people with long term conditions to help them stay well.

	Jun '24	Jul '24	Aug '24
Core primary care appointments	656,896	713,263	624,880
% same day appointments	50.9%	50.6%	52.6%
% appointments within 2 weeks	91.1%	91.2%	91.8%

Primary Care Reporting

Primary care performance is managed via the Primary Care Committee. The Primary Care Quality & Performance Report covers the following themes:

- **Clinical and quality indicators** include health checks, care planning, patient experience, CQC ratings and complaints.
- **Activity and appointments indicators** include provision and uptake of General practice services.
- **Workforce indicators** include clinical and admin FTE, and uptake of the Primary Care network Additional Roles Reimbursement Scheme (ARRS).

Papers for the Primary Care Contracting Committee including the Primary Care Quality & Performance Report can be found here.

Overview of Mental Health Services (1/2)

NHS North Central London Integrated Care Board

NCL remains on track to meet the planned 2024/25 **Children and Young People (CYP) Access** trajectory. NCL ICB has continued to invest in community CYP mental health provision through Mental Health Investment Standard (MHIS) schemes, involving collaboration with providers to monitor progress via highlight reporting covering recruitment, delivery milestones, risks, and issues. Access to CAMHS increased for CYP at schools supported by Mental Health Support Teams (MHST), and NCL will increase from 16 to 19 MHSTs (53% coverage) during 2024/25. System Development Funding alongside MHIS investment will support achievement of the access target, reductions in the numbers of CYP waiting for meaningful support and the lengths of those waits, plus an increase in the proportion of CYP and parents/carers with paired outcome measure scores, showing statistically significant improvement.

Overall performance of **Talking Therapies (TT)** continues to remain challenged**,** with completed courses of treatment (2+contacts and discharge) and Reliable Improvement currently below the August 2024 target. The North London Mental Health Partnership (NLMHP) have developed and are implementing a recovery plan to bring performance back on track. Initiatives include:

- A marketing and communications strategy developed to target referrals at Step 2 (mild to moderate anxiety and depression) where there are not long waiting times.
- Long waits between 1st and 2nd appointments (Step 3) – NLMHP have created an improvement trajectory, and will continue to monitor DNAs and cancellations which can impact recovery rates.
- Services will continue with recruitment plans. Where there are vacant posts while waiting for staff to be onboarded, digital options (e.g., Xyla) are being used to mitigate the effect as far as possible.
- Complexity of referrals – there continues to be an increase in the level of complexity of referrals, so increasing demand for Step 3 intervention, resulting in longer waiting times. NLMHP are working with partners to review pathways to enable patients to be assessed and seen in the right place, at the right time.

Patients seen by the NCL **Perinatal Services** at the end of August 2024 was 1,607 based on local data. Key challenges faced were retention of agency staff and insufficient referral numbers. Work is underway to increase referral numbers (e.g., targeted communications on social media outlets and the implementation of a self-referral pathway), and by the end of Q3 most vacant posts are expected to be filled by the recruitment drive.

Adult Community Access performance is relatively stable but tracking below plan. The first model planning workshop for the single point of access was held in September 2024, and next steps are to progress work via 6 identified workstreams – data, digital, engagement, model development, estates and workforce. Overall recruitment remains a challenge, but progress has been seen in the neuro-development disorder, and personality disorder workstreams.

	Jun '24	Jul '24	Aug '24
CYP Access (12MR) *[Target Aug-24: 21,605* *Y/E: 24,989]*	21,440	21,182	20,934
TT 2+ Contacts & Discharge (YTD) *[Target Aug-24: 6,436* *Y/E: 15,586]*	3,535	4,985	6,380
TT Reliable Recovery (Monthly) *[Target Aug-24: 45.9%* *Y/E: 48.2%]*	46.7%	48.4%	46.4%
TT Reliable Improvement (Monthly) *[Target Aug-24: 68.0%* *Y/E: 68.1%]*	64.4%	69.0%	67.0%
Perinatal (12MR) *[Target Aug-24: 1,625* *Y/E: 2,010]*	1,544	1,565	1,607
Adult Community Access (12MR) *[Target Aug-24: 21,421* *Y/E: 23,823]*	20,924	21,030	21,075

Overview of Mental Health Services (2/2)

NHS North Central London Integrated Care Board

NCL has prioritised work on improving the physical health of people with severe mental illness (SMI) via the Longer Lives delivery plan. Q1 performance on **SMI Physical Health Checks (SMI-PHC)** in the previous 12 months as reported by General Practice shows 56.9% compared to target of 65.2%. However, performance is tracking above the same period last year, suggesting an underlying, upward trajectory continuing. This indicator also has an historical pattern of below target performance in Q1 to Q3, before an upsurge at year end. Patients have health checks completed over several appointments throughout the year, and with achievement requiring all steps to be completed, Q4 is a key period for realising plans.

In 2024/25 the **Out of Area Placements (OAP)** metric has changed from measuring the number of bed days to measuring the number of people inappropriately placed in an acute setting. NLMHP has been working with system colleagues to achieve the ambition of zero by year-end. A model has been agreed to support discharge by including a team of discharge co-ordinators and network navigators with the aim of reducing re-admissions and length of stay. Additional weekend senior clinical cover has been put in high demand sites (when staffing availability permits) to help reduce weekend demand, and a 7-day flow process is being mobilised to enable better flow on weekends.

Whilst NCL ICB is currently below the 2024/25 Operating Plan target for **Dementia,** performance still consistently tracks above the NHS national ambition of 66.7% - Camden and Islington have dementia diagnosis rates among the highest in London. The NLMHP Memory Service workstream continues to focus on extending the post diagnostic service into Barnet, Enfield and Haringey in order to increase the value of residents receiving a diagnosis. An away day is scheduled during October 2024 with representatives from each NCL borough, to put together an action plan for each service.

As of September 2024, NCL ICB has met all three targets related to **Learning Disability and Autism (LDA)**

- Annual Health Checks: NCL ICB Q2 performance is 37.0% and remains on track to meet the yearend target of 75.0%. NCL offers an annual health check to anyone over the age of 14 with a learning disability. The LDA Programme has established an annual health check working group to ensure an NCL System approach toward service provision. Communications have been sent to practices who are yet to commence checks by Q2.

- Inpatients: At Q2, the adult inpatient count is 32 within the target of 40, while CYP inpatients stand at 7 within the target of 11. Improved performance is related to the harmonisation of processes and administration across learning difficulties and mental health for the individualised aspects of the LDA programme. This has improved dynamic support register referrals and enabled effective planning for care and treatment reviews (CTR), as well as care, education and treatment reviews. Also, CTR meetings for autism/mental health are now established for Barnet, Enfield and Haringey, as these were not previously in place.

	Q1	Q2	Q3
SMI - PHC (12MR) *[Target Q1: 65.2% Y/E: 71.0%]*	56.9%	TBC	TBC

	Jun '24	Jul '24	Aug '24
OAP – Active Inappropriate (Monthly) *[Target Q2: 8 ,Y/E 0]*	TBC	8	5
Dementia Diagnosis (Monthly) *[Target Q2: 68.9% Y/E: 69.0%]*	67.8%	67.4%	67.3%

	Jul '24	Aug '24	Sep '24
LD&A - AHCs (YTD) *[Target Q2: 33.3% Y/E: 75.0%]*	24.2%	30.4%	37.0%
LD&A – Adult Inpatients (Monthly) *[Target Q2: 40 , Y/E: 39]*	n/a	33	32
LD&A – CYP Inpatients (Monthly) *[Target Q2: 11 ,Y/E: 9]*	7	8	7

Overview of Community Services

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The NCL Operating Plan trajectory was not achieved in August 2024 for **patients waiting over 52 weeks** on adult and Children and Young People (CYP) waiting lists.

The percentage of CYP waiting within 18 weeks decreased by 2.7% to 65.6% in August 2024. There was though, a rise in the number of CYP waiting over 52 weeks, particularly in autism and therapy services, as demand exceeded capacity. NCL ICB is in discussion with providers to approve investment to expand capacity and establish a standardised Neurodevelopmental Disorder (NDD) Diagnosis pathway for CYP aged 0-18 across NCL.

In NMUH, further work is being done on data validation as they have moved the Rio server from BEH to NMUH as part of the Community Services transfer. For waiting times reporting overall, work continues on the alignment of local and national waiting times data, as not all data for service lines is reported in national datasets.

For the adult waiting list, the rehabilitation service has a high volume of patients waiting for more than a year. This is due to staffing capacity issues, mainly at WH - a recovery plan is in development. The proportion of adults waiting less than 18 weeks remains stable.

Urgent community response (UCR) teams provide urgent care to people in their homes, so reducing hospital attendance and admissions. Each provider within NCL has consistently surpassed the 2-hour UCR national target in 2024/25. There is however some variation within the local teams, primarily due to increased demand and staffing challenges. The lead provider (CNWL) has proposed an NCL UCR Coordination Hub model to key system stakeholders. Workstreams include, ReferaPatient contracting, integration of LAS and 111, service mapping (flow into and out from the Hub), and training. The UCR Delivery Group has agreed that UCR priority areas for 2024/25 (falls and catheter pathways) remain areas of opportunity in NCL, and these are aligned with regional priorities.

Virtual wards (VW) allow patients to safely and conveniently receive acute care at their usual place of residence. The NCL plan for 2024/25 is to increase adult and CYP capacity to a minimum of 266 beds by January 2025, with a stretch target of 313 beds. This will be provided alongside a minimum of 80% utilisation of VW capacity in all services.

In August 2024, NCL **community bed occupancy** was 84.5% against the 92.1% target. NCL ICB has launched various initiatives to recover the position. These include utilising the flex criteria across all units, testing new pathways such as in-reach to A&E and acute wards, strengthening community access via UCR, and developing pathways to community beds directly from hyper-acute stroke units and acute stroke units.

	Jun '24	Jul '24	Aug '24
Waiting List % <18 weeks (CYP) *[Local target: 66.0%]*	66.5%	68.3%	65.6%
Waiting List >52 weeks (CYP)	517	567	615
Waiting List % <18 weeks (Adults)	92.6%	94.2%	93.8%
Waiting List >52 weeks (Adults)	47	63	65
UCR Referrals (YTD) *[Target Aug-24: 7,332]*	5,014	6,674	8,223
% Virtual Wards Occupancy *[Operating Plan monthly target: 80.0%]*	79.5%	74.2%	67.4%
Community bed Occupancy *[Operating Plan monthly target: 92.1%]*	84.5%	86.6%	84.5%

Overview of Urgent & Emergency Services (1/2)

North Central London Integrated Care Board

Emergency Department (ED) attendances in NCL remain high, with September 2024 activity comparable to September 2023. Through August there had been a significant increase in ambulance conveyances during 2024/25 demonstrating the higher acuity of presentations, but the September 2024 data shows current levels on a par with the same period last year. ED activity to date, is approximately 4% higher than last year and pre-covid levels, with most notable growth in the over 65 cohort. However, this increased demand is not translating to a similar rise in emergency admissions.

Challenges contributing to a significant number of 12-hour breaches include increased patient complexity, stretched community services, infection control, and a high percentage of No Criteria to Reside (NCTR) patients (13%). There has also been significant mental health patient demand. Despite these challenges, local and system improvements have boosted A&E 4-hour performance – NCL has been tracking above the 2024/25 Operating Plan trajectory since June 2024 as the system works towards meeting the national ambition of 78.0% achievement by March 2025.

Following a national review in July 2024 by NHSE, and due to ongoing challenges in performance, NCL ICS has been escalated to Tier 1 for UEC. As a Tier 1 system, NCL ICS will receive the highest level of support, overseen by the national integrated UEC team.

NCL Providers are actively implementing local improvement plans aligned with the three national priorities set out by NHSE, with the primary goal of reducing time people spend in A&E or waiting for ambulances in the community:

Priority 1 - Maintain Capacity Expansion: sustain the capacity expansion achieved during 2023/24.

Priority 2 - Increase Productivity: enhance productivity in both acute and non-acute services, focusing on flow, length of stay, and clinical outcomes.

Priority 3 - Shift Activity: develop services that move urgent care away from acute hospital settings, supporting proactive care, admissions avoidance, and hospital discharge.

Action plans emphasise strategies like maximising alternate care pathways, improving discharge processes, and optimising resource use within intermediate care, to support flow improvement across the patient journey. There is renewed focus on improving local partnerships and working with care homes to reduce conveyances to ED.

	Jul '24	Aug '24	Sep '24
A&E 4-hour Waits *[Target Mar-25: 78.0%]*	74.3%	76.4%	75.0%
A&E 12 Hours in Department *[From arrival]*	4,695	3,080	3,475
Ambulance Handover Delays (>30 minutes)	2,680	2,388	2,222
Ambulance Handover Delays (>60 minutes) *[National target – 0]*	288	254	300
NHS 111 – Calls Abandoned *[National target <3%]*	8.5%	1.5%	2.4%
Long Lengths of Stay (>21 days) *[Target Mar-25: 516]*	607	598	620

Overview of Urgent & Emergency Services (2/2)

North Central London
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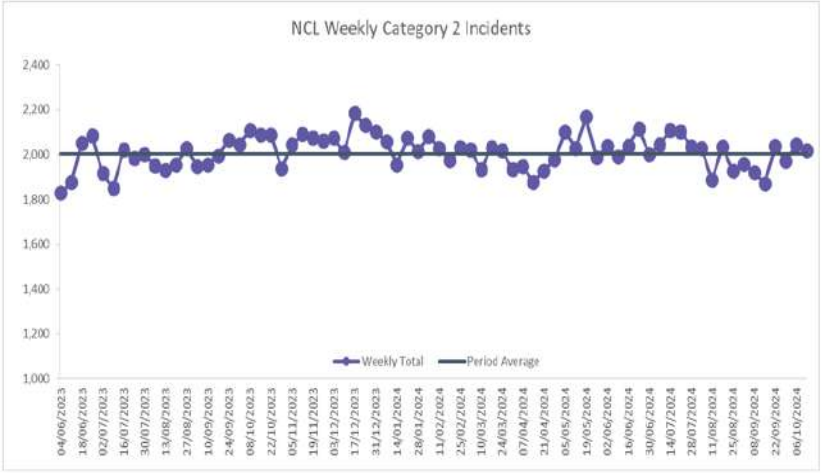
London Ambulance Service (LAS)

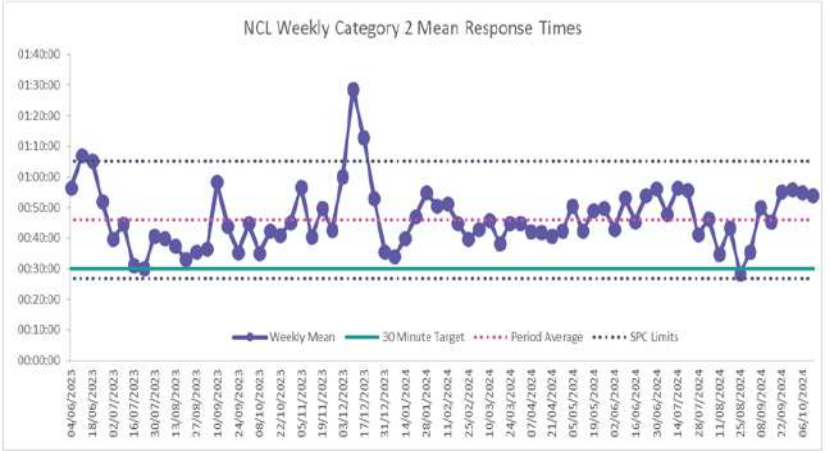
LAS handover performance remains challenged across NCL. In September 2024, there were 2,222 handovers taking over 30 minutes, with 300 of these taking more than 60 minutes. Whilst the volume of handovers exceeding 30 minutes is still high, it is the lowest NCL value recorded since August 2023 and is approximately 11% lower than September 2023. Handovers within 45 minutes showed some improvement in September 2024, averaging around 91%.

LAS incidents have increased compared to last year but have remained steady around the period average for the last few weeks. Improvements in handover processes have contributed to lower average response times for Category 2 calls, but NCL remains the most challenged system in London. Ongoing actions in place to drive improvement include:

- Implementing 'hello clinicians' at the front door, whereby a clinician makes an initial patient assessment, triaging and prioritising based on clinical need, thus identifying and redirecting non-critical cases to help alleviate pressure on ED.
- Strengthening triage and streaming services, to increase the number of patients directed away from ED.
- Improving access and scope of Same Day Emergency Care (SDEC) services to reduce avoidable admissions.

These actions are being supported by sharing of good practice via the NCL Flow Operations Group, such as SDEC Access Improvement and the REACH Model (Remote Emergency Access Coordination Hub) which aims to reduce unnecessary hospital visits by using other appropriate pathways. An LAS-led care coordination hub is due to be piloted in November 2024, allowing pre-conveyance triage, for rapid access to a senior clinical decision maker to deliver expert advice, or direct referrals to the service that best meets the patient's need. As an additional component to improve Category 2 response times, the NCL System is looking to review LAS job-cycle times, to support discussions around potential operational efficiencies.





NHS 111

The NCL NHS111 Alliance contract delivered by LAS and LCW has shown significant performance improvement with a call answering time of 39 seconds and a call abandonment rate of 2.4% in September 2024. Call answer times were as high as 400 seconds in September 2023 and then 273 seconds in April 2024, while the call abandonment rate has been on target for the past 2 months. The performance improvement seen is in line with the successful transition of call handling from LCW to LAS, providing greater resilience. National resilience support, provide by Vocare, continued to be in place throughout August 2024 with 15% of calls being routed to this service. This support will have a phased reduction during Q2 2024/25, after which the provision will cease. Service activity and performance is monitored and managed through formal monthly contract meetings with the NCL Alliance Partnership.

Overview of Elective Services

North Central London Integrated Care Board

NCL providers continue to reduce the number of long waiting patients in line with the national objective to clear 65 week waits by the end of September 2024. The total amount of 65 week waits in NCL has halved since April 2024, and of the patients at the start of the year who were identified to be potential breaches at the end of September 2024, that number has currently reduced by 96.3%. NCL Trusts progressed plans to clear and maintain the waiting list to below 65ww by end of September 2024, although there were some challenged specialties. As the ambition to eliminate 65 week waits by September 2024 will not be fully met, and in line with other systems regionally and nationally, NCL ICB has worked with NHSE London, GOSH, RFL and UCLH to develop refreshed trajectories for clearance. NCL Trusts are currently delivering the revised plans.

The majority of the longest waiting patients are attributed to capacity constraints across surgery and within specialised and complex paediatric services. A new workstream has commenced to identify challenged services in NCL, and work through an escalation hierarchy to support local additional capacity, and also explore mutual aid within or outside of NCL. The NCL System is working to ensure mitigations for these areas are in place including use of the independent sector, additional waiting list initiatives, and mutual aid solutions across the patch.

NCL continues to work collaboratively to identify opportunities to utilise alternative pathways through community services and improve patient pathways. Key aspects of the elective recovery plan include:

- Referral optimisation – referrals to be managed appropriately first time.
- Improving productivity – assessing theatre utilisation data to optimise usage, and the use of consultant connect and advice and guidance to manage relevant pathways in primary care.
- Increasing capacity – additional sessions to deliver more appointments and procedures.
- Outpatient transformation – innovative delivery including digital and patient-initiated follow-ups, with a significant emphasis on reducing outpatient follow-ups in line with national guidance.
- Mutual aid, to ensure that patient waits are equitable across providers and capacity is utilised fully.

The bi-weekly NCL ICB led Planned Care Delivery Group, continues to monitor and assess risk across the sector, with key stakeholder engagement present from all NCL providers.

	Jun '24	Jul '24	Aug '24
RTT Waiting List *[Target Mar-25: 263,175]*	278,513	276,040	280,602
RTT 65ww *[Target Sep-24: 0]*	2,076	1,802	1,546
RTT 52ww *[Target Mar-25: 4,337]*	8,391	7,701	7,289

	Jun '24	Jul '24	Aug '24
Electives YTD vs 2024/25 Op Plan *[Inpatients + Day Cases]*	111.0%	110.1%	109.6%
Outpatient First YTD vs 2024/25 Op Plan *[Excluding OPPROC]*	111.7%	112.3%	109.7%
Outpatient FU YTD vs 2024/25 Op Plan *[Excluding OPPROC]*	110.3%	111.7%	108.9%
Outpatient Procedures YTD vs 2024/25 Op Plan	125.0%	126.1%	125.3%

Overview of Diagnostic Services

North Central London
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Based on NCL providers' aggregated data, diagnostic performance regarding the percentage of patients waiting over six weeks improved by 1.2% to 8.4% in August 2024. For the same period, NCL ICB is now ranked the number one ICB in England in terms of diagnostic performance, currently reporting 8.5%.

RFL have the highest proportion (37.3%) of the NCL imaging backlog. The NCL MRI backlog continues to decrease at all providers, with recovery plans progressing well. The NCL CT backlog is relatively stable across the system, with the highest proportion recorded at RFL (70.4%) - the majority of patients here require a cardiac CT scan. The NCL NOUS backlog continues to show material reductions, at NMUH in particular where there were 1,144 patients waiting over 6 weeks at the end of Q1 – this cohort has now reduced to 296 patients for August 2024. Mutual aid is in place with the Community Diagnostic Centres for imaging modalities at all NCL providers.

RFL's neurophysiology backlog continues to grow, particularly in EMGs, due to a longstanding lack of capacity. RFL is the only NCL provider that offers GP direct access for neurophysiology. A business case is being developed for an additional full-time consultant, and sector-wide mutual aid is being explored. An NCL ICB-led Neurophysiology Task and Finish Group is collecting system-wide data to ensure complete visibility of demand and capacity, covering all activity and not just that which is reportable via DM01.

The overall NCL endoscopy backlog continues to show improvement into Q2. RFL holds the majority of NCL patients (77.2%) and had shown a backlog increase since June 2024 due to the addition of overdue surveillance patients to the DM01 waiting list. RFL receives mutual aid from UCLH for endoscopy, and discussions are ongoing with WH to resume mutual aid which ceased in in July 2024. UCLH is planning to set up the extra list to help manage the demand.

Regarding the NHSE ambition to report all overdue surveillance patients on the DM01 waiting list post Q2, NCL providers have submitted a revised position based on September 2024 data. This shows a reduction in this cohort of 29.6% from August 2024, and an overall reduction of 64.6% since the audit commenced based on March 2024 data. NCL ICB has held regular meetings with providers to oversee progress and to identify any clinical harm resulting from any delay. All NCL providers are expected to transfer relevant patients to the DM01 waiting list from October 2024 reporting onwards, and this is part of the effort across England, to ensure compliance with national guidance. This move is likely to result in a dip in diagnostic performance from Q3, particularly at GOSH where there are pressures in cardiac MRIs and echocardiography. GOSH are working on a capacity model and an associated recovery trajectory to address this issue, with NCL ICB in continuous dialogue to support recovery actions.

	Jun '24	Jul '24	Aug '24
Diagnostic Waiting List *[NCL Provider View]*	50,802	48,963	45,603
Diagnostic Waits > 6 weeks % *[NCL Provider View]*	12.9%	9.6%	8.4%
Diagnostic Waits > 6 weeks *[NCL Provider View]*	6,553	4,713	3,834
Diagnostic Waits > 13 weeks *[NCL Provider View]*	731	479	488

Overview of Cancer Services

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In 2024/25, the focus is on improving performance against the Faster Diagnosis Standard (FDS), to 77%, by March 2025 (towards the 80% ambition by March 2026), improving performance against the 62-day operational standard to 70% by March 2025, and increasing the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition, by 2028.

In August 2024, NCL's FDS performance was 1.8% below plan, while 62-day performance was 0.6% above plan. Recognising the Trusts' FDS and 62-day performance challenges, RFL was moved into Tier 1 and NMUH to Tier 2, in September 2024. Although NHSE consolidated the 10 cancer wating times standards into 3 standards in October 2023, NCL will continue to oversee outliers across the previous 10 standards. Subsequent radiotherapy and 62-day consultant upgrade performance has been highlighted as an area of focus.

The NCL Cancer Alliance (NCL CA) and NCL ICB continue to oversee the implementation of the cancer operational performance delivery plan for 2024/25. Highlights include a series of provider business cases to increase capacity to close the gap where it is outstripped by demand, and the development of action plans resulting from the nationally mandated requirement to complete the pathway analyser tool, for tumour sites that are underperforming against the FDS.

The implementation of four transformational projects is being ramped up to close the performance gap through efficiencies:

- In breast, RFL and UCLH have commenced delivery of breast pain clinics. WH is on track to start delivery in Q3 2024/25.
- In skin, the aim is for 50% of urgent suspected cancer referrals to go through a teledermatology pathway. RFL, UCLH and WH are on-track to deliver this by Q4 2024/25.
- In gynaecology, RFL has begun piloting the endometrial assessment model (already being delivered at UCLH) at two sites (Barnet and RFL Hampstead), while WH is expected to start a pilot in Q3 2024/25.
- The NCL CA is supporting a workstream to optimise multi-disciplinary team meetings (MDTs). RFL's programme, initially focussing on breast, renal, prostate and hepato-biliary, has identified several improvement areas including, adopting Standards of Care (SoC) and strengthening pre-MDT processes, and MDT referral proforma.

The NCL CA will lead NCL in implementing these pathways, including investment in workforce where operational bandwidth has been a barrier to implementing new pathways in the past. Sufficient radiology, endoscopy, and for treatments, radiotherapy capacity to meet current demand, continues to be a challenge - the NCL CA is supporting providers and the NCL Diagnostic Networks, to progress plans to bridge the shortfall and build long-term sustainability across the NCL footprint.

To further support recovery and system resilience, the NCL CA has completed a mid-year review, focussing the reallocation of uncommitted 2024/25 funding and identified underspends to areas of the system that are most pressurised. This will support Trusts and the wider system to mitigate upcoming winter pressures.

	Jun '24	Jul '24	Aug '24
Cancer Diagnosis Standard (FDS) *[Aug-24 Plan Target: 73.0%]*	73.0%	71.5%	71.2%
Cancer 62-Day Standard *[Aug-24 Plan Target: 64.0%]*	63.1%	63.4%	64.6%

NCL Providers (as of 27th October 2024)	**Cancer 62-Day Backlog* as % of Waiting List**
Royal Free London	10.2%
North Middlesex	10.0%
Royal National Orthopaedic	9.8%
Whittington Health	9.1%
University College London	7.2%
NCL	**9.4%**

**All referral routes*

System Oversight Framework (SOF) – Segment 3 (1/2)

North Central London Integrated Care Board

Royal Free London (RFL)

SOF3 arrangements continue with monthly performance meetings in place and a joint executive level quarterly meeting with RFL and NMUH led by the NCL ICB CEO. Revised 2024/25 SOF guidance is expected this year.

Cancer 62-day performance has replaced the cancer 62-day backlog as an Operating Plan metric for 2024/25. RFL performance has been lower than the trajectory in each month of 2024/25 so far. August 2024 performance was 57.3% against a trajectory of 57.4%, with the March 2025 ambition set at 70.2% achievement. Faster Diagnosis Standard (FDS) performance has also been challenged in 2024/25. August 2024 performance was 68.1% against a trajectory of 71.8%. The March 2025 target for RFL is 77.0% in line with the national ambition.

Due to FDS and 62-day performance challenges, RFL were moved into Tier 1 for cancer in September 2024, with the aim to provide more targeted support for cancer service improvement. The RFL Cancer Improvement Programme commenced at the end of July 2024, looking to deliver improvement projects initially across lower GI, endoscopy, gynaecology, breast and urology. These aspire to favourably impact on patient service provision, and the resultant reported performance.

The A&E 4-hour Operating Plan trajectory has been achieved over the first 6 months of 2024/25. There is continued focus on modelling of capacity and flow across sites, exploring front door alternatives to ED, and how Same Day Emergency Care (SDEC) pathways and virtual ward utilisation can be maximised. RFL have also achieved plans throughout 2024/25 for 12 hours in ED performance. September 2024 was 7.3% against a plan of 8.3%.

Performance of ambulance handovers within 30 minutes against the trajectory was achieved in each of the last four months to September 2024. The latest performance shows 67.6% against a plan of 64.0%. The March 2025 ambition is 79.7%.

North Middlesex University Hospital (NMUH)

SOF3 exit criteria for NMUH continue across UEC and cancer, and mirror those established for RFL trajectories to enable peer support.

Cancer performance remains challenged in 2024/25. NMUH moved to Tier 2 for cancer in September 2024 and this will bring additional funding to help improve cancer services, alongside previously approved NCL Cancer Alliance funded initiatives.

The 62-day performance for August 2024 shows achievement at 55.5% against a trajectory of 63.8% - the March 2025 ambition is 70.3%. FDS achievement has been relatively stable in year, but remains below trajectory, with August 2024 reported as 63.0% against the plan of 69.0%.

Primary drivers for FDS underperformance are urology and colorectal services, with a lack of diagnostic capacity identified. An outsourcing contract commenced in September 2024 to support CT colonography, alongside the continued use of Community Diagnostic Centres for radiology capacity.

The A&E 4-hour Operating Plan performance stands at 70.1% against a plan of 71.0% for September 2024. Performance had initially improved in the first two months of Q2, but further work remains on flow initiatives, to achieve the trajectory of 78.0% for March 2025.

Delivery on the ambulance handover target has been particularly challenged and remains a key focus into 2024/25. Performance has continued to improve in each month of 2024/25. September 2024 performance (58.0%) was 17.5% higher than that of April 2024 (40.5%).

2024/25 stretch trajectories for ambulance handovers and 12 hours in ED are being agreed locally and will be signed off in year.

System Oversight Framework (SOF) – Segment 3 (2/2)

North Central London Integrated Care Board

Tavistock & Portman (T&P)

The SOF process in place at T&P is focussed on the progress of areas aligned to revised exit criteria and agreed milestones based on 5 themes – long term strategy, finance, leadership and governance, quality, and the Gender Identify Clinic (GIC) service. The oversight mechanisms include a quarterly executive group focussed on performance and improvement chaired by the ICB Executive Director of Performance and Transformation, and an Oversight Board chaired by NHSE.

The exit criteria aligned to stated themes are set out below:

Longer Term Strategy – the development of strategy agreed with NCL ICB and NHSE, that is clinically, operationally, and financially sustainable.

Estates – T&P will agree its estates requirements and an approach to the location of services, alongside an implementation plan aligned with NCL System requirements.

Strengthened Board Leadership & Governance – T&P Executive Team responsibilities will be clearly set out, with a development plan in place. A robust organisation wide governance structure will be implemented, with clear assurance processes at committees and through the Board. The Executive Team will be regularly sighted on key risks and actions taken via appropriate escalation routes.

Strengthened Organisational Wide Governance – this will cover an updated Freedom to Speak Up policy, alongside the Board approved People Plan. T&P will evidence that it has engaged with the NHSE Pricing and Costing Team and reviewed its finance team capacity to deal with information submissions. An agreed plan will be in place to deal with any identified capacity gaps and ensure ongoing compliance with the provider licence.

Updated Quality Framework – this will set out roles, responsibilities and escalation processes, including those regarding NCL ICB and NHSE where applicable. There will be evidence that incident and risk reporting systems are in place, and that the data is being used to drive learning and quality improvements. As of April 2024, this framework is in place.

GIC Service Control of Clinical Risks – T&P will demonstrate a clear understanding of the clinical risks within the service, and the associated waiting list.

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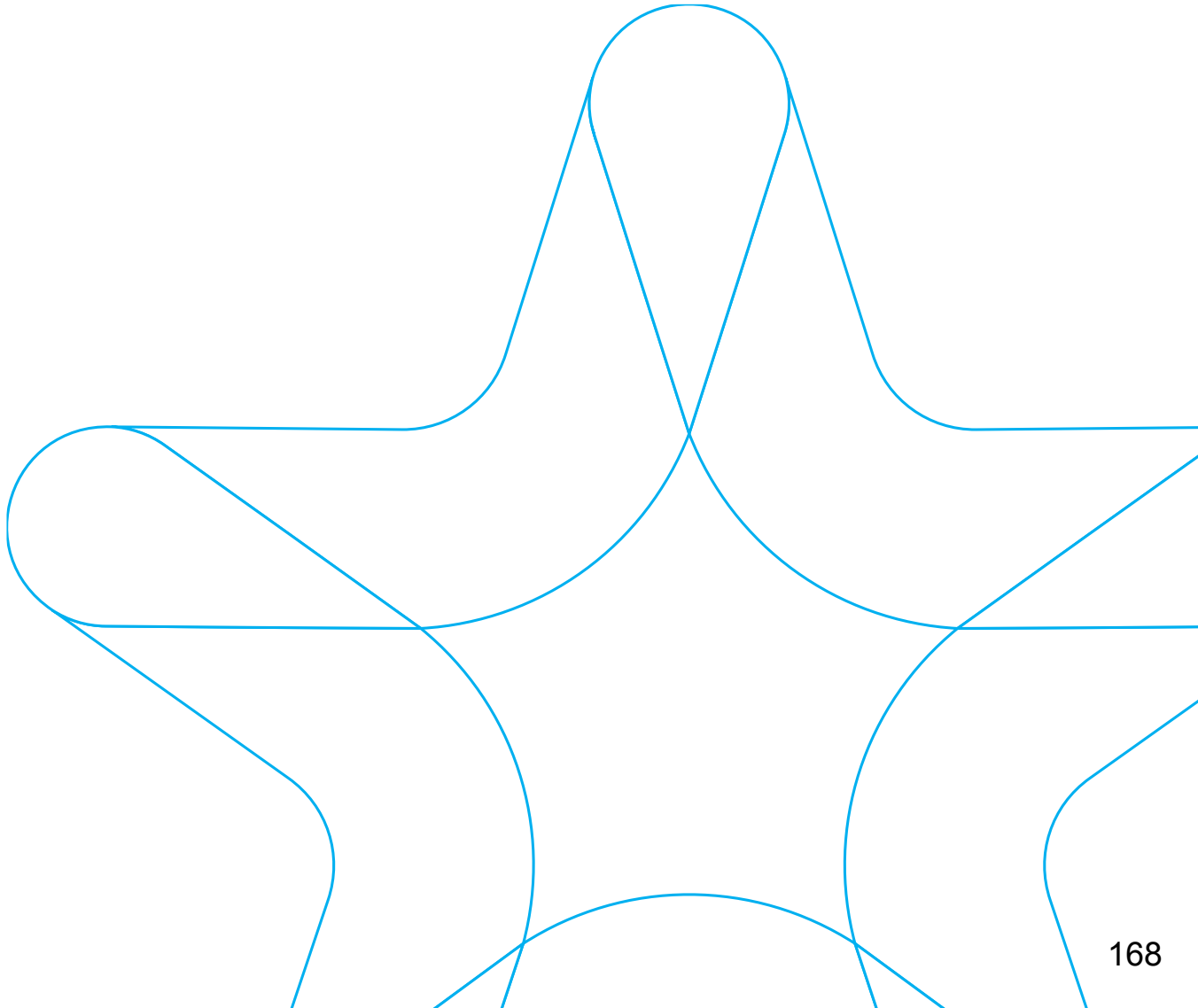
Appendices



Appendix 1– NCL Balanced Scorecard

North Central London Integrated Care Board

NCL ICS Level Scorecard (15-10-24)

	Key Performance Indicator	Target	Reporting Period	Current Performance	Trend	Year-End Forecast	Notes
ICS Finance	Bottom line (YTD)	(33.3m)	YTD M5	(43.8m)		0.0m	*NCL ICS reported a YTD deficit of £43.8m at M5 which is adverse to plan by £10.5m.*
	Efficiency delivery (YTD)	78.2m	YTD M5	71.3m		231.0m	*As of M5, NCL were reporting YTD savings of £71.3m which represents delivery of 30% of the total savings requirement for 24/25.*
	Agency Spend (YTD)	42.9m	YTD M5	44.2m		100.1m	*Agency spend is adverse against plan at M5 by £1.3m.*
	Capital (YTD)	55.6m	YTD M5	39.4m		223.7m	*The YTD capital position at M5 is underspent by £16.2m.*
	Cash (YTD)	n/a	YTD M5	806.4m		727.1m	*There is a net £24.5m decrease in cash balances between Apr-24 and Sep-24 representing a 3% decrease in cash. This is equivalent to a net decrease of 3 days (6%) cash in hand from 50 days to 47 days.*
	ERF	399.8	YTD M5	420.3m		988.7m	*Overperformance of £20.5m YTD across the system.*
Performance & Quality	Ambulance handover <45 mins	100%	w/e 06/10/24	89.0%	Declining		*NCL is now regularly >90% after being >80% at the start of 24/25*
	A&E 4-Hr Performance	Sep '24 >74.9%	Sep '24	75.0%	Declining	on target	*The latest validated performance met the Sep-24 target*
	Long Length of Stay (21 Days+)	Sep '24 <514	Sep '24	620	Declining	on target	*The number of stays 21 days and over increased across NCL providers in September*
	Elective Activity (% of 23/24)		YTD M5	110.5%	Declining		*A decrease in the cumulative position when compared to last month.*
	Total Waiting List Size	Oct '24 <265,096	w/e 06/10/24	291,728	Declining	off target	*The NCL total waiting list size has been growing in recent months; there have been variances from provider to provider.*
	RTT 65ww	Oct '24 - zero	w/e 06/10/24	976	Improving	off target	*Trusts across NCL had plans to deliver 65ww clearance by end of Sept-24; whilst the reduction has been very significant, further work is required to clear the final challenged specialties.*
	Cancer Backlog - % of PTL	6.4%	w/e 06/10/24	8.1%	Steady	off target	*The NCL backlog position is largely driven by urology (211), lower GI (130), and breast (78).*
	Cancer 62 day performance	Aug '24 >64.0%	Aug '24	64.6%	Improving	on target	*NCL 62 day performance met the Aug-24 target*
	Cancer FDS	Aug '24 >73.0%	Aug '24	71.2%	Declining	on target	*NCL FDS performance remains challenged with only UCLH and RNOH currently meeting their FDS plans*
	Diagnostic % >6 weeks	Mar '25 <5.0%	w/e 06/10/24	10.8%	Improving		*Based on the latest validated data, NCL ICB was England's best-performing ICB, with a 8.5% 6ww performance in Aug-24.*
	MH - Talking Therapies 2 contacts + discharge	End Q2 - 7,745	YTD Aug '24	6,380	Declining		*Completed treatment volumes decreased in Aug-24*
	MH - Out of Area Placements	End Q2 - 8	YTD Aug '24	5	Improving		*The numbers of Out of Area Placements is in line with the target for the end of Q2.*
	CAMHS Access	Jul '24 21,183	Jul '24	21,182	Improving		*Includes MHST count and all NCL providers*
	Never Events	0	Sep '24	2			*The Patient Safety Incident Response Framework (PSIRF) does not distinguish incidents as "Serious Incidents" and therefore data referring to SIs and NEs currently reported on the scorecard may not be completely accurate. The Quality and Clinical Standards team are working with the analytics team to develop a "Quality dashboard" that will be incorporated into the NCL balanced scorecard at a future date.*
	Serious Incidents	0	Sep '24	8			
	HCAI - *C.Diff*	12 month rolling - 297	Aug '24	285			*Represents NCL ICB total cases*
	HCAI - MRSA	0	Aug '24	32			*Represents NCL ICB total cases*
Efficiency/ Workforce	Staff in Post v Plan	Op Plan	M5	0.4%			*Values are based on the 24/25 Operating Plan submission*
	Vacancy Rate	n/a	M5	9.2%			*GOSH, MEH and WH are below the NCL 9.2% average.*
	Sickness Rate	c4%	M2	4.1%			*The overall NCL sickness rate has remained steady over recent reporting periods.*
	Theatre Productivity	85%	4 wks to 25/08/24	79.6%			*Value represents 'capped utilisation'.*
	Daycase as a % of Elective	85%	Jul '24	87.1%			*MEH and WH are currently meeting the target. The DC rate YTD 24/25 for NCL acute providers is 84.2%*
	Outpatient FU Reduction		YTD M5	108.6%			*Value represents comparison to the 23/24 position*

Appendix 2 – NCL Mental Health + LD&A Dashboard

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North Central London ICS - Mental Health and LD&A Operating Plan Measures		TARGET 23/24 - Q3	2023/24			TARGET 23/24 - Q4	2023/24			Plan 24/25	TARGET 24/25 - Q1	2024/25			TARGET 24/25 - Q2	2024/25		
			October	November	December		January	February	March			April	May	June		July	August	September
CYP - MH	CYP Access 1 Contact (Incl MHST)	19,327	20,453	20,739	21,224	20,579	21,616	22,028	22,170	24,989	20,821	20,864	21,277	21,440	22,030	21,182	20,934	TBC
Adult - MH	Talking Therapies 2+ Contacts & Discharge	n/a	9,125	10,095	11,210	n/a	12,325	13,600	14,805	15,586	3,870	1,225	2,455	3,535	7,745	4,985	6,380	TBC
	Talking Therapies - Reliable Recovery	n/a	43.1%	44.3%	42.4%	n/a	43.4%	45.0%	45.7%	48.2%	47.1%	44.7%	44.0%	46.7%	47.2%	48.4%	46.4%	TBC
	Talking Therapies - Reliable Improvement	n/a	65.9%	66.5%	64.1%	n/a	61.9%	66.3%	64.7%	68.1%	67.7%	64.9%	64.6%	64.4%	67.8%	69.0%	67.0%	TBC
	Perinatal	948	944	1,040	1,135	1,347	1,257	1,355	1,466	2,010	1,517	1,519	1,537	1,544	1,678	1,565	1,607	TBC
	Adult Community Access- 2 Contacts	19,870	20,372	20,624	20,793	21,491	21,007	21,229	21,244	23,823	21,350	21,324	TBC	20,924	21,721	21,030	21,075	TBC
	SMI - Physical Health Checks	13,851	11,063	11,194	11,343	14,028	11,914	12,792	14,507	71.0%	65.2%	56.9%			67.1%	TBC		
	Number of Inappropriate Active OAPs	155	420	618	1,042	0	173	257	593	0	12	20	17	n/a	8	8	5	TBC
	Dementia Diagnosis Rate 65+	66.7%	68.2%	68.2%	68.2%	66.7%	67.8%	67.5%	67.2%	69.0%	68.9%	67.0%	67.3%	67.8%	68.9%	67.4%	67.3%	TBC
LD&A	Annual Health Checks	49.2%	39.1%	48.3%	53.5%	75.0%	60.5%	69.3%	82.6%	75.0%	14.7%	3.4%	12.1%	17.9%	33.3%	24.2%	30.4%	37.0%
	Adult inpatients (ICS Commissioned)	23	20	19	18	23	15	14	14	18	18	n/a	n/a	14	18	n/a	12	14
	Adult inpatients (NHSE Commissioned)	15	24	23	23	14	33	22	22	21	22	n/a	n/a	21	22	n/a	21	18
	CYP inpatients	6	8	9	7	5	11	11	12	9	11	10	6	10	11	7	8	7

Appendix 3 – Acute Dashboard

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NCL - Selected Acute Services		2023/24						2024/25					
		October	November	December	January	February	March	April	May	June	July	August	September
UEC	*4-Hour AE performance target*	*75.6%*	*76.0%*	*74.9%*	*75.7%*	*77.3%*	*78.4%*	*71.0%*	*71.5%*	*72.7%*	*73.1%*	*73.8%*	*74.8%*
	4-Hour AE performance	69.4%	66.9%	65.4%	67.9%	68.8%	71.0%	71.4%	69.8%	72.8%	74.3%	76.4%	75.0%
	12 hour waits from arrival	4,605	4,920	5,205	5,350	4,760	5,155	5,325	5,965	4,700	4,695	3,080	3,475
	LAS handovers	8,392	8,006	8,275	8,245	7,989	8,282	8,006	8,544	8,139	8,536	8,392	7,890
	Ambulance handovers 30 min+	2,688	2,490	2,985	3,163	2,934	2,907	2,877	2,961	2,580	2,680	2,388	2,222
	Ambulance handovers 60 min+	222	175	350	447	326	495	494	458	283	288	254	300
RTT	RTT admitted pathways %	57.6%	57.3%	59.8%	58.4%	58.9%	58.7%	58.6%	60.1%	61.4%	60.3%	61.4%	*TBC*
	RTT non-admitted pathways %	66.4%	65.6%	67.1%	64.1%	65.3%	65.0%	66.5%	68.7%	68.1%	68.1%	68.8%	*TBC*
	RTT incompletes plan	*259,978*	*259,218*	*259,109*	*259,404*	*259,249*	*259,133*	*269,621*	*268,823*	*268,502*	*267,803*	*267,091*	*266,066*
	RTT incompletes	268,969	265,640	266,991	264,509	268,618	273,934	273,453	276,454	278,513	276,040	280,602	*TBC*
	52+ waits plan	*5,546*	*4,910*	*4,208*	*3,840*	*3,368*	*3,088*	*8,598*	*8,130*	*7,658*	*7,181*	*6,853*	*6,385*
	52+ waits	8,600	8,684	8,429	8,377	8,373	8,759	8,219	8,267	8,391	7,701	7,289	*TBC*
	65+ waits plan	*1,874*	*2,231*	*2,219*	*2,276*	*2,333*	*2,390*	*2,316*	*1,785*	*1,268*	*831*	*404*	*0*
	65+ waits	2,269	2,162	2,495	2,529	2,177	1,650	1,798	1,978	2,076	1,802	1,546	*TBC*
Diagnostics	*Imaging plan*	*57,582*	*58,814*	*49,800*	*55,640*	*53,758*	*57,588*	*61,229*	*63,404*	*63,885*	*65,209*	*62,616*	*62,513*
	Imaging activity	62,164	64,283	57,747	64,309	66,234	68,256	63,389	65,633	65,760	70,341	64,630	*TBC*
	Endoscopy plan	*4,434*	*4,577*	*3,863*	*4,218*	*4,198*	*4,759*	*4,153*	*4,273*	*4,375*	*4,576*	*4,250*	*4,489*
	Endoscopy activity	4,823	4,954	4,275	4,642	4,472	4,554	4,493	4,755	4,709	5,189	4,866	*TBC*
	Total diagnostic 6+ weeks	3,744	3,154	3,713	3,543	2,788	4,268	5,220	6,348	6,553	4,713	3,834	*TBC*
	Total diagnostic 6+ weeks %	91.2%	92.6%	90.8%	91.5%	93.8%	91.0%	89.1%	87.6%	87.1%	90.4%	91.6%	*TBC*
Cancer	31 day cancer treatments	1,648	1,629	1,392	1,505	1,507	1,526	1,600	1,457	1,520	1,720	1,407	*TBC*
	Cancer 31-day decision to treat %	81.1%	89.1%	88.6%	84.1%	91.3%	91.4%	91.2%	89.9%	87.7%	92.8%	90.8%	*TBC*
	62+ backlog plan	*609*	*592*	*578*	*559*	*541*	*515*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*
	62+ backlog	788	691	675	692	553	566	710	733	713	667	763	696
	62 day cancer treatments	696	761	680	707	710	674	697	654	721	750	665	*TBC*
	Cancer 62 days plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*62.6%*	*63.6%*	*65.6%*	*66.3%*	*64.0%*	*67.4%*
	Cancer 62 days achievement	56.8%	59.8%	63.8%	57.4%	61.5%	64.9%	62.8%	62.6%	63.1%	63.4%	64.6%	*TBC*
	28-day Faster Diagnosis Standard plan	*77.6%*	*73.0%*	*72.5%*	*73.9%*	*75.0%*	*76.3%*	*71.6%*	*72.5%*	*73.2%*	*74.0%*	*73.0%*	*74.1%*
	28-day Faster Diagnosis Standard %	69.0%	69.6%	71.6%	68.2%	73.5%	72.9%	68.4%	70.2%	73.0%	71.5%	71.2%	*TBC*
Beds	*Average G&A beds occupancy plan*	*95.9%*	*96.4%*	*96.2%*	*96.8%*	*96.3%*	*95.4%*	*92.3%*	*91.9%*	*92.1%*	*90.6%*	*91.3%*	*91.4%*
	Average adult G&A beds occupancy	91.9%	93.5%	90.3%	91.5%	92.3%	92.3%	92.2%	91.8%	91.6%	91.0%	88.8%	90.3%
	Average adult CC beds occupancy plan	*79.8%*	*79.3%*	*79.7%*	*82.7%*	*81.3%*	*81.3%*	*85.1%*	*84.6%*	*84.6%*	*84.8%*	*85.7%*	*84.7%*
	Average adult CC beds occupancy	78.2%	82.1%	82.2%	82.1%	83.8%	83.4%	81.3%	83.1%	82.0%	79.2%	81.3%	80.4%
	Length of stay 21+ plan	*512*	*470*	*474*	*532*	*488*	*455*	*515*	*557*	*544*	*520*	*512*	*514*
	Length of stay 21+	594	606	573	588	583	558	627	644	619	607	598	620
	Criteria to reside plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*12.5%*	*11.9%*	*11.6%*	*11.4%*	*10.9%*	*13.5%*
	Criteria to reside	13.1%	13.1%	12.3%	11.5%	12.8%	12.3%	12.1%	11.1%	13.1%	13.5%	13.6%	13.5%

North Central London
Integrated Care Board

North Central London ICB
Board of Members Seminar
12 November 2024

Report Title	Month 6 Finance Board Report	**Date of report**	23 October 2024	**Agenda Item**	3.2
Lead Director / Manager	Phill Wells Chief Finance Officer	**Email / Tel**		phill.wells@nhs.net	
Board Member Sponsor	Dr Usman Khan				
Report Author	Becky Booker Director of Financial Management	**Email / Tel**		r.booker@nhs.net	
Name of Authorising Finance Lead	Phill Wells Chief Finance Officer	**Summary of Financial Implications** For Month 6 (September 2024): • NCL ICS reported a YTD deficit of £39.8m at M6 which is adverse to plan by £4.4m. This is an improvement on the M5 adverse variance of £10.5m. • NCL ICB reports a year to date (YTD) and Forecast breakeven position.			
Report Summary	**NCL ICS** NCL ICS reported a YTD deficit of £39.8m at M6 which is adverse to plan by £4.4m. This is an improvement on the M5 adverse variance of £10.5m. There is an overall improvement in the straight-line run rate between M5 and M6 driven by nine organisations. Of the £4.4m YTD adverse variance, £3.9m relates to the loss of elective income due to industrial action (IA) in June and July with £7.7m attributed to CIP shortfall offset by £6.5m of ERF overperformance excluding IA impact. M6 has seen an improvement in IA related variances due to the ICS receiving £4.2m of income to offset direct costs of IA. ERF performance shows a worsening due to RFL reclassifying an element of ERF overperformance in M6 against as CIP. **NCL ICB** For Month 6 (September 2024) the ICB reports a forecast break-even position against plan. Within this however, Acute reports an overperformance of £16.3m driven by HCDD and Unbundled Diagnostics (£11.7m) and pressures within Independent Sector (£4.0m). Non-Acute reports a forecast overperformance of £11.9m mainly due to pressures reported within Continuing Healthcare (£10.3m). This has been offset by a £3.2m pay underperformance and the				

	release of recurrent and non-recurrent benefits from Financial Recovery & Reserves, enabling the ICB to report breakeven position. The ICB reports a net risk position of £7.5m at Month 6. The ICB plan assumes CIP efficiencies of £26.2m. The target does not assume any use of non-recurrent measures or cost avoidance schemes and is assumed as fully delivered in the financial plan. The Month 6 CIP performance shows an adverse variance of £4.7m against the Month 6 plan of £26.2m. This adverse variance is primarily driven by slippage and unidentified CIP in Complex Care (£3.7m) and unidentified CIP in Prescribing (£1.0m). Against the £26.2m target, the ICB has identified £15.2m in recurrent schemes, £6.3m in non-recurrent schemes, with £4.7m currently unidentified. In addition to the above CIP target the ICB has achieved £8.1m of efficiency as part of ICB 2024/25 Financial Planning process.
Recommendation	The Board of Members is asked to **NOTE** the contents of this report
Identified Risks and Risk Management Actions	The ICB reports a net risk position of c£7.5m. At Month 6 all risks have been mitigated by in-year recurrent and non-recurrent measures. Any emerging risks will be covered via a financial recovery plan. .
Conflicts of Interest	This paper was written in accordance with the Conflicts of Interest Policy
Resource Implications	To note that any recurrent cost pressures that materialise in-year will impact the ICBs 2024/25 financial position.
Engagement	This report is presented to the Board.
Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	The report will be presented to the Board on a quarterly basis.
Next Steps	This report is to be reviewed by the Board.
Appendices	None.

North Central London Health and Care
Integrated Care System

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2024/25 Month 6 Finance Report

As at 30th September 2024

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M6 Financial Position Overview – Revenue

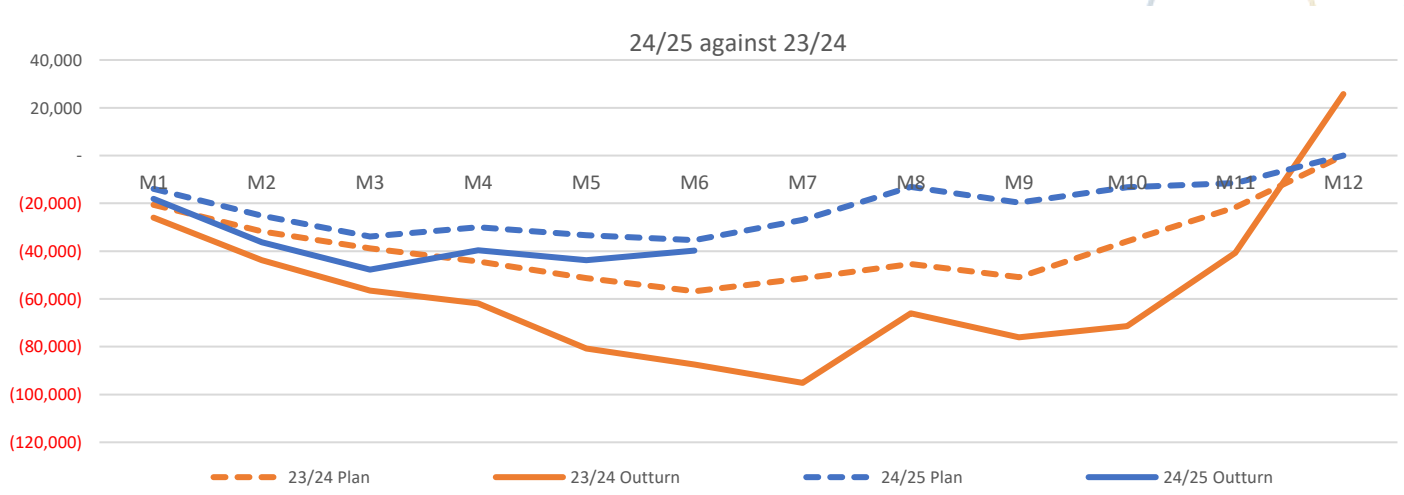
- NCL ICS reported a YTD deficit of £39.8m at M6 which is adverse to plan by £4.4m. This is an improvement on the M5 adverse variance of £10.5m.
- There is an overall improvement in the straight-line run rate between M5 and M6 driven by nine organisations.
- Of the £4.4m YTD adverse variance, £3.9m relates to the loss of elective income due to industrial action (IA) in June and July with £7.7m attributed to CIP shortfall offset by £6.5m of ERF overperformance excluding IA impact.
- M6 has seen an improvement in IA related variances due to the ICS receiving £4.2m of income to offset direct costs of IA. ERF performance shows a worsening due to RFL reclassifying an element of ERF overperformance in M6 against as CIP.

	NCL M5 – M6 YTD variance		
	M5	M6	Movement
	£'000	£'000	£'000
System adverse variance	**(10,509)**	**(4,397)**	**6,112**
Adverse variance explained by IA	**(8,182)**	**(3,903)**	**4,279**
Comprised of:			-
IA Costs	(4,538)	(259)	4,279
ERF loss of income	(3,644)	(3,644)	-
Adverse variance excluding IA	**(2,327)**	**(494)**	**1,833**
Comprised of:			-
ERF (excluding IA impact)	9,208	6,585	(2,623)
CIP shortfall	(6,503)	(7,742)	(1,239)
Other	(5,033)	663	5,696

	M6 Year to date			M6 Forecast Outturn			Straightline Run Rate		
Organisation	YTD Plan (12th June submission)	YTD Actual	YTD Variance	Annual Plan (12th June submission)	Forecast Outturn	FOT Variance	M5 run rate	M6 run rate	Improvement /(Deterioration)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Trust Total	(42,276)	(46,672)	(4,396)	(14,552)	(14,552)	(0)	(118,625)	(93,343)	25,282
NCL ICB	6,882	6,882	-	14,552	14,552	0	13,450	13,764	314
System Total	**(35,394)**	**(39,790)**	**(4,396)**	**-**	**0**	**0**	**(105,176)**	**(79,579)**	**25,597**

Delivering the 24/25 breakeven plan

- NCL ICS is currently on track to delivering the 24/25 plan of breakeven for the system.
- The graph below shows NCL actuals for 24/25 are tracking better than 23/24.
- The shape of the planned financial trajectory broadly reflects the NCL phasing of the delivery of provider efficiency savings towards the end of the financial year.



24/25 M6 Financial Position - Overview

North Central London Health and Care
Integrated Care System

Efficiency savings at M6

	Efficiency savings at M6					
	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	Annual Plan £'000	FOT £'000	Variance £'000
System Total	98,105	90,360	(7,746)	238,708	231,007	(7,701)
Recurrent Only	85,868	62,443	(23,425)	205,642	173,691	(31,951)

- As of M6, NCL ICS were reporting YTD savings of £90.4m which represents delivery of 31% of the total savings requirement for 24/25. The ICS is forecasting an under delivery of savings totalling £7.7m. This is driven by a shortfall of £4.7m at the ICB and £3m at MEH.
- While the YTD plan assumed c.88% of CIP to be delivered to be recurrent in nature, c.71% of actual CIP delivered to date is recurrent. Any under delivery of recurrent CIP in 24/25 has an adverse impact on the opening plan position for 25/26.

Capital position at M6

	ICS Capital Programme at M6					
	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	Control Total £'000	FOT £'000	Variance £'000
ICS Capital Programme	69,045	47,098	21,948	223,723	223,785	(62)

- The YTD capital position at M6 is underspent by £21.9m with the FOT showing a small overspend against plan due to a disposal at GOSH that has not yet materialised. The FOT will be updated to match the plan in M7. This indicates the 24/25 capital allocation will be fully utilised.
- The system reserve currently includes £12.6m of CDEL that will be distributed to trusts following in-year capital reforecasting exercise current being undertaken.

IFRS16 position at M6

	IFRS16 at M6					
	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	Control Total £'000	FOT £'000	Variance £'000
IFRS16 Position	7,751	7,877	(126)	43,993	43,993	0

- The YTD IFRS 16 position is an adverse variance of £0.1m. The adverse variance is mainly driven by Whittington due to in-year rent reviews and RFL due to the phasing of the plan with leases commencing earlier than anticipated.
- The 24/25 allocation will be fully utilised. We are holding a system reserve of £9.7m which we will seek to allocate as part of our in-year capital reforecasting exercise currently underway.

Agency at M6

	Agency at M6					
	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	Agency Cap £'000	FOT £'000	Variance £'000
Agency	51,349	52,450	(1,101)	101,830	100,277	1,553

- Agency spend is adverse against plan at M6 by £1.1m. As of M6, all providers are forecasting agency spend in line with plan with the exception RFL who are forecasting an underspend of £1.5m. The FOT represents 98.4% of NCL's 24/25 agency cap.
- NHSE set the 24/25 agency cap at £101.9m. This represents 3% of the system's total planned pay bill for 24/25. Staying within the 24/25 cap will ensure NCL meets one of the its plan commitments of reducing agency to a maximum of 3% of the total pay bill across 24/25.

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NCL ICB Month 6 Finance Position

As at 30th September 2024

Month 6 Summary Position

North Central London Integrated Care Board

Month 6 Summary Position

Background

The System submitted a 2024/25 balanced plan on 12th June 2024. As part of this, the ICB submitted a surplus plan of **£14.6m**.

The ICB plan includes a number of efficiencies required to deliver to the surplus position. These include a CIP target of **£26.2m**, running cost reductions of **£4.8m**, and the requirement to deliver in-year non-recurrent measures of **£14.6m**. The running cost reductions have already been realised as part of the financial planning process.

The plan also assumes full mitigation of in-year risks, currently **£18.9m** as at Month 6 (risk adjusted).

Month 6 (September 2024)

For Month 6 (Sep'24) the ICB reports a forecast break-even position against plan. Within this however, Acute reports an overperformance of **£16.3m** driven by HCDD and Unbundled Diagnostics (£11.7m) and pressures within Independent Sector (£4.0m).

Non-Acute reports a forecast overperformance of **£11.9m** mainly due to pressures reported within Continuing Healthcare (£10.3m).

This has been offset by a £3.2m pay underperformance and the release of recurrent and non-recurrent benefits from Financial Recovery & Reserves, enabling the ICB to report breakeven position.

Summary financial position (£m)

	YTD			Full Year		
	Bud	Actual	Var	Bud	FOT	Var
	£m	£m	£m	£m	£m	£m
Revenue Resource Limit	**1,868.2**	**1,868.2**	**0.0**	**3,686.0**	**3,686.0**	**0.0**
Acute	933.3	941.6	(8.3)	1,830.2	1,846.5	(16.3)
Non-Acute	867.6	872.9	(5.3)	1,721.3	1,733.2	(11.9)
Other Pgrm Services	47.4	33.9	13.5	94.0	65.8	28.2
Running Costs	12.9	12.9	0.0	25.9	25.9	(0.0)
Total Operational	**1,861.3**	**1,861.3**	**(0.0)**	**3,671.4**	**3,671.4**	**0.0**
Reserves & Contingency	0.0	0.0	0.0	0.0	0.0	0.0
Total Non Operational	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Total Expenditure	**1,861.3**	**1,861.3**	**(0.0)**	**3,671.4**	**3,671.4**	**0.0**
Surplus / (Deficit)	**6.9**	**6.9**	**(0.0)**	**14.6**	**14.6**	**0.0**

Month 6 Summary Position (cont.)

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Month 6 Summary Position

Pay

The below table summarises the Month 6 pay position split between Programme and Running Cost. The YTD position is £2.7m favourable to budget.

Pay is forecasting a total favourable variance of £3.2m, which is mainly driven by vacancies. Running cost pay is forecasting a favourable variance of £1.7m. Non-RCA (Programme) pay costs are forecasting a favourable variance of (£1.5m). The forecast includes double running, transition, and at-risk costs (£2.0m), excluding these costs the ICB would be reporting an overall favourable variance of c£5.2m.

Running/Programme	Budgeted WTE	YTD Budget	YTD Actual	YTD Variance Fav/(Adv)	2024/25 Annual Budget	Forecast Outturn	Forecast Variance Fav/(Adv)
	WTE	£000	£000	£000	£000	£000	£000
Running	157	8,955	7,627	1,328	17,910	16,252	1,658
Programme	512	20,431	19,095	1,336	40,862	39,327	1,535
	669	**29,386**	**26,722**	**2,664**	**58,772**	**55,579**	**3,193**

Month 6 Summary Position (cont.)

North Central London Integrated Care Board

Month 6 Summary Position

Use of Non-Recurrent Funds

During 2024/25 planning the ICB committed the use of **c£14.6m** of non-recurrent funding to deliver a planned surplus of **£14.6m** (as per final submitted plan on 12th June) to achieve a System breakeven position. The ICB has initiated an in-year recovery programme to ensure this target is met, noting that use of non-recurrent measures to support recurrent expenditure adversely affects the ICBs underlying position. The underlying position will continue to be monitored and reported throughout the financial year.

Complex Individualised Commissioning (CIC) and Continuing Health Care (CHC)

At Month 6 the ICB is reporting a position for Complex Care, Complex Individualised Commissioning (CIC) and Continuing Healthcare (CHC), of £111.0m (£5.4m adverse) YTD and FOT of £221.4m (£10.3m adverse).

The adverse variance is largely driven by CHC Fully Funded of £7.2m (of which £3.7m is CIP slippage and £3.5m a combination of price and activity). There are further adverse variances in Funded Nursing Care (FNC) of £2.3m, and Children of £0.3m largely activity driven.

Acute Services

At Month 6 the Acute position is reporting an adverse variance to plan of £16.3m, driven by spend within High-Cost Drugs and Devices (HCDD) £11.7m and increased spend with Independent Sector providers (£4.0m).

Other Programme & Running Costs

Other Programme Reports a favourable YTD and forecast position of £13.5m and £28.2m respectively. This is driven by the by the release of both recurrent and non-recurrent measures to offset pressures reported within Continuing Care, Acute Services and Prescribing.

Running Costs reports a breakeven position.

Month 6 Summary Position (cont.)

North Central London Integrated Care Board

Month 6 Summary Position

Underlying Position (ULP)

For Month 6 the ICB reports a ULP deficit of **c£37.5m**, which represents a deterioration £10.3m from the reported Month 5 position. The deterioration is driven by pressures reported within CHC (incl. Discharge) and within Acute driven by HCDD and Independent Sector pressures.

Risks & Mitigations

The ICB reports a net risk position of **c£7.5m** (Month 5 c£10.2m).

At Month 6 all risks have been mitigated by in-year recurrent and non-recurrent measures. Any emerging risks will be covered via a financial recovery plan.

To note that the use of non-recurrent mitigations to cover recurrent risks will impact on the ICB's underlying financial position.

Cost Improvement Programme (CIP)

The Month 6 CIP performance shows an adverse variance of £4.7m against the Month 6 plan of £26.2m. This adverse variance is primarily driven by slippage and unidentified CIP in Complex Care (£3.7m) and unidentified CIP in Prescribing (£1.0m).

Against the **£26.2m** target, the ICB has identified **£15.2m** in recurrent schemes, **£6.3m** in non-recurrent schemes, with **£4.7m** currently unidentified.

In addition to the above CIP target the ICB has achieved £8.1m of efficiency as part of ICB 2024/25 Financial Planning process.

ICB Month 6 Year to Date Financial Performance

North Central London Integrated Care Board

The table below provides commentary on variances by service area

YTD Financial Performance (£m)

Service	Year to Date			Key Variances
	Budget £m	Actual £m	Variance £m	
Allocations				
In year allocations	1,868.2	1,868.2	0.0	
Total Allocations	**1,868.2**	**1,868.2**	**0.0**	
Expenditure				
Acute	933.3	941.6	(8.3)	**Adverse Variance:** Driven by HCDD cost pressures and increased activity within Independent Sector providers.
Non-Acute				
Mental Health & LD	235.1	235.3	(0.2)	
Delegated Commissioning	165.7	165.7	(0.0)	
Community Services	178.9	178.9	0.0	
Primary Care	25.2	25.2	0.0	
Primary Care - Prescribing	102.4	102.6	(0.2)	
Primary Care - Dental, Ophthalmic & Pharmacy	81.5	81.0	0.5	
Continuing Care	78.7	84.1	(5.4)	**Adverse Variance:** Driven by CIP slippage and adverse variances in CHC Fully Funded, Funded Nursing Care, and Children
Total	**867.6**	**872.9**	**(5.3)**	
Other Programme Services & Running Costs				
Other Programme Services	47.4	33.9	13.5	**Favourable Variance:** Due to the release of recurrent and non-recurrent measures to enable the ICB to report a breakeven position
Running Costs	12.9	12.9	0.0	
Total	**60.3**	**46.8**	**13.5**	
Total Expenditure	**1,861.3**	**1,861.3**	**(0.0)**	
Surplus / (Deficit)	**6.9**	**6.9**	**0.0**	

ICB Forecast Outturn Financial Performance

North Central London Integrated Care Board

The table below provides commentary on variances by service area

FOT Financial Performance (£m)

Service	Forecast			Key Variances
	Budget	Actual	Variance	
	£m	£m	£m	
Allocations				
In year allocations	3,686.0	3,686.0	0.0	
Total Allocations	**3,686.0**	**3,686.0**	**0.0**	
Expenditure				
Acute	1,830.2	1,846.5	(16.3)	**Adverse Variance:** Driven by HCDD cost pressures and increased activity within Independent Sector providers.
Non-Acute				
Mental Health & LD	470.3	471.2	(1.0)	**Adverse Variance:** Due to an increase in the number of invoices for non-contracted activity
Delegated Commissioning	317.9	317.9	0.0	
Community Services	357.8	357.4	0.4	**Favourable Variance:** Due to purchasing of fewer beds from Marie Curie Hospice whilst they address RAAC concrete issues within their buildings.
Primary Care	50.4	50.4	0.0	
Primary Care - Prescribing	204.8	205.9	(1.0)	**Adverse Variance:** Due to CIP slippage within prescribing
Primary Care - Dental, Ophthalmic & Pharmacy	162.6	162.6	0.0	
Continuing Care	157.4	167.8	(10.3)	**Adverse Variance:** Driven by CHC Fully Funded (£7.2m) of which (£3.7m) is CIP slippage and (£3.5m) a combination of price and activity. There are further adverse variances in FNC (£2.3m) and Children (£0.3m) largely activity driven.
Total	**1,721.3**	**1,733.2**	**(11.9)**	
Other Programme Services & Running Costs				
Other Programme Services	94.0	65.8	28.2	**Favourable Variance:** Due to the release of recurrent and non-recurrent measures to enable the ICB to report a breakeven position
Running Costs	25.9	25.9	(0.0)	
Total	**119.9**	**91.7**	**28.2**	
Total Expenditure	**3,671.4**	**3,671.4**	**0.0**	
Surplus / (Deficit)	**14.6**	**14.6**	**0.0**	

Month 6 Risks & Mitigations

North Central London Integrated Care Board

Risk Summary

Directorate	Risk value £'000	% RAG rating	Rag Rating	Risk adjusted value £'000	Risk adjusted Mitigation £'000	Net Risk £'000	Comments
RISKS							
Continuing Healthcare	(14,700)	50%		(7,350)	0	(7,350)	Mainly driven by CIP non-delivery and the risk of activity and price increases
Primary Care - Prescribing	(7,725)	30%		(2,318)	0	(2,318)	Due to CIP non-delivery and risk of activity increases, and increased drug costs
Acute	(7,151)	28%		(1,998)	733	(1,265)	Mainly due to increased costs within High Cost Drugs & Devices
Community	(1,420)	63%		(899)	0	(899)	Mainly due to Community Equipment contract exceeding plan
Mental Health	(3,360)	43%		(1,430)	741	(689)	Driven by CIP delivery risk
Primary Care	(400)	81%		(322)	0	(322)	Risks associated with GP collective action
Primary Care - DOP	(2,717)	91%		(2,480)	2,480	0	Pharmacy First Funding gap, fully mitigated via additional funding expected from NHSE
Other Programme / R/Cost	(4,031)	51%		(2,062)	7,410	5,348	Risk due to non-recurrent measures required for the ICB to achieve its plan for 2024/25. The mitigation is due to benefits arising from a Financial Recovery plan
TOTAL RISKS	**(41,504)**	**45%**		**(18,859)**	**11,364**	**(7,495)**	
					Mitigations required	7,495	
					REPORTED RISK POSITION	**0**	

Month 6 Risk Position

For Month 6, the total identified risks amount to **£41.5m**. These risks have been evaluated and categorised using a RAG (Red, Amber, Green) rating system, which assesses the likelihood of each risk materialising. The total risk adjusted position for Month 6 is **£18.9m**, a reduction of c£11.7m from the risk adjusted position reported in Month 5.

The risks reported within Other Programme / R/Cost mainly relate to the non-recurrent measures required for the ICB to achieve its plan for 2024/25. Any recurrent risks that materialise, and covered via non recurrent measures, will adversely impact the ICBs underlying position.

Mitigations

The ICB reports a fully mitigated risk position for Month 6. Identified mitigations are currently **£11.4m** (risk adjusted), the ICB therefore requires additional mitigations of **£7.5m** to fully cover the risk position at Month 6. These additional mitigations are expected to be achieved through an in-year financial recovery programme, noting that the use of non-recurrent mitigations to cover recurrent risks will impact on the ICB's underlying financial position.

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Appendices

Appendix 1 - Income & Expenditure
Appendix 2 - Cash Flow Statement
Appendix 3 - Block Contracts

Appendix 1: Income & Expenditure Statement

	2024/25 In-Month AP6 - SEP 24			2024/25 Year to Date AP6 - SEP 24			2024/25 Annual Forecast			2023/24 Outturn		
	Admin	Prog	Total	Admin	Prog	Total	Admin	Prog	Total	Admin	Prog	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Operating Revenue												
Prescription fees and charges	0	(676)	(676)	0	(7,649)	(7,649)	0	(14,959)	(14,959)	0	(14,683)	(14,683)
Education, training and research	0	0	0	0	0	0	0	0	0	0	0	0
Non-patient care services to other bodies	0	(1,806)	(1,806)	0	(10,889)	(10,889)	0	(21,941)	(21,941)	0	(24,027)	(24,027)
Other Contract income	0	(17)	(17)	0	(102)	(102)	0	(203)	(203)	0	(7,000)	(7,000)
Other non contract revenue	0	(1,304)	(1,304)	0	(6,627)	(6,627)	0	(12,774)	(12,774)	0	(12,601)	(12,601)
Total Operating revenue	**0**	**(3,803)**	**(3,803)**	**0**	**(25,267)**	**(25,267)**	**0**	**(49,878)**	**(49,878)**	**0**	**(58,312)**	**(58,312)**
Operating Expenses	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Expenses												
Perm E/ees - Salaries and Wages	1,020	2,005	3,025	5,796	12,067	17,863	15,538	36,026	51,564	16,387	23,645	40,033
Perm E/ees - Social Security Costs	98	274	371	547	1,651	2,198	0	0	0	1,970	3,008	4,978
Perm E/ees - Em/er Contribs to NHS Pension	105	346	450	610	2,083	2,693	0	0	0	4,700	3,912	8,611
Perm E/ees - Apprenticeship Levy	15	0	15	89	0	89	178	0	178	213	0	213
Perm E/ees - Termination benefits	0	(0)	(0)	0	939	939	0	0	0	0	8,972	8,972
Other E/ees - Salaries and Wages	181	473	653	570	2,443	3,012	714	3,302	4,015	2,325	5,730	8,055
Total Gross employee expenses	**1,418**	**3,096**	**4,515**	**7,612**	**19,182**	**26,793**	**16,430**	**39,327**	**55,757**	**25,595**	**45,268**	**70,863**
Other Operating Expenses												
Services from other CCGs and NHS England	0	6	6	8	36	44	0	72	72	47	85	132
Services from foundation trusts	0	111,080	111,080	0	663,555	663,555	0	1,326,756	1,326,756	0	1,378,493	1,378,493
Services from other NHS trusts	0	98,195	98,195	0	584,849	584,849	0	1,169,770	1,169,770	0	1,173,340	1,173,340
Purchase of healthcare from non-NHS bodies	0	39,735	39,735	0	233,186	233,186	0	429,263	429,263	0	409,897	409,897
Purchase of social care	0	718	718	0	4,126	4,126	0	8,252	8,252	0	8,225	8,225
Chair and Non Executive Members	5	0	5	58	0	58	0	0	0	314	0	314
Supplies and services – clinical	0	131	131	0	785	785	0	1,569	1,569	0	1,958	1,958
Supplies and services – general	518	(1,045)	(527)	3,733	12,093	15,826	5,861	22,540	28,401	1,096	11,840	12,935
Consultancy services	0	19	19	0	19	19	0	0	0	198	1,011	1,209
Establishment	4	234	238	211	1,788	1,999	540	3,862	4,403	562	3,990	4,552
Transport	0	4	4	0	4	4	0	0	0	1	0	2
Premises	63	449	513	170	1,892	2,063	345	4,079	4,424	337	3,851	4,188
Depreciation	84	0	84	505	0	505	1,009	0	1,009	1,009	0	1,009
Audit fees	20	0	20	121	0	121	242	0	242	216	0	216
· Internal audit services	23	0	23	138	0	138	252	0	252	256	0	256
· Other services	0	0	0	0	0	0	0	0	0	26	0	26
General Dental services and personal dental services	0	7,628	7,628	0	44,568	44,568	0	88,656	88,656	0	84,447	84,447
Prescribing costs	0	16,934	16,934	0	102,144	102,144	0	204,948	204,948	0	206,931	206,931
Pharmaceutical services	0	3,055	3,055	0	22,161	22,161	0	44,698	44,698	0	46,133	46,133
General Ophthalmic services	0	1,159	1,159	0	7,317	7,317	0	15,065	15,065	0	14,731	14,731
GPMS/APMS and PCTMS	0	32,120	32,120	0	173,844	173,844	0	348,782	348,782	0	319,744	319,744
Other professional fees excl. audit	(3)	40	37	37	852	889	23	2	25	134	1,786	1,920
Legal Fees	43	(17)	26	233	17	250	831	20	851	491	177	669
Education and training	(21)	274	253	112	1,195	1,308	340	2,347	2,687	161	544	705
Other expenditure	1	0	1	7	0	7	13	(14,605)	(14,592)	24	1,079	1,103
Total other costs	**739**	**310,719**	**311,458**	**5,331**	**1,854,432**	**1,859,763**	**9,456**	**3,656,075**	**3,665,531**	**4,871**	**3,668,263**	**3,673,135**
Net Operating Expenditure	**2,157**	**313,815**	**315,972**	**12,943**	**1,873,614**	**1,886,557**	**25,886**	**3,695,402**	**3,721,288**	**30,467**	**3,713,531**	**3,743,998**
Net Expenditure	**2,157**	**310,012**	**312,169**	**12,943**	**1,848,347**	**1,861,290**	**25,886**	**3,645,525**	**3,671,411**	**30,467**	**3,655,219**	**3,685,686**
Revenue Resource Limit	**2,157**	**311,290**	**313,447**	**12,943**	**1,855,229**	**1,868,172**	**25,886**	**3,660,077**	**3,685,963**	**33,646**	**3,662,955**	**3,696,601**
Surplus / (Deficit) from Operations	**(0)**	**1,278**	**1,278**	**(0)**	**6,882**	**6,882**	**(0)**	**14,552**	**14,552**	**3,179**	**7,736**	**10,915**

Appendix 2: Cashflow Statement

North Central London
Integrated Care Board

	AP1 - APR 24	AP2 - MAY 24	AP3 - JUN 24	AP4 - JUL 24	AP5 - AUG 24	AP6 - SEP 24	AP7 - OCT 24	AP8 - NOV 24	AP9 - DEC 24	AP10 - JAN 25	AP11 - FEB 25	AP12 - MAR 25	Total
	Actual	Actual	Actual	Actual	Actual	Actual	F/Cast	F/Cast	F/Cast	F/Cast	F/Cast	F/Cast	F/Cast
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance bfwd	**905**	**553**	**995**	**3,340**	**3,169**	**3,531**	**1,393**	**501**	**586**	**527**	**510**	**568**	**905**
RECEIPTS													
Main Cash Drawdown	276,000	287,000	284,700	272,500	280,000	274,000	266,795	271,000	266,000	271,000	268,500	269,500	3,286,995
Supplementary Drawdown	41,000	4,800	0	0	0	0	29,827	0	0	0	0	0	75,627
Other	3,112	3,338	2,361	1,665	6,642	1,430	3,236	0	0	0	0	0	21,783
VAT	224	211	210	1,207	524	340	250	250	250	250	250	250	4,217
Total Receipts	**320,335**	**295,349**	**287,271**	**275,372**	**287,166**	**275,770**	**300,108**	**271,250**	**266,250**	**271,250**	**268,750**	**269,750**	**3,388,621**
PAYMENTS													
NHS Payables	234,297	208,042	207,948	211,852	231,738	207,278	228,647	208,139	207,496	207,493	207,431	208,099	2,568,460
Non NHS Payables	81,754	82,839	72,967	59,496	51,084	66,618	67,402	58,376	54,164	59,123	56,611	56,610	767,044
Salaries & Wages (inc Tax, NI & Pension)	4,637	4,026	4,011	4,196	3,982	4,012	4,950	4,650	4,650	4,650	4,650	4,650	53,064
Total Payments	**320,688**	**294,907**	**284,926**	**275,544**	**286,804**	**277,907**	**300,999**	**271,165**	**266,309**	**271,266**	**268,692**	**269,359**	**3,388,567**
BALANCE CFWD	**553**	**995**	**3,340**	**3,169**	**3,531**	**1,393**	**501**	**586**	**527**	**510**	**568**	**959**	**959**

Appendix 3: Block Contracts

NCL ICB Block Contract Summary as at 30th September 2024

Area	Trust	Budget £'000
Acute Services - NHS (BLOCK)	Barts Health NHS Trust	31,190
	Barking, Havering And Redbridge University Hospitals NHS Trust	1,238
	Chelsea And Westminster Hospital NHS Foundation Trust	4,305
	East And North Hertfordshire NHS Trust	1,612
	Great Ormond Street Hospital For Children NHS Foundation Trust	19,557
	Guy's And St Thomas' NHS Foundation Trust	18,664
	Homerton University Hospital NHS Foundation Trust	19,035
	Imperial College Healthcare NHS Trust	23,562
	King's College Hospital NHS Foundation Trust	3,468
	Lewisham And Greenwich NHS Trust	836
	London Ambulance Service NHS Trust	91,777
	London North West University Healthcare NHS Trust	18,365
	Mid and South Essex NHS Foundation Trust	677
	Moorfields Eye Hospital NHS Foundation Trust	31,249
	North Middlesex University Hospital NHS Trust	306,091
	The Princess Alexandra Hospital NHS Trust	1,536
	Royal Free London NHS Foundation Trust	587,844
	Royal National Orthopaedic Hospital NHS Trust	23,644
	St George's University Hospitals NHS Foundation Trust	1,775
	The Royal Marsden NHS Foundation Trust	1,213
	University College London Hospitals NHS Foundation Trust	379,240
	West Hertfordshire Hospitals NHS Trust	2,140
	Whittington Health NHS Trust	227,425
	LVA - NHST	4,716
	LVA - NHFT	7,743
Acute Services NHS Block Total		**1,808,904**

Appendix 3: Block Contracts (cont.)

NCL ICB Block Contract Summary as at 30th September 2024 (cont.)

Area	Trust	Budget £'000
Mental Health Services Block	Barnet, Enfield And Haringey Mental Health NHS Trust	189,517
	Central And North West London NHS Foundation Trust	6,325
	Camden And Islington NHS Foundation Trust	141,144
	Central London Community Healthcare NHS Trust	2,965
	East London NHS Foundation Trust	1,120
	Royal Free London NHS Foundation Trust	2,238
	South London And Maudsley NHS Foundation Trust	1,807
	Tavistock And Portman NHS Foundation Trust	15,339
	Whittington Health NHS Trust	3,885
	North Middlesex University Hospital NHS Trust	839
Mental Health Services Total		**365,180**
Community Health Services Block	Barnet, Enfield And Haringey Mental Health NHS Trust	237
	Central And North West London NHS Foundation Trust	42,910
	Central London Community Healthcare NHS Trust	58,968
	Camden And Islington NHS Foundation Trust	227
	London North West University Healthcare NHS Trust	170
	North Middlesex University Hospital NHS Trust	40,690
	Royal Free London NHS Foundation Trust	5,773
	Tavistock And Portman NHS Foundation Trust	40
	University College London Hospitals NHS Foundation Trust	99
	Whittington Health NHS Trust	99,554
Community Health Services Block Total		**248,668**
Primary Care Dental, Opthalmic & Pharmacy	Secondary Dental Care – Intra Trust	31,436
	Secondary Dental Care – Inter Trust	8,549
	Secondary Dental Care – LVA Trust	985
Primary Care Dental, Opthalmic & Pharmacy Total		**40,970**
Total Commissioning Expenditure		**2,463,722**

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
12 November 2024

Report Title	Board Assurance Framework ('BAF') Report	**Date of report**	4 November 2024	**Agenda Item**	3.3
Lead Director / Manager	Ian Porter, Executive Director of Corporate Affairs	**Email / Tel**		Ian.porter3@nhs.net	
Board Member Sponsor	Frances O'Callaghan, Chief Executive Officer				
Report Author	Andrew Spicer, Assistant Director of Governance, Risk and Legal Services	**Email / Tel**		Andrew.spicer1@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** The BAF report assists the ICB in managing its most significant financial risks.			

Report Summary

This report is the NCL ICB Board of Members Board Assurance Framework ('BAF'). It captures the most serious risks that have been identified as threatening the achievement of the ICB's strategic objectives.

This report contains the following sections:

- Risk Overview. This sets out the movement of the BAF risks together with key highlights to bring to the Board's attention. This section also focusses on the key interrelationships between the risks and on emerging areas of risks to draw the Board's attention to;
- BAF Risk Overview Report. This report is at Appendix 1. It is a strategic snapshot of each BAF risk including risk scores, strategic updates and movement over the previous four Board reports;
- BAF Register. This is the full BAF risk register should Board members require further detail on each risk and the risk plans to control the risks (including controls, gaps in controls and actions). The full version of the BAF risk register is here.

Risk Overview

There are 7 risks in total on the BAF:

- 1 is an ICB only risk (Fin29);
- 1 is an ICB risk generated from risks or issues in other organisations (Perf28);
- 4 are system risks (Perf29, Comm32, Fin36, Fin39);
- 3 of the 7 risks are below the BAF threshold but included for information (see below);
- 2 risks (Qual64 and PC3) have reduced below the BAF threshold but have been reported on the BAF Overview Report.

There are no new risks on the BAF:

Two risks have decreased:

- Qual64- Failure to undertake timely Continuing Healthcare assessments and reviews within 28 days (Threat). Decreased from 16 to 12. Additional controls and resources are being put into place to work more closely with Local Authorities which will strengthen the position in undertaking timely assessments and reviews. The risk description was also amended to strengthen its focus on delivery of the national metric, the impact on patients and the partnership nature of this risk;
- PC3- Strikes by NHS staff (Threat). Decreased from 20 to 12. The risk has reduced due to junior doctors having accepted the Government's pay offer.

3 risks are below the BAF threshold but are included on the BAF for oversight:

- Perf28- Failure of Primary Care patient access (Threat);
- Comm22- Failure of the Integrated Care Board to effectively and safely manage the specialist services devolution in 2024/25, impacting on the delivery of population health improvements (Threat);
- Fin29- Failure of North Central London Integrated Care Board ('ICB') to remain within its Running Cost Allowance ('RCA') 2024/25 and 2025/26 (Threat).

The risks together with their strategic narratives are contained in the BAF Risks Overview Report in Appendix 1.

Key highlights to bring to the Board's attention are:

<u>Performance</u>
The overall A&E performance of NCL ICB's acute providers remains below the trajectory of 76%. Whilst we are below the trajectory, since the start of the financial year there has been an improvement in performance of approximately 3.6%, improving from 71.4% in April 2024 to 75% in September 2024. The performance rose to 76.4% for August 2024.

However, based on the Q1 performance and following a national review in July 2024 the Integrated Care System ('ICS') has been escalated to Tier 1 for Urgent and Emergency Care ('UEC'). The performance of North Middlesex University Hospital and the impact on other North Central London provider due to this, was cited as a particular area of concern. Following the Tier 1 notification there was a national visit to North Middlesex Hospital on 11th September. Outputs from the visit builds on existing plans to accelerate the improvement across the key patient safety standard. Progress is being monitored via fortnightly meetings involving the Trust, ICB and regional as well as national teams.

Winter 2045/25
In preparation for Winter 2024/25 NCL has worked to evaluate and refine last year's dynamic plan (the winter play book), building on the NHS England recovery plan for urgent and emergency care services which was published in January 2023 and the recent national seven UEC priorities. Recognising the breadth of UEC pathways we have included all parts of the system in our Winter Plan with a focus on proactive actions informed by data to target the interventions.

Preventative work, through vaccinations as the most effective way to prevent infectious diseases, is a critical part of our plans. Further, we have increased primary care capacity via schemes that will deliver proactive care in autumn to support at-risk cohorts to stay well in winter. NCL is one of the only systems to

	direct winter capacity funding to primary care systematically. Other proactive actions include: 1. Enhanced use of pharmacy first as an alternative to Urgent Treatment Centres, GP services and emergency departments; 2. Work with care homes to support unwell but not acutely ill residents; 3. Development of pre-conveyancing modes through London Ambulance Service – work has started on the NCL Integrated Care Hub to support winter pressures; 4. Enhancing 111 resilience and capacity. Implementation and impact of our winter plans will be overseen via the NCL Flow Operations Group ('FOG') and in turn the NCL Flow Board. Management and mitigation of risk in real time will be via the NCL System Coordination Centre. <u>NHS Strikes</u> With the junior doctors agreeing the Government's pay offer the risk of strikes by NHS staff and the corresponding disruption to services has significantly decreased. However, there is continued risk due to the GP planned action which started from 1st April 2024. This is not strike action but rather a 'work to rule' and none of the collective action by GPs breaches the GP core contracts. This risk emerged from national industrial action taken by unions and NHS staff regarding pay and working conditions disputes. However, one option suggested by the BMA can include limiting the number of patient appointments per GP per day to the recognised safe working maximum level of 25, and stopping or reducing work that GPs are not formally contracted to carry out. Regional planning sessions are in place (the first was held on 16th July 2024) to develop plans for the GP planned action. Primary Care leads are involved with these meetings and will lead on any action needed. We continue to monitor the situation on a weekly basis across North Central London and also with the region. **<u>Looking Forward</u>** The ICB's approach to risk management continues to evolve with oversight by the Audit Committee. An item on risk management to consider further developments on the ICB's approach to risk is planned for the Board seminar in December 2024 or February 2025.
Recommendation	The Board of Members is asked to: • **NOTE** the report and provide feedback on the risks; and • **IDENTIFY** any strategic gaps within the Board's remit, and propose any areas where further investigative work may support further risk mitigation.
Identified Risks and Risk Management Actions	The BAF is a risk management document which highlights the most significant risks to the achievement of the ICB's strategic objectives.
Conflicts of Interest	Conflicts of interest are managed robustly and in accordance with the ICB's Conflict of Interest Policy.
Resource Implications	Updating of the BAF is the responsibility of each risk owner and their respective directorates. The Governance and Risk Team helps to support this by providing monitoring, guidance and advice.

Engagement	The BAF report is presented to each Board of Members meeting. There has also been discussions on risk with the Executive Management Team and the Audit Committee.
Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	The Board Assurance Framework report is presented to each Board of Members meeting. Risks are kept under review by the risk owners and by the committees of the Board of Members.

Next Steps	The next steps are as follows:
	• To continue to manage risks in a robust way;
	• To continue the development of the ICB's approach to system risk management. This includes:
	  ○ Increased independent scrutiny and oversight of our key risks and our developing approach through the Audit Committee;
	  ○ Further identification and development of system risks;
	  ○ Consideration of the ICB's role in system risk management;
	  ○ Consideration of the ICB's approach to risk appetite.

Appendices	The following documents are included: • Appendix 1- BAF Risks Overview Report; • BAF Register; • Risk Scoring Key.

North Central London ICB BAF Risks - Oversight Report

Risk ID	Risk Title	Risk Owner	Committee	Risk description	Strategic update	2024 Current Risk Score MAR	MAY	JULY	OCT	Movement From Last Report	Target Risk Score
System Risks											
PERF29	Failure to achieve the 4 hour A&E wait standard (Threat).	Richard Dale - Executive Director of Performance and Transformation	Strategy and Development Committee	**CAUSE:** If the ICB fails to ensure adequate capacity and operational resilience to affectively manage the flow of patients through the Emergency Department ('ED') and the hospital, **EFFECT:** there is a risk that patients will not be seen within the expected 4 hours and receive sub-optimal care, which may have an adverse effect on their health outcomes. **IMPACT:** this may result in the ICB missing the national expectation that 76% of patients are seen within 4 hours of arrival to the ED, increasing waiting times and increasing the potential risk of harm and adversely impact on System Oversight Framework segmentation.	The overall performance of the NCL ICB'S acute providers remains below the A&E trajectory of 76%, and in consequence of this, the ICS has been escalated to Tier 1 for Urgent and Emergency Care ('UEC'), following a national review in July 2024. The performance of North Middlesex University Hospital, and the impact of this on other providers in NCL, was cited as a particular area of concern. However, there has been improvement since the start of the financial year of approximately 3.6%. Performance averaged 76.4% for August 2024 but dropped to 75% in September 2024. NHS England published a progress update on the 2- year UEC Recovery Plan in May 2024, aimed at supporting planning over the summer and improving system resilience ahead of next winter. The ambitions for 2024/25 were recently set out in the operational planning guidance and all providers have refreshed their operational plans for 2024/25, including performance improvement trajectories together with underpinning actions to deliver against the priority areas. An initial gap analysis has been undertaken to assess NCL Providers, including Acute, Mental Health and community against the latest publication, to identify NCL-specific priorities and next steps. The three priority areas outlined in the letter are to: 1. Maintain General and Acute bed capacity, and ambulance capacity 2. Increase the productivity of acute and non-acute services and improve flow, length of stay and clinical outcomes 3. Continue to develop services that shift activity from acute hospital settings. Work is ongoing to establish specific priorities for each provider, including Mental Health and Community Providers, as well as system level priorities. These are expected to support: 1. Improving front door and ambulance handover 2. Better utilisation of ambulatory pathways 3. Improving flow and discharge 4. Strengthening local partnership engagement. This work is consolidated via the Flow Operations Group where there is a programme of reporting on delivery of progress on system projects, a series of deep dive analyses and sharing of good practice, covering all areas of the patient pathway, which is strengthening our processes and practices across the system. A system-wide UEC event took place on 5 September 2024, which aimed to ensure joined up working across the system, test resilience to system pressures and identify how we maximise the use of RAIDR (health intelligence and risk stratification tool) and move towards a more proactive model. Outcomes of the event will inform the winter playbook 2024/25, which sets out the likely scenarios for winter and a dynamic set of actions to be taken to proactively manage the health of the most vulnerable communities, as well as system resilience actions and process for management of these operationally through the winter. The playbook will also closely align to the priorities set out in the recently published NHS England Winter Letter.	16	16	16	16	➔	12
COMM32	Failure to provide adequate Child and Adolescent Mental Health Services ('CAMHS') (Threat).	Sarah Mansuralli - Chief Strategy and Population Health Officer	Strategy and Development Committee	**CAUSE:** If the ICB fails to respond to the significantly increased need for Child and Adolescent Mental Health Services (CAMHS) services, **EFFECT:** There is a risk that local children and young people ('CYP') with mental health conditions do not access the timely, good quality mental health care they need. **IMPACT:** This may result in the deterioration of CYP's' mental health and national targets not being met by the ICB and create a long term population health impact.	In April 2024 the Strategy and Development Committee ('SDC') asked the ICB to consider commissioning options to improve cohesion and reduce fragmentation within Child and Adolescent Mental Health Services ('CAMHS') provision in order to increase the pace of improvement on outcomes and better meet rising need. Fragmentation makes services complex to navigate for children and young people and their families/carers and it also further impacts services accessibility and users' overall experience and outcomes, for example, being asked the same questions by service teams multiple times, having many people involved in their health care but lack of clarity on who is responsible for what, not really knowing what is going on, and falling between the gaps or "bouncing" between services. Reducing this fragmentation will support more effective use of resources, ability to standardise models and processes within and across boroughs and provide an environment that supports more flexible and effective ways of working. Following discussions at the SDC and ICB Board seminar in June 2024, a steer has been given for the ICB to work with its NHS CAMHS providers to identify a process to enable the system to work together and form consensus on a two-lead provider approach, one in the north and one in the south of NCL. It is expected that once this process is agreed, followed and the outcome successfully implemented, this may increase the level of the controls sufficiently that the risk rating is lowered from 16 to 12. In addition to this, Mental Health ('MH') Joint Service Performance Group meetings ('JPRGs') have been established, providing a bi-Monthly forum for providers and the ICB to meet. The focus is understanding drivers of challenge for CAMHS and to jointly develop and monitor delivery of improvement plans. The group reports into the formal MH Programme structure. Improvements to shared data access and visibility will be implemented via the shared Patient Tracker List ('PTL') across trusts and extend functionality across providers in NCL. Currently there is insufficient visibility of the numbers of patients waiting for treatment making it difficult to know where fluctuations in demand may be occurring and therefore responding as a system to pressures. This is being supported by the Health Technology Adoption and Accelerator Fund (from NHS England) providing £100k to support this work. An NCL standardised neurodevelopmental diagnostic ('NDD') pathway has now been finalised, following workshops, a summit and incorporating best practice and understanding of local population needs. Two Project Development Plans have been developed for the under 5s and over 5s, to secure funding in 2024/5 and 2025/26 to ensure there is sufficient capacity to align demand with need. This will ensure that children and young people are assessed within the timeframes set by NICE and national targets and receive timely access to the appropriate support. It will also ensure that there are consistent thresholds across boroughs to access the diagnostic pathway. These have now secured system endorsement and final allocations for each provider is being confirmed (recognising revised phasing / tapering due to slippage in timescales), with the focus shifting to detailed implementation planning. A further Project Development Plan has been developed and endorsed for recurrent funding from 2024/25 in core community CAMHS. This will address both the long waits that children and young people experience in receiving treatment, and ensuring there is sufficient capacity to give the care and treatment required to meet children and young people's needs. This investment will be significant in addressing the gaps identified in the MH Services Review and supporting the attainment of the Core Offer across NCL. Delivering the complex CAMHS service improvement programme of work will require ongoing consideration of leadership capacity and capability.			16	16	➔	12
FIN36	St Pancras Hospital Transformation Programme Funding (Threat).	Phill Wells - Chief Finance Officer	Finance Committee	**CAUSE:** If there is insufficient funding to deliver the complete St. Pancras transformation programme, **EFFECT:** There is a risk that the system will need to significantly re-evaluate and reprioritise it use of its Capital Departmental Expenditure Limits allocation to ensure the transformation programme has sufficient funds to complete. **IMPACT:** This may result in a number of other capital schemes being cancelled, delayed or reprioritised, having a negative impact across the system, patients and services affected, reputation damage and relationships.	There is currently a financial shortfall in the St Pancras Hospital ('SPH') Transformation Programme ('Programme'). The Chief Finance Officer ('CFO') at Camden and Islington NHS Foundation Trust ('C&I') continues to work on defining the size of the financial shortfall more accurately. If the ICB wants the Programme to complete in full, the system may be required to reprioritise and reallocate its Capital Departmental Expenditure Limits ('CDEL'). This in turn may have an impact on other North Central London capital programmes. However, the size and scale of the potential impact will not be known until the exact size of the financial shortfall is confirmed. As the size of the financial shortfall is refined, options will be explored in order to propose mitigations where possible. A dedicated finance resource was hired to review the overall programme finances and determine all costs to ensure confidence in the figures presented and allow the size of the funding shortfall to be confirmed. Project teams have been set-up to determine the costs for the various service relocations required to vacate the St Pancras site and decommission the buildings before the land sale. The Programme Team are currently in discussions with the developer to evaluate options to for a mutually acceptable and financially viable programme. The Master Development Framework Agreement ('MDFA') has been paused to allow this work to progress without adversely affecting the agreement. The pause is expected to last for 6 months from August 2024. Programme workstreams have been tasked with identifying solutions to achieve vacant possession of the site for (a) Royal Free London Trust services, (b) Central and North West London Trust services, and (c) North London Mental Health Partnership services. Commissioners have been engaged to work collaboratively with each Trust to determine potential solutions for affected services.	20	20	20	20	➔	9
FIN39	Insufficient ICS Capital Allocation to Deliver ICS Strategic Priorities and Address Issues with Key Infrastructure (Threat).	Phill Wells - Chief Finance Officer	Finance Committee	**CAUSE:** If the ICS does not have sufficient capital allocation and the ICB does not effectively allocate the capital allocation, **EFFECT:** There is a risk that the ICS will not be able to deliver its strategic priorities whilst also addressing issues with key infrastructure. **IMPACT:** This may result in under delivery of ICS strategic priorities, some key estates becoming unusable or sub-par, a negative impact on population health and patient care and reputation damage.	The NCL ICS capital allocation for 2024/25 is £226.3m, consisting of £178m of core allocation and adjustments of £4.1m for delivering against the system breakeven plan in 2023/24, £25.7m for reporting a surplus in 2023/24 and £17.9m for submitting a breakeven plan for 2024/25. However, the current ICS strategic priorities, together with the list of urgent capital projects submitted by system partners, significantly exceeds the core capital allocation we are likely to receive over the longer term. The ICB is working with system partners to understand the underlying issues, associated risks, mitigations and any opportunities. The main competing priorities are to make new investments, such as Start Well, Electronic Patient Records (part funded by the national team but needing a significant local funding element), improving Primary Care estate, alongside maintaining and replacing equipment and estate. A significant element of the NCL estate requires backlog maintenance and there is insufficient capital allocation to meet all demands. Of the £25.7m received for reporting a 2023/24 surplus, £16.1m has been set aside to specifically target critical infrastructure projects. A prioritisation exercise has been undertaken to agree distribution and a proposal to distribute £14.3m of the £16.1m strategic reserve was presented and agreed at the System Management Board on 26 June 2024. The distributed capital departmental expenditure limits were transacted to trusts during the month 3 reporting period. A mid-year review of 2024/25 spending forecasts will be undertaken and re-allocation, where required, will be agreed by the end of November 2024.	20	20	20	20	➔	15
System Risk - below BAF threshold, but included for oversight											

COMM22	Failure of the Integrated Care Board to effectively and safely manage the specialist services devolution in 2024/25, impacting on the delivery of population health improvements (Threat).	Sarah Mansuralli - Chief Strategy and Population Health Officer	Strategy and Development Committee	**CAUSE:** If the ICB fails to effectively manage the devolution of many specialist services to the ICB, and the opportunity to integrate pathways and tackle the underlying population health issues that are causing the growth in specialist activity and spend is lost, **EFFECT:** There is a risk that the expected improved health outcomes are lost and that provider services are destabilised and expertise is lost. There is also a risk that services are lost, particularly fragile services including Highly Specialised Services which, whilst not being devolved, could be destabilised if other related services experience issues. Changes to services and changes to the funding formula for specialised services could also lead to further provider and/or individual service pressures and resulting impacts on outcomes and performance. **IMPACT:** This may result in a negative impact on quality and equity of access, as well as, loss of workforce, increasing waiting times, significant cost pressures and the lost opportunity to improve outcomes.	NCL were the only ICB to submit an Expression of Interest to host the Specialised Commissioning Shared Commissioning Team ('SSSCT') and we expect to hear the outcome of the process late October/early November 2024. There is concern about the lack of information that has been provided by NHS England ('NHSE') about this team and the potential risks (financial and operational) that may transfer with them and, so the ICB is undertaking an in-depth due diligence process before the final agreement is signed. The ICB continues to progress the work on Renal Dialysis and are awaiting costings from the Royal Free London as well as a discussion with NHSE on the strategic approach to financing the changes. This work is supported by the London Kidney Network. The draft clinical strategy has been developed and was presented to the Clinical Advisory Group in September 2024. Recruitment to the expanded Delegated Services Team commenced in late September 2024 which will ensure activity speeds up in the time period prior to delegation. However, we have made good use of the support from our partners at Transformation Partners in Health & Care to bridge the gap.	12	12	12	12		→	9
System Risks - reducing to below BAF threshold and not included on the BAF												
PC3	Strikes by NHS staff (Threat).	Sarah Morgan - Chief People Officer	NCL People Board	**CAUSE:** If industrial action taken by various Unions within healthcare, due to pay and working conditions disputes, continues without resolution, **EFFECT:** There is a risk that services will face significant reduction, cancellations of elective activity, and a reduced ability for London Ambulance Service ('LAS') to respond to non-life and limb patients during the time of industrial action. **IMPACT:** This may result in an increase in negative patient experience and negative patient outcomes, and a reduction in the quality of service delivered and capacity. This may also result in a disengaged workforce, and may exacerbate exiting system-wide workforce challenges.	This risk emerged from national industrial action taken by unions and NHS staff regarding pay and working conditions disputes. The General Practitioner ('GP') members of the British Medical Association ('BMA') voted 99.2% to reject the contract changes for 2024/25. All ICBs received a letter on 18 April 2024 from the Chair of the GP Committee in England giving notice of GP action during 2024/25 with a recommendation this is considered in Board risk registers and scenario planning to take place. This is now under consideration for NCL ICB by the primary care and workforce teams, supported by the NCL System Coordination Centre and Emergency Preparedness, Resilience and Response teams. The Primary Care GP planned action commenced on 1 August 2024. This collective action is not a strike but more akin to a "work to rule". None of the suggested options for the collective action breaches the GP contract. However one option suggested by the BMA can include limiting the number of patient appointments per GP per day to the recognised safe working maximum level of 25, and stopping or reducing work that GPs are not formally contracted to carry out. Regional planning sessions are in place, with the first held 16 July 2024, to develop plans for the GP planned action. Primary Care leads are involved with these meetings and will lead on any action needed. It is hard to assess the level of action being taken as practices are not required to inform the ICB and although Local Medical Committees have knowledge they will not share it. Soft intelligence seems to indicate that the level of action being taken in NCL is less disruptive than in other ICBs (NEL reports reduced appointment levels in some practices). The GP collective action continues to be monitored through the Primary Care Team supported by the GP Provider Collaborative. There is currently no new junior doctor industrial action envisaged as the new Government has made a pay offer which as been accepted. With the risk of strike action by junior doctors significantly reduced, this risk's rating has been reduced from 20 to 12.	20	20	20	12		↓	12
QUAL64	Failure to deliver against the national metric of achieving 80% of completed Continuing Healthcare assessments within 28 days (Threat).	Chis Caldwell - Chief Nursing Officer	Quality and Safety Committee	**CAUSE:** If the ICB and its Local Authority partners fail to undertake patient assessment within the statutory target of 28 days and manage care reviews, **EFFECT**: There is a risk that the ICB will be unable to ensure that patients are in receipt of the appropriate package of care to meet their individual needs within the most appropriate setting. The ICB may also have increased costs due to the incorrect commissioner (funding stream) being identified and agreed. **IMPACT:** This may result in a increase in negative patient experience and a negative impact on patient choice for patients awaiting assessment while in an interim funded placement. This may also result in significant increased cost to the ICB as well as reputational damage, and an increase in complaints and appeals and impact the ICB's ability to meet future NHSE targets.	Under the NCL Continuing Healthcare ('CHC') Decision Support Tool ('DST') Recovery Programme the 2024/25 Quarter 1 Trajectory Target of 20% for CHC Referrals completed within 28-days was achieved. However, In Quarter 2 under the target of 30%-39.9% was not achieved with a delivery of 22% due to limited social work allocation and annual leave and staffing constraints over the summer period, and no decrease in demand. Weekly DST Recovery Meetings are held to identify and resolve issues/barriers. Joint ICB & local authority ('LA') Senior Responsible Officers for the recovery programme have been identified. A rapid review of the current assessment processes has commenced by borough to identify process improvements which can increase productivity and efficiency to enable a greater number of assessments to be completed within the 28 days. Focussed discussions are being held with LAs Directors of Adult Social Services ('DASS'), the Director of Complex Care and the Assistant Director of Complex Care (CHC) to investigate where delays persist and to identify barriers to fulfilling the Social Worker Trajectory commitment, with the aim of completing 42 DSTs per month. The London Borough of Barnet DASS has agreed to 12 social worker allocations and a burndown chart in development, which may be replicated across all NCL boroughs. Meetings have also been held with other LAs and the potential for joint meetings to review weekly performance and issues is being explored. An established internal and external escalation pathway is in place, with discussions with the NCL LAs being led by the Director of Complex Care. This situation has been escalated via the Chief Strategy and Population Health Officer into the Better Care Fund/LAs finance joint working discussions. LAs supporting CHC assessments is built into the recharge arrangements. The ICB continues to keep NHS England apprised of the situation through assurance meetings and their support where needed. This risk and its controls have been reviewed and, as part of this, the current rating has been reduced from 16 to 12 given the processes and plans being put in place to work more closely with the LAs, including setting up joint ICB/LA weekly review meetings of performance which should further strengthen the position in meeting the 28-days target.			16	12		↓	6
ICB Risk arising from risks or issues in other organisations - below BAF threshold, but included for oversight												
PERF28	Failure of Primary Care patient access (Threat).	Sarah McDonnell-Davies - Executive Director of Place	Primary Care Committee	**CAUSE:** If the ICB fails to address patient and stakeholder concerns around timely and appropriate access to general practice, **EFFECT:** There is a risk of exacerbating patient perception that they cannot see a GP and so either do not present to services when they need to, or do not present to the right place at the right time. There is a risk to the reputation of provision and commissioning. There is a risk to NHS staff of negativity and abuse. **IMPACT:** This may result in delays to patients accessing care or pressures elsewhere in the system. There may be a negative impact on the workforce and providers.	Access to Primary Care remains a key challenge and risk. Demand increased significantly during the COVID-19 pandemic and continues to increase, exacerbating access challenges. This is under regular discussion at the London Primary Care Board with NCL input. The ICB published a system capacity and access plan in November 2023 as part of responding to the Access Recovery Plan, showing that the ICB were on track with delivery, and highlighted specific areas of more challenged delivery which are common to those experienced by other ICBs. The next update is required to be presented to the ICB public Board of Members meeting in Autumn 2024. Further work is required to address access to Primary Care, including: • Patient experience; • Ease of access (including digital inclusion / exclusion); and, • Contributing factors including workforce and patient needs and expectations. On average practices have provided a 15 to 30% increase in appointments compared to before COVID-19. This outstrips population growth and is indicative of practices meeting increased demand. With such a significant rise in activity in general practice, work is also needed on understanding the nature of the increased demand and how this is best met. This will be overseen by the Primary Care Committee. The ICB has recently been asked to participate in a national pilot looking at evidencing and quantifying the gap between resource and need in general practice, which will help inform future policy.	12	12	12	12		→	9
ICB Only Risk below BAF threshold, but included for oversight												
FIN29	Failure of North Central London Integrated Care Board ('ICB') to remain within its Running Cost Allowance ('RCA') 2024/25 and 2025/26 (Threat).	Phill Wells - Chief Finance Officer	Finance Committee	**CAUSE:** If the ICB fails to mitigate any RCA overspend in Financial Years 2024/25, and 2025/26 due to the failure of the Organisational Design Programme to deliver the required efficiencies savings and/or due to the delayed implementation of new structures impacting on the delivery of 2024-25 RCA efficiencies, **EFFECT:** There is a risk that the ICB will be in breach of its statutory duty to stay within its RCA. **IMPACT:** This may result in the ICB being referred to the Secretary of State by its Auditors, with associated increased financial scrutiny and intervention from NHS England, and causing significant reputational damage.	As the organisational change programme progresses, there will be continual review of the controls and Running Cost Allowance ('RCA') impact on pay and non-pay costs to provide assurance on meeting required reductions. Financial modelling is currently forecasting achievement of the running cost reduction for 2024/25 and 2025/26. RCA budgets will be monitored in year to ensure that the forecasted efficiencies are achieved and that the ICB remains within the RCA. The ICB is awaiting for NHS England guidance on the announced pay awards and the impact on the RCA allocation.	12	9	9	9		→	4

Risk Key

Risk Improving ↓

Risk Worsening ↑

Risk neither improving nor worsening but working towards target →

NCL ICB BAF risks - October 2024

ID	Risk Owner	Risk Manager	Objective	Risk	Consequence (Initial)	Likelihood (Initial)	Rating (Initial)	Controls in place	Evidence of Controls	Overall Strength of Controls in place	Consequence (Current)	Likelihood (Current)	Rating (Current)	Controls Needed	Actions	Action Deadline	Update on Actions	Consequence (Target)	Likelihood (Target)	Rating (Target)	Estimated date of target risk score achievement	Committee	Strategic Update for Committee	Date of Last Update	Status
Continuing System Risks																									
PERF29	Richard Dale - Executive Director of Performance and Transformation	Elizabeth Ogunoye - Director of System Operations & Assurance	Support system recovery and strengthen both Urgent Care & Integrated Urgent Care	**Failure to achieve the 4 hour A&E wait standard (Threat).** **CAUSE:** If the ICB fails to ensure adequate capacity and operational resilience to effectively manage the flow of patients through the Emergency Department ('ED') and the hospital, **EFFECT**: there is a risk that patients will not be seen within the expected 4 hours and receive sub-optimal care, which may have an adverse effect on their health outcomes. **IMPACT**: this may result in the ICB missing the national expectation that 76% of patients are seen within 4 hours of arrival to the ED, increasing waiting times and increasing the potential risk of harm and adversely impact on System Oversight Framework segmentation.	4	5	20	C1. Local system partners work together to support safe and effective delivery of and develop place-based plans to improve pathways and monitor delivery against outcomes; C2. Fortnightly NCL Flow Operational Group ('FOG') oversees recovery and improvement plans and that agreed priorities are being implemented, in accordance with evidence-based practice and national requirements and in line with analysis of the most significant drivers of underperformance. FOG oversees progress against planned performance improvement trajectories, highlights risks and identifies and agrees mitigations and support as appropriate; C3. The System Coordination Centre proactively manages UEC system flow, capacity, and performance to improve quality of care, safety, and patient outcomes across the patch. This involves leading on daily system operational calls to escalate key issues and facilitate the system support required to resolve; C4. Quarterly System Oversight Framework ('SOF') meetings supported by monthly individual Provider Performance Review meetings for North Middlesex University Hospital ('NMUH') and Royal Free London ('RFL') to cover outstanding Urgent and Emergency Care ('UEC') issues.	C1. Local partnership meeting minutes and papers; C2. FOG minutes and papers; C3. Daily system calls in place, followed by summary report; C4. SOF meeting minutes and papers.	AVERAGE: The controls have a 61 – 79% chance of successfully controlling the risk	4	4	16	CN1. Daily performance monitoring dashboard available to the system. CN2. Fortnightly Flow Oversight Group in place to support mitigation of system-wide pressures. CN3. The System Coordination Centre (SCC) oversees operational resilience and takes the lead on system escalation and resolution of issues bringing together all key stakeholders as required. CN4. SCC led daily system calls in place to assess and coordinate mitigating actions.	A1. System Control Centre ('SCC') supports mitigation of on-going pressures taking a concerted and proactive approach to resolving key systemic and emerging issues impacting clinical and operational performance; A2. All providers have undertaken a UEC improvement gap analysis, to help identify areas of further development needed to support improvement in ED 4 hour performance. This includes community and mental health providers, to ensure that plans are reflective of flow through the system. Plans are centred around the five key priority areas set out in the UEC Recovery Plan: - Streaming and redirection; - Rapid Assessment and Treatment; - Improving ambulance handovers and supporting the implementation of London Ambulance Service (LAS) performance against the standard of 18mins to respond to Category 2 calls in NCL; - Maximising use of Urgent Treatment Centres; - Reducing time in ED/other actions; A3. Identified three quality metrics to monitor improvement alongside delivery of the 78% A&E standard; A4. Develop a winter playbook for 2024/25.	A1. 31.12.2024 A2. 31.12.2024 A3. 31.12.2024 A4. 31.03.2025	A1. Providers are progressing against implementation of their localised plans to improve UEC performance. Progress against plans is being actively monitored via FOG. A2. FOG agreed quality metrics to be monitored alongside A&E standard; these are: - Patients waiting in ED for 12 hours; - Percentage of conveyed patients handed over within 45mins; - Discharges before 12.00 and 17.00. A3. The system continues to focus on improving discharge before 12.00/17.00 together with a collective effort to reduce delays over 7, 14 and 21 days. The ICS has implemented a new reporting tool which monitors daily discharges compared to an expected number of discharges required to manage demand. This has been made part of circulated daily reports. The system discharge escalation process has been refined to maximize resources and impact on patients. A4. A winter playbook is in development, building upon the winter playbook 2023/24 and incorporating outputs from the "Delivering UEC priorities" event held in September 2024.	3	4	12	31.12.2024	Strategic and Development Committee	The overall performance of the NCL ICB'S acute providers remains below the A&E trajectory of 76%, and in consequence of this, the ICS has been escalated to Tier 1 for Urgent and Emergency Care ('UEC'), following a national review in July 2024. The performance of North Middlesex University Hospital, and the impact of this on other providers in NCL, was cited as a particular area of concern. However, there has been improvement since the start of the financial year of approximately 3.6%. Performance averaged 76.4% for August 2024 but dropped to 75% in September 2024. NHS England published a progress update on the 2- year UEC Recovery Plan in May 2024, aimed at supporting planning over the summer and improving system resilience ahead of next winter. The ambitions for 2024/25 were recently set out in the operational planning guidance and all providers have refreshed their operational plans for 2024/25, including performance improvement trajectories together with underpinning actions to deliver against the priority areas. An initial gap analysis has been undertaken to assess NCL Providers, including Acute, Mental Health and community against the latest publication, to identify NCL-specific priorities and next steps. The three priority areas outlined in the letter are to: 1. Maintain General and Acute bed capacity, and ambulance capacity 2. Increase the productivity of acute and non-acute services and improve flow, length of stay and clinical outcomes 3. Continue to develop services that shift activity from acute hospital settings. Work is ongoing to establish specific priorities for each provider, including Mental Health and Community Providers, as well as system level priorities. These are expected to support: 1. Improving front door and ambulance handover 2. Better utilisation of ambulatory pathways 3. Improving flow and discharge 4. Strengthening local partnership engagement. This work is consolidated via the Flow Operations Group where there is a programme of reporting on delivery of progress on system projects, a series of deep dive analyses and sharing of good practice, covering all areas of the patient pathway, which is strengthening our processes and practices across the system. A system-wide UEC event took place on 5 September 2024, which aimed to ensure joined up working across the system, test resilience to system pressures and identify how we maximise the use of RAIDR (health intelligence and risk stratification tool) and move towards a more proactive model. Outcomes of the event will inform the winter playbook 2024/25, which sets out the likely scenarios for winter and a dynamic set of actions to be taken to proactively manage the health of the most vulnerable communities, as well as system resilience actions and process for management of these operationally through the winter. The playbook will also closely align to the priorities set out in the recently published NHS England Winter Letter.	23.09.2024	Open
COMM32	Sarah Mansuralli - Chief Strategy and Population Health Officer	Anna Stewart - Director of Service Development, Maternity Neonates and Children's	Tackle health inequalities and strengthen the system approach to population/place based health and care management	**Failure to provide adequate Child and Adolescent Mental Health Services ('CAMHS') (Threat).** **CAUSE:** If the ICB fails to respond to the significantly increased need for Child and Adolescent Mental Health Services (CAMHS) services, **EFFECT:** There is a risk that local children and young people ('CYP') with mental health conditions do not access the timely, good quality mental health care they need. **IMPACT:** This may result in the deterioration of CYP's' mental health and national targets not being met by the ICB and create a long term population health impact.	4	4	16	C1. ICB additional financial investment in CAMHS, for improving and expanding services, is at a faster rate of growth than in other health care areas in NCL; C2. Mental Health Core Offer for children and young people is comprehensive, relevant and clear, so that consistent and equitable support exists for Children and Young People (CYP) across NCL; C2. NHS CAMHS Providers are collaborating informally for the whole to be greater than the sum of the parts. Shared ICB and Provider consideration of change in our system's capacity and ways of working to deliver change and make transformation happen is underway. Joint CAMHS performance management is being strengthened. However, the pace of change enabled through informal collaboration is currently suboptimal to improve patient outcomes sufficiently quickly; C3. CAMHs logged in the Mental Health Strategic Delivery and Performance Group ('MH SDPG') Risks and mitigations log, which is reviewed on a monthly basis and any escalations required feed into the Mental Health Service Review Programme Board; C4. Bi-monthly System Service Performance Review Group meetings between provider and ICB colleagues; C5. ICB to consider commissioning options to improve cohesion and reduce fragmentation in order to increase pace of improvement on CAMHS outcomes.	C1. MH Programme Board - meeting notes and actions; C2. MH Outcomes dashboard / performance packs/ MH CYP Provider Collaboration Group - meeting notes and actions; C3. MH Strategic Delivery and Performance Group (SDPG) / Programme Board meeting minutes / actions log / communication; C4. Joint Service Performance and Review Group (JSPRG) notes and action log; C5: Strategy and Development Committee (SDC) papers for April, July and August 2024 and minutes.	WEAK: The controls have a 1-60% chance of successfully controlling the risk.	4	4	16	CN1. Improvements to shared data access and visibility; CN2. Implement Standardised pathways focusing on waiting lists / integrated Neurodevelopment Disorders Diagnosis (NDD) pathway; CN3. Ensure actions are completed to support continuity of service provision of 8 directly commissioned ICB CAMHS services with VCSE organisations until March 2026; CN4. ICB to consider commissioning options to improve cohesion and reduce fragmentation in order to increase pace of improvement on CAMHS outcomes (phase 2). CN5. Undertake phase 3 of the NCL CAMHS review (more detail tbc after completion of phase 2).	A1. For Patient Tracker List (PTL) for CYP to be implemented across NCL. Barnet Enfield Haringey Mental Health Trust (BEH MHT) to lead the expansion of the PTL across other NCL CAMHS providers, and group set up to review data access, identify and resolve data challenges and implement improved opportunities; A2. Approve PDPs and confirmation of allocations to each provider for increased investment in 1) core community CAMHS services, 2) NCL Waiting Room and 3) Autism / ADHD diagnosis (over 5s); A3. Issue contract letters to ensure continuation of service (with requirements as set out by S&DC on 17.04.24); A4. Secure committee and board approval for recommendations related to commissioning options to improve cohesion and reduce fragmentation in order to increase pace of improvement of CAMHS outcomes (phase 2); A5. Phase 3 actions to be developed after approval for phase 2 NCL CAMHS review.	A1. 31.10.2024 A2. 31.10.2024 A3. 31.12.2024 A4. Closed A5. 31.03.2025	A1. Funding confirmed. BEH MHT to work towards key milestones (optimising data recording, building PTL across other providers). Data quality group set up that feeds into JSPRG. Standard agenda for discussion on progress and resolving data challenges. Discovery phase completed at most providers. Ongoing discussions to understand progress, barriers to next steps and updated schedule; A2. PDPs finalised by providers with detailed support and review provided by commissioning and finance colleagues in the ICB. PDPs secured system endorsement at MH Programme Board (5 July 2024) and System Management Board (SMB) (17 July 2024). However, given slippage in timescales through 24/25 in developing the PDPs and a reduction in the funding available from the CSR investment pot, revised proposals required to reflect more realistic phasing / tapering of investment - particularly for the NDD diagnostic pathway. Final funding / activity proposals are being confirmed with the provider leads and letters being prepared to confirm allocations for each provider, aiming for issue by end September / early October 2024; A3. Detail on VCSE CAMHS contracts (incl. recommendation from S&DC in April 2024 to extend contracts until March 2026) included within the paper going to Procurement & Oversight Group in mid September 2024. Following outcome from POG, actions will be enacted to put contract extensions in place; A4. **Complete** - Further discussion of commissioning options and outline (v. high level) way forward at S&DC in August 2024. Endorsement to proceed with phase 3 - noting further detailed planning required, ongoing provider engagement and subject to further review from S&DC and Board at key milestones. A5. Commissioning resources to deliver A5 (i.e. progressing with phase 3) are now in place and an outline plan discussed at the S&D Committee in August 2024. A more detailed plan is being developed with a focus on engagement with providers and ensuring that the steps being taken are compliant with relevant guidance.	3	4	12	31.03.2025	Strategy and Development Committee	In April 2024 the Strategy and Development Committee ('SDC') asked the ICB to consider commissioning options to improve cohesion and reduce fragmentation within Child and Adolescent Mental Health Services ('CAMHS') provision in order to increase the pace of improvement on outcomes and better meet rising need. Fragmentation makes services complex to navigate for children and young people and their families/carers and it also further impacts services accessibility and users' overall experience and outcomes, for example, being asked the same questions by service teams multiple times, having many people involved in their health care but lack of clarity on who is responsible for what, not really knowing what is going on, and falling between the gaps or "bouncing" between services. Reducing this fragmentation will support more effective use of resources, ability to standardise models and processes within and across boroughs and provide an environment that supports more flexible and effective ways of working. Following discussions at the SDC and ICB Board seminar in June 2024, a steer has been given for the ICB to work with its NHS CAMHS providers to identify a process to enable the system to work together and form consensus on a two-lead provider approach, one in the north and one in the south of NCL. It is expected that once this process is agreed, followed and the outcome successfully implemented, this may increase the level of the controls sufficiently that the risk rating is lowered from 16 to 12. In addition to this, Mental Health ('MH') Joint Service Performance Group meetings ('JPRGs') have been established, providing a bi-Monthly forum for providers and the ICB to meet. The focus is understanding drivers of challenge for CAMHS and to jointly develop and monitor delivery of improvement plans. The group reports into the formal MH Programme structure. Improvements to shared data access and visibility will be implemented via the shared Patient Tracker List ('PTL') across trusts and extend functionality across providers in NCL. Currently there is insufficient visibility of the numbers of patients waiting for treatment making it difficult to know where fluctuations in demand may be occurring and therefore responding as a system to pressures. This is being supported by the Health Technology Adoption and Accelerator Fund (from NHS England) providing £100k to support this work. An NCL standardised neurodevelopmental diagnostic ('NDD') pathway has now been finalised, following workshops, a summit and incorporating best practice and understanding of local population needs. Two Project Development Plans have been developed for the under 5s and over 5s, to secure funding in 2024/5 and 2025/26 to ensure there is sufficient capacity to align demand with need. This will ensure that children and young people are assessed within the timeframes set by NICE and national targets and receive timely access to the appropriate support. It will also ensure that there are consistent thresholds across boroughs to access the diagnostic pathway. These have now secured system endorsement and final allocations for each provider is being confirmed (recognising revised phasing / tapering due to slippage in timescales), with the focus shifting to detailed implementation planning. A further Project Development Plan has been developed and endorsed for recurrent funding from 2024/25 in core community CAMHS. This will address both the long waits that children and young people experience in receiving treatment, and ensuring there is sufficient capacity to give the care and treatment required to meet children and young people's needs. This investment will be significant in addressing the gaps identified in the MH Services Review and supporting the attainment of the Core Offer across NCL. Delivering the complex CAMHS service improvement programme of work will require ongoing consideration of leadership capacity and capability.	01.10.2024	Open
FIN36	Phill Wells - Chief Finance Officer	Phill Wells - Chief Finance Officer	Maintain strong financial vigilance.	**St Pancras Hospital Transformation Programme Funding (Threat).** **CAUSE:** If there is insufficient funding to deliver the complete St. Pancras transformation programme, **EFFECT:** There is a risk that the system will need to significantly re-evaluate and reprioritise it use of its Capital Departmental Expenditure Limits allocation to ensure the transformation programme has sufficient funds to complete. **IMPACT:** This may result in a number of other capital schemes being cancelled, delayed or reprioritised, having a negative impact across the system, patients and services affected, reputation damage and relationships.	4	5	20	C1. Camden & Islington ('C&I') Programme Governance; C2. CNWL and Royal Free London ('RFL') Project Groups; C3. CEO Sponsor Group; C4. St Pancras Transformation Programme Board; C5. Finance & Business Case Group; C6. Revised governance structure agreed and in place; C7. NHSE/DHSC regulatory oversight, including Gateway Review mechanism.	C1. Monthly Programme Board Papers, Updates to C&I Trust Board; C2. Regular Project meeting papers; C3. E-mails and papers; C4. Monthly meeting papers; C5. Monthly meeting papers; C6. Structure, Programme Board and Finance & Business Case Group ToR, meeting papers and minutes; C7. Gateway Review report & Gateway Review action plan.	AVERAGE: The controls have a 61 – 79% chance of successfully controlling the risk	4	5	20	CN1. We need to know the size of any funding shortfall in the programme; CN2. Robust business cases and financial models, assumptions and costs to ensure the transformation programme is completed; CN3. Revised programme governance structure.	A1. C&I CFO to identify size of funding shortfall and ensure ICB CFO is in agreement; A2. SRO and programme team to continue to work with the developer to maximise the land value; A3. Scenario planning to identify options for the delivery of the transformation programme should there be a funding shortfall.	A1. 28.02.2025 A2. 31.10.2025 A3. 28.02.2025	A1. C&I CFO is currently working on this. A2. The SRO and the Programme Team are currently in discussions with the developer and Camden Council. Options to deliver a mutually acceptable and financially viable programme are being determined. The Master Development Framework Agreement ('MDFA') has been paused to allow this work to progress without adversely affecting the agreement. The pause is expected to last for 6 months and the planning application will not be completed or submitted until this work is complete. The planning submission date will be delayed from the current December 2024 date in the programme plan by the time taken to agree mutually acceptable options. The land sale value ('RLV') will not be confirmed until approval of the planning application. This too will be delayed from the current September 2025 date in the programme plan by the time taken to complete the options work. A3. This action is dependent upon the completion of A1.	3	3	9	31.10.2025	Finance Committee (Part 1/Part2)	There is currently a financial shortfall in the St Pancras Hospital ('SPH') Transformation Programme ('Programme'). The Chief Finance Officer ('CFO') at Camden and Islington NHS Foundation Trust ('C&I') continues to work on defining the size of the financial shortfall more accurately. If the ICB wants the Programme to complete in full, the system may be required to reprioritise and reallocate its Capital Departmental Expenditure Limits ('CDEL'). This in turn may have an impact on other North Central London capital programmes. However, the size and scale of the potential impact will not be known until the exact size of the financial shortfall is confirmed. As the size of the financial shortfall is refined, options will be explored in order to propose mitigations where possible. A dedicated finance resource was hired to review the overall programme finances and determine all costs to ensure confidence in the figures presented and allow the size of the funding shortfall to be confirmed. Project teams have been set-up to determine the costs for the various service relocations required to vacate the St Pancras site and decommission the buildings before the land sale. The Programme Team are currently in discussions with the developer to evaluate options to for a mutually acceptable and financially viable programme. The Master Development Framework Agreement ('MDFA') has been paused to allow this work to progress without adversely affecting the agreement. The pause is expected to last for 6 months from August 2024. Programme workstreams have been tasked with identifying solutions to achieve vacant possession of the site for (a) Royal Free London Trust services, (b) Central and North West London Trust services, and (c) North London Mental Health Partnership services. Commissioners have been engaged to work collaboratively with each Trust to determine potential solutions for affected services.	30.09.2024	Open
FIN39	Phill Wells - Chief Finance Officer	Gary Sired - Director of System Financial Planning	Maintain strong financial and reputational vigilance	**Insufficient ICS Capital Allocation to Deliver ICS Strategic Priorities and Address Issues with Key Infrastructure (Threat).** **CAUSE:** If the ICS does not have sufficient capital allocation and the ICB does not effectively allocate the capital allocation, **EFFECT:** There is a risk that the ICS will not be able to deliver its strategic priorities whilst also addressing issues with key infrastructure. **IMPACT:** This may result in under delivery of ICS strategic priorities, some key estates becoming unusable or sub-par, a negative impact on population health and patient care and reputation damage.	5	4	20	C1. Each trust has completed a 10-year capital pipeline return; C2. Meetings to review the pipeline returns have been arranged; C3. An Infrastructure Group, led by Moorfields CEO, has been set up to consider the system Infrastructure Strategy; C4. The 24/25 ICS capital programme will be set as part of the 24/25 planning round, overseen by System Management Board; C5. Infrastructure priorities agreed with system partners; C6. 2024/25 ICS capital allocation agreed.	C1. Reports, meeting papers and minutes; C2. Reports, meeting papers and minutes; C3. Reports, meeting papers and minutes; C4. Reports, meeting papers and minutes; C5. Critical infrastructure risk questionnaire (completed by trusts in June 2024, ICB's estates team prioritisation exercise; C6. Agreed by SMB on the 24 April 2024 - minutes.	WEAK: The controls have a 1 – 60% chance of successfully controlling the risk	5	4	20	CN1. Need to diagnose the issue and have a joint understanding across providers; CN2. Need to undertake an exercise to assess infrastructure priorities; CN3. Need to undertake an exercise to test the effectiveness and accuracy of the infrastructure plans; CN4. Providers need to take responsibility to ensure their key infrastructure is fit for purpose and optimised.	A1. Meet with providers to discuss capital pipeline returns and assess the issues; A2. Need to establish an NCL infrastructure strategy that recognises the current operating environment and the limits on capital allocation; A3. Agree Medium Term 3-5 year capital programme, subject to national allocation beyond 2024/25; A4. Undertake mid-year review of 2024/25 spending forecasts and agree re-allocation where required.	A1. Closed. A2. 31.10.2024 A3. 31.10.2024 A4. 30.11.2024	A1. Completed A2. Draft infrastructure strategy submitted to NHSE London Region who are reviewing the submission, with feedback expected in October 2024. A3. 10-year capital pipeline collection being compiled to support the infrastructure strategy - draft submitted July, following Regional feedback further submissions made in Sept. Final submission, after national team feedback, expected to be made in October 2024. A4. In progress - To set out the "deep dive" process to review forecast spend. Timetable agreed and templates issued to providers late September 2024.	5	3	15	31.03.2025	Finance Committee	The NCL ICS capital allocation for 2024/25 is £226.3m, consisting of £178m of core allocation and adjustments of £4.1m for delivering against the system breakeven plan in 2023/24, £25.7m for reporting a surplus in 2023/24 and £17.9m for submitting a breakeven plan for 2024/25. However, the current ICS strategic priorities, together with the list of urgent capital projects submitted by system partners, significantly exceeds the core capital allocation we are likely to receive over the longer term. The ICB is working with system partners to understand the underlying issues, associated risks, mitigations and any opportunities. The main competing priorities are to make new investments, such as Start Well, Electronic Patient Records (part funded by the national team but needing a significant local funding element), improving Primary Care estate, alongside maintaining and replacing equipment and estate. A significant element of the NCL estate requires backlog maintenance and there is insufficient capital allocation to meet all demands. Of the £25.7m received for reporting a 2023/24 surplus, £16.1m has been set aside to specifically target critical infrastructure projects. A prioritisation exercise has been undertaken to agree distribution and a proposal to distribute £14.3m of the £16.1m strategic reserve was presented and agreed at the System Management Board on 26 June 2024. The distributed capital departmental expenditure limits were transacted to trusts during the month 3 reporting period. A mid-year review of 2024/25 spending forecasts will be undertaken and re-allocation, where required, will be agreed by the end of November 2024.	23.09.2024	Open
System Risk - below BAF threshold, but included for oversight																									
COMM22	Sarah Mansuralli - Chief Strategy and Population Health Officer	Mark Eaton - Director of Strategic Commissioning & Procurement	Embed and deliver the commissioning pipeline Tackle health inequalities and strengthen the system approach to population / place based health and care management	**Failure of the Integrated Care Board to effectively and safely manage the specialist services devolution in 2024/25, impacting on the delivery of population health improvements (Threat).** **CAUSE:** If the ICB fails to effectively manage the devolution of many specialist services to the ICB, and the opportunity to integrate pathways and tackle the underlying population health issues that are causing the growth in specialist activity and spend is lost, **EFFECT:** There is a risk that the expected improved health outcomes are lost and that provider services are destabilised and expertise is lost. There is also a risk that services are lost, particularly fragile services including Highly Specialised Services which, whilst not being devolved, could be destabilised if other related services experience issues. Changes to services and changes to the funding formula for specialised services could also lead to further provider and/or individual service pressures and resulting impacts on outcomes and performance. **IMPACT:** This may result in a negative impact on quality and equity of access, as well as, loss of workforce, increasing waiting times, significant cost pressures and the lost opportunity to improve outcomes.	4	4	16	C1. A London wide Governance Structure has been established incorporating colleagues from the East of England and South East Region to aid multi-regional decision making. This is backed up by a new approach to multi-ICB decision making which has been agreed across London; C2. A North London Governance structure (aligned to the London wide Governance) has been established with providers and commissioners to deal with shared issues; C3. NCL has established a Delegated Services Board to involve all of our providers in updates concerning Specialised Services (and other Delegated Services such as Dental) and as both a communication route out and for escalations from providers; C4. We have completed a full Legacy Risk Log as part of our due diligence and in response to a condition for delegation; C5. We are progressing key clinical workstreams related to Sickle Cell, Liver, Renal and Dental Services; C6. We have completed (and updated) a Pre-Delegation Assurance Framework (PDAF) that demonstrates the readiness of NCL for delegation; C7. We have transitioned GOSH from NHSE as the host commissioner to NCL and have formed a GOSH Collaborative Commissioning Forum (CCF) to test new approaches to making multi-ICB decisions related to GOSH.	C1. Minutes of Joint Committee and London Regional Executive Team (LRET); C2. Minutes of the North London Programme Board; C3. Minutes of the NCL Delegated Services Board; C4. Legacy Risk Log; C5. Progress Updates on Clinical Workstreams; C6. PDAF Document to NHSE (and NHSE Response); C7. GOSH Hosting agreement and also the GOSH CCF notes.	STRONG. The controls have a 80%+ chance or higher of successfully controlling the risk	4	3	12	CN1. Finalise the next steps for hosting the NHSE Staffing Hub (to be called the Specialised Services Shared Commissioning Team); CN2. Develop and implement an NCL Clinical Strategy for Specialised Services aligned to the NCL Population Health & Integrated Care Strategy; CN3. Sign the Delegation Agreement (preceded by some due diligence) and complete a Safer Delegation Checklist (SDCL); CN4. With the decision to delegate a range of Specialised Mental Health Services we need to conclude some due diligence on the risks associated with these; CN5. Clarity on any residual financial disputes between NHSE and providers for Spec Comm Services; CN6. There is a specific need to resolve the medium and longer term issues related to Renal Dialysis as a specific (and urgent) matter with NHSE prior to delegation.	A1. Team hosted by a London ICB; A2. Clinical Strategy agreed and in place; A3. Delegation Agreement to be signed; A4. MH Due Diligence Completed; A5. Area of dispute fully understood; A6. Renal Dialysis issues resolved.	A1. 31.03.2025 A2. 31.10.2024 A3. 31.03.2025 A4. 31.10.2024 A5. 30.09.2024 A6. 31.03.2025	A1. The Expression of Interest has been submitted and we await feedback. A2. The clinical strategy, building on existing workstreams and the work undertaken within the legacy risk log work, is under way and we expect a draft version in October 2024 and the final version the following month. A3. We await sight of a draft agreement and will then seek legal advice. A4. The paper for this is being prepared. A5. We await this information from NHSE; A6. We are progressing the workup on this via the Dialysis Demand Group.	3	3	9	31.03.2027	Strategy and Development Committee	NCL were the only ICB to submit an Expression of Interest to host the Specialised Commissioning Shared Commissioning Team ('SSSCT') and we expect to hear the outcome of the process late October/early November 2024. There is concern about the lack of information that has been provided by NHS England ('NHSE') about this team and the potential risks (financial and operational) that may transfer with them and, so the ICB is undertaking an in-depth due diligence process before the final agreement is signed. The ICB continues to progress the work on Renal Dialysis and are awaiting costings from the Royal Free London as well as a discussion with NHSE on the strategic approach to financing the changes. This work is supported by the London Kidney Network. The draft clinical strategy has been developed and was presented to the Clinical Advisory Group in September 2024. Recruitment to the expanded Delegated Services Team commenced in late September which will ensure activity speeds up in the time period prior to delegation. However, we have made good use of the support from our partners at Transformation Partners in Health & Care to bridge the gap.	09.10.2024	Open
ICB Risk arising from risks or issues in other organisations - below BAF threshold, but included for oversight																									
PERF28	Sarah McDonnell-Davies - Executive Director of Place	Sarah McIlwaine - Director of Primary Care	Tackle health inequalities and strengthen the system approach to population / place-based health and care management	**Failure of Primary Care patient access (Threat).** **CAUSE:** If the ICB fails to address patient and stakeholder concerns around timely and appropriate access to general practice, **EFFECT:** There is a risk of exacerbating patient perception that they cannot see a GP and so either do not present to services when they need to, or do not present to the right place at the right time. There is a risk to the reputation of provision and commissioning. There is a risk to NHS staff of negativity and abuse. **IMPACT:** This may result in delays to patients accessing care or pressures elsewhere in the system. There may be a negative impact on the workforce and providers.	3	4	12	C1. ICB Primary Care, Analytics, Digital and Comms teams developing insights into access in general practice; C2. Primary Care Operational Group meetings with stakeholders including Local Medical Committees ('LMC') to maintain visibility on pressures and support any escalations; C3. ICB programme to delivery the requirements of the primary care access recovery programme and support all practices to transition to a standard "Modern General Practice" operating model. Commissioned change management programme to provide hands-on support to practices; C4. Communication campaign being developed for local residents to ensure the services offered by and approach to accessing general practice and wider primary care is clear; C4. Engagement of key stakeholders including staff, NHSE, LMC, Clirs; C5. System Executive briefed on the challenges and supporting local solutions; C6. Annual primary care winter plans which include additional resources to support access over Q4; C7. Support for General Practice staff - recruitment, retention, wellbeing, zero tolerance of abuse.	C1. Data and insights including Q&P report for PCC; C2. Reports, meeting notes, minutes; C3. Reports, meeting notes, minutes, EMT, PCC and Board papers; C4. Communications plan (in development); C5. Reports, meeting notes and minutes, ICS communications, JHOSC papers; C6. Reports, meeting notes, minutes; C7. Workforce plans including People Strategy and Training Hub programme.	WEAK: The controls have a 1 – 60% chance of successfully controlling the risk	3	4	12	CN1. Provide an update to the ICB Board again in November 2024; CN2. Successful delivery of the local programme of work to respond to the national Access Recovery Plan for General Practice, including success of the commissioned change management programme; CN3. Successful delivery of the planned comms campaign.	A1. Primary care team to complete board report; A2. Primary care team to deliver the access recovery plan requirements, drawing in support from other ICB teams as required and working with commissioned change provider and practices in order to support the adoption of Moden General Practice model by March 2025; A3. Public communications plan to launch and impact of the communications campaign to be measured.	A1. 31.11.2024 A2. 01.04.2025 A3. 01.04.2025	A1. Supported by A2. Report went to PCC 15.10.24 prior to submission to the ICB Board. A2. Continued delivery of the ICB work programme and the commissioned change support offers to practices is on track. A3. September the public communications launched, included intentions for measuring impact of the communications campaign.	3	3	9	01.04.2025	Primary Care Committee	Access to Primary Care remains a key challenge and risk. Demand increased significantly during the COVID-19 pandemic and continues to increase, exacerbating access challenges. This is under regular discussion at the London Primary Care Board with NCL input. The ICB published a system capacity and access plan in November 2023 as part of responding to the Access Recovery Plan, showing that the ICB were on track with delivery, and highlighted specific areas of more challenged delivery which are common to those experienced by other ICBs. The next update is required to be presented to the ICB public Board of Members meeting in Autumn 2024. Further work is required to address access to Primary Care, including: • patient experience; • ease of access (including digital inclusion / exclusion); and, • contributing factors including workforce and patient needs and expectations. On average practices have provided a 15 to 30% increase in appointments compared to before COVID-19. This outstrips population growth and is indicative of practices meeting increased demand. With such a significant rise in activity in general practice, work is also needed on understanding the nature of the increased demand and how this is best met. This will be overseen by the Primary Care Committee. The ICB has recently been asked to participate in a national pilot looking at evidencing and quantifying the gap between resource and need in general practice, which will help inform future policy.	01.10.2024	Open

Risk Scoring Key

Risk Scoring
This is separated into Consequence and Likelihood.

Consequence Scale:

Level of Impact on the Objective	Descriptor of Level of Impact on the Objective	Consequence for the Objective	Consequence Score
0 - 5%	Very low impact	Very Low	1
6 - 25%	Low impact	Low	2
26-50%	Moderate impact	Medium	3
51 – 75%	High impact	High	4
76%+	Very high impact	Very High	5

Likelihood Scale:

Level of Likelihood the Risk will Occur	Descriptor of Level of Likelihood the Risk will Occur	Likelihood the Risk will Occur	Likelihood Score
0 - 5%	Highly unlikely to occur	Very Low	1
6 - 25%	Unlikely to occur	Low	2
26-50%	Fairly likely to occur	Medium	3
51 – 75%	More likely to occur than not	High	4
76%+	Almost certainly will occur	Very High	5

Level of Risk and Priority Chart
This chart shows the level of risk a risk represents and sets out the priority which should be given to each risk:

LIKELIHOOD	CONSEQUENCE				
	Very Low (1)	Low (2)	Medium (3)	High (4)	Very High (5)
Very Low (1)	1	2	3	4	5
Low (2)	2	4	6	8	10
Medium (3)	3	6	9	12	15
High (4)	4	8	12	16	20
Very High (5)	5	10	15	20	25

1-3 Low Priority	4-6 Moderate Priority	8-12 High Priority	15-25 Very High Priority