North Central London
Integrated Care Board

NHS North Central London ICB
Board of Members Meeting

Tuesday, 7 November 2023
2pm – 3.30pm
Clerkenwell Room
2nd Floor, Laycock Professional Development Centre
Laycock Street
N1 1TH

AGENDA
Part 1

Item	Title	Lead	Action	Page	Time
1.	**INTRODUCTION**				
1.1	Welcome and Apologies	Mike Cooke	Note	Oral	2pm
1.2	Declarations of Interest (not otherwise stated)	Mike Cooke	Note	3	
1.3	Draft Minutes of the NCL ICB Board of Members Meeting on 25 July 2023	Mike Cooke	Approve	8	
1.4	Draft Minutes of the NCL ICB Annual General Meeting on 19 September 2023	Mike Cooke	Approve	19	
1.5	Matters Arising	Mike Cooke	Note	22	
1.6	Report from the Chief Executive Officer	Frances O'Callaghan	Note	25	2.10pm
2.	**STRATEGY AND BUSINESS**				
2.1	National Delivery Plan for Recovering Access to Primary Care – NCL approach	Sarah McDonnell-Davies	Note	31	2.20pm
2.2	Mental Health Update	Sarah Mansuralli and Jinjer Kandola	Note	44	2.40pm
3.	**OVERVIEW REPORTS**				
3.1	Integrated Performance and Quality Report	Richard Dale and Dr Chris Caldwell	Note	58	3.00pm
3.2	Finance Report	Phill Wells	Note	80	3.10pm

3.3	Board Assurance Framework	Ian Porter	Note	100	3.15pm
4.	**GOVERNANCE**				
4.1	Update to Governance Arrangements	Ian Porter	Approve	110	3.20pm
5.	**ITEMS FOR INFORMATION AND ASSURANCE**				
5.1	Update on the Delegation of Commissioning of Specialised Services	Sarah Mansuralli	Note	148	3.25pm
5.2	Minutes of the Audit Committee Meeting on 6 June 2023	Kay Boycott	Note		
5.3	Minutes of the Finance Committee Meetings on 13 June and 5 September 2023	Usman Khan	Note		
5.4	Minutes of the Integrated Medicines Optimisation Committee Meeting on 6 June 2023	Jonathan Levy	Note		
5.5	Minutes of the People Board Meeting on 15 May 2023	Liz Sayce	Note		
5.6	Minutes of the Procurement Oversight Group Meetings on 21 March and 19 July 2023	Phill Wells	Note		
5.7	Minutes of the Quality and Safety Committee Meeting on 23 May 2023	Liz Sayce	Note		
5.8	Minutes of the Strategy and Development Committee Meeting on 5 July 2023	Mike Cooke	Note		
6.	**ANY OTHER BUSINESS**				
7.	**DATE OF NEXT MEETING**				
7.1	26 March 2024				
8.	**PART 2 MEETINGS**				
8.1	To resolve that as publicity on items contained in Part 2 of the agenda would be prejudicial to public interest by reason of their confidential nature, representatives of the press and members of the public should be excluded from the remainder of the meeting. Section 1 (2) Public Bodies (Admission to meetings) Act 1960.				

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 November 2023

Report Title	Declaration of Interests Register – NCL ICB Board of Members	**Date of report**	30 October 2023	**Agenda Item**	1.2
Integrated Care Board Sponsor	Mike Cooke Chair, NCL ICB	**Email / Tel**		mike.cooke4@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 2023

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 Mike **Cooke**	Chair North London Integrated Care System		Yes			direct						BEAT is commissioned by some commissioning organisations to provide services. This declaration is for transparency. There is no conflict of interest between the roles flagged in this declaration.
		BEAT, the national Eating Disorders Charity	No	no	yes	direct	Chair of Trustees	19/11/2019	current	18/11/2019	11/07/2023	
	Chair of ICB Board											
	Member of ICB Finance Committee											
	Chair of ICB Strategy and Development Committee											
	Attend Remuneration Commmittee											
	Chair of ICS Community Partnership Forum											
	Attend other committees as and when required											
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	26/05/2023	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.'
	Member of ICB Board of Members											
	Member of ICB Finance Committee											
	Member of ICB Strategy and Development Committee											
	Member of ICB Executive Management Team											
	Member of ICB Community Partnership Forum											
	Attend other ICB Committees as necessary											
Mr Phill **Wells**	Chief Finance Officer								current	23/06/2022	10/07/2023	
	NCL ICB Board Member and Chief Finance Officer										10/07/2023	
	Member of ICB Finance Committee										10/07/2023	
	Attendee of ICB Audit Committee										10/07/2023	
	Member of ICB Executive Management Team	Audit and Risk Committee, Department for Digital, Culture, Media and Sport	yes	yes	no	direct	Independent Member (ended May 23)	2016	15/05/2023	23/06/2022	10/07/2023	Where decisions to be taken by the ICB contain a potential or perceived conflict, I will excuse myself from the decision making process and a suitable deputy will act in my place
	Member of Strategy and Development Committee	Essex County Council	no	no	no	indirect	Partner is an IT Director (ended May23)	01/09/2019	15/05/2023	21/07/2022	10/07/2023	
	Member of Procurement Oversight Group	The Air Ambulance Service	yes	yes	no	direct	Trustee and Chair of Audit and Risk Committee	01/03/2022	current	23/06/2022	10/07/2023	
Dr Jo **Sauvage**	Chief Medical Officer		yes	yes	yes	direct		01/07/2022	current	10/07/2022	06/07/2023	
	Member of ICS Community Partnership Forum		no	yes	no	direct			current	10/07/2022	06/07/2023	
	Member of ICB Board	London Clinical Executive Group	no	yes	no	direct	NCL Clinical Representative		current	10/07/2022	06/07/2023	
	Member of ICB Executive Management Team	London People Board	no	yes	no	direct	Commissioning Representative		current	10/07/2022	06/07/2023	
	Member of Quality and Safety Committee	London Primary Care School Board	no	yes	no	direct	ICS Representative		current	10/07/2022	06/07/2023	
	Member of the Strategy and Development Committee	London Primary Care Board	no	yes	no	direct	NCL Representative		current	10/07/2022	06/07/2023	
	Member of Primary Care Committee	London Urgent and Emergency Care Board	no	yes	no	direct	NCL Representative		current	10/07/2022	06/07/2023	
	Member of Population Health Improvement Committee	Greener NHS England, London	no	yes	no	direct	Clinical Director		current	10/07/2022	06/07/2023	
	Also participate in multiple work streams NHS England & Improvement and Health Education England, London Region:	Membership Expert Advisory Group for Evidence based interventions. Hosted by Academy of Royal Colleges	no	yes	no	direct	Member		current	10/07/2022	06/07/2023	
		Net Zero Clinical Transformation Advisory Board	no			direct	Member		current	06/07/2023		
		London Sustainability Network	yes	yes	no	direct	Clinical Director		current	06/07/2023		
		Islington GP Federation	yes	yes	yes	direct	GP Practice is a member	2016	current	10/07/2022	06/07/2023	
		City Road Medical Centre	yes	yes	yes	direct	GP Partner	06/11/2018	current	10/07/2022	06/07/2023	
		South Islington PCN	no	yes	yes	direct	GP Pracitce is a member	01/07/2019	current	01/07/2022	06/07/2023	
Mrs Kay **Boycott**	Non Executive Member, Member of the ICB Board,		yes	yes	yes	Direct		01/07/2022	current	11/07/2022	17/07/2023	
	Member of ICB Strategy and Development Committee	Eakin Healthcare Group	yes	yes	yes	Direct	Director	01/09/2021	current	11/07/2022	17/07/2023	
	Member of ICB Quality and Safety Committee	London Fire Brigade	yes	yes	yes	Direct	Independent Audit Committee Member	30/10/2020	current	11/07/2022	17/07/2023	
	Chair of ICB Audit Committee	Durham University	yes	yes	yes	Direct	Lay member of Council and Audit and Risk Committee Chair	25/11/2018	current	11/07/2022	17/07/2023	
	Member of ICB Finance Committee	English Heritage Trust	yes	yes	yes	Direct	Director	30/12/2021	current	11/07/2022	17/07/2023	
	Member of ICB Remuneration Committee	Isle of Wight Youth Trust	no	yes	no	Direct	Chair	12/07/2023	current	12/07/2023		They are commissioned by the Hampshire and Isle of Wight ICB to provide counselling services, not involved in any NCLICB work
		Various	yes	yes	yes	Direct	Advisor		current	11/07/2022	17/07/2023	These are infrequent and under NDA - In previous NHS roles I have agreed I would declare if relevant to a specific agenda item
		PWC	no	no	no	Indirect	Husband is a partner	06/07/2023	current	06/07/2023		
Ms Liz **Sayce OBE**	Non Executive Member, Member of the ICB Board							01/07/2022	current	26/08/2022	10/07/2023	
	Chair of ICB Remuneration Committee										10/07/2023	
	Chair of ICB Quality and Safety Committee	Action on Disability and Development International	no	yes		direct	Trustee	26/01/2021	current	26/08/2022	10/07/2023	
	Member of ICB Audit Committee	London School of Economics	yes	yes		direct	Visiting Professor in Practice		current	26/08/2022	10/07/2023	
	Vice-Chair of ICB Integrated Medicines Optimisation Committee	Social Security Advisory Committee	yes	yes		direct	Member and Vice-Chair	2016	current	31/07/2023	10/07/2023	
	Member of ICB Primary Care Committee	Fabian Society Commission on Poverty and Regional Inequality	yes	yes		direct	Commissioner	2021	current	26/08/2022	10/07/2023	
	Chair NCL People Board	Royal Society of Arts	no	no	yes	direct	Fellow		current	26/08/2022	10/07/2023	
		Institute for Employment Studies Commission on the Future of Employment Support	yes	yes	no	direct	Commissioner	2022	2024	26/08/2022	10/07/2023	
		Recovery Focus (a national voluntary organisation)	no	no	no	indirect	Partner is a Trustee		current	26/08/2022	10/07/2023	
		Furzedown Project, Wandsworth, Charity no 1076087	no			direct	Trustee	24/11/2022	current	24/11/2022	10/07/2023	

NCL ICB Board of Members Declaration of Interest Register - November 2023

		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	10/07/2023	I would declare a specific interest if my partner at any point worked with an organisation in North Central London, and recuse myself from any discussions relating to that organisation as needed
Dr Christine **Caldwell**	Chief Nursing Officer	Middlesex University	no	yes	no	Direct	visiting honorary Professor	30/03/2023	current	30/03/2023	06/07/2023	
	Member of ICB Board	Barnet Enfield Haringey MHT	no	no	no	indirect	daughter is an employee	01/01/2023	current	06/07/2023		
	Member of Executive Management Team											
	Member of Quality and Safety Committee											
	Member of Strategy and Development Committee											
	Member of Primary Care Committee											
Mr Mark **Lam**	Board Member ICB		no	yes	no	Direct	Member	01/03/2023	current	12/04/2023	08/06/2023	
		Royal Free Hospitals	yes	yes	no	Direct	Chair	01/04/2021	current	12/04/2023	08/06/2023	
		North Middlesex University Hospital	yes	yes	no	Direct	Chair	01/10/2021	current	12/04/2023	08/06/2023	
		UCL Partners	yes	yes	no	Direct	Director	12/04/2021	current	12/04/2023	08/06/2023	
		UCL Health Alliance	yes	yes	no	Direct	Vice Chair	12/12/2022	current	12/04/2023	08/06/2023	
		Social Work England	yes	yes	no	Direct	Non Executive Director	11/01/2019	current	12/04/2023	08/06/2023	
		JT Group	yes	yes	no	Direct	Non Executive Director	01/04/2023	current	12/04/2023	08/06/2023	
		Games Workshop Group PLC	yes	yes	no	Direct	Non Executive Director	12/04/2023	current	12/04/2023	08/06/2023	
		Hastings International Piano	no	no	yes	direct	Trustee	27/05/2011	current	12/04/2023	08/06/2023	
Dr Usman **Khan**	Board Member ICB		no	yes	no	Direct	Member		current	07/09/2022	18/07/2023	
	Chair of ICB Primary Care Committee	ModusEurope	yes	yes	yes	Direct	director	29/11/2012	current	07/09/2022	18/07/2023	
	Chair of ICB Finance Committee	Motor Neurone Disease (Sales) Ltd	yes	yes	yes	Direct	director	27/06/2022	current	07/09/2022	18/07/2023	
	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	18/07/2023	
	Member of ICB Remuneration Committee	Motor Neurone Disease Association	yes	yes	yes	Direct	Chair of Trustees / director	01/07/2021	current	07/09/2022	18/07/2023	
		FIPRA, a European public affairs consultancy	yes	yes	yes	Direct	Senior Advisor for EU Health Policy	01/50/2020	current	07/09/2022	18/07/2023	
		KU Leuven University, Belgium	yes	yes	yes	Direct	Visiting Professor in Health Management and Policy		current	07/09/2022	18/07/2023	
		Good Governance Institute	no	yes	No	Direct	Senior Advisor / Associate	01/02/2022	current	07/09/2022	18/07/2023	
Baroness Julia **Neuberger DBE**	Board Member ICB			yes	yes	direct	Member	01/07/20222	current	07/07/2022	16/07/2023	
	Member of ICB Strategy and Development Committee	UCLH	yes	yes	yes	direct	Chair	25/02/2019	current	07/07/2022	16/07/2023	
		Whittington Health Trust	yes	yes	yes	direct	Chair	01/04/2020	current	07/07/2022	16/07/2023	
		Walter and Liesel Schwab Charitable Trust	no	yes	no	direct	Trustee	06/12/2001	current	07/07/2022	16/07/2023	
		Rayne Foundation	no	yes	no	direct	Trustee	09/09/2018	current	07/07/2022	16/07/2023	
		Independent Age	no	yes	no	direct	Trustee	09/10/2019	current	07/07/2022	16/07/2023	
		The Lyons Learning Trust	no	yes	no	direct	Trustee	13/04/2016	current	07/07/2022	16/07/2023	
		Leo Baeck Institute	no	yes	no	direct	Trustee	15/07/2020	current	07/07/2022	16/07/2023	
		Yad Hanadiv Charitable Foundation	no	yes	no	direct	Trustee	2021	current	07/07/2022	16/07/2023	
		UK Commission on Bereavement	no	yes	no	direct	Member / Bereavement Commissioner	2021	current	07/07/2022	16/07/2023	
		UCL Health Alliance	no	yes	no	direct	Vice Chair	2021	current	07/07/2022	16/07/2023	
		House of Lords	yes	yes	no	direct	Independent Cross Bench Peer	2011	current	07/07/2022	16/07/2023	
		West London Synagogue	no	yes	no	direct	Rabbi Emirata	01/03/2020	current	07/07/2022	16/07/2023	
		Public Voice Representative	no	no	no	direct	Public Voice Representative	01/11/2022	current	16/07/2023		
Ms Harjinder **Kandola MBE**	Board Member ICB							01/07/2022	current	10/07/2023		
		Barnet Enfield Haringey Mental Health Trust	yes	yes	yes	direct	Chief Executive	16/07/2018	current	10/07/2023		
		Camden and Islington Foundation Trust	yes	yes	yes	direct	Chief Executive	01/10/2021	current	10/07/2023		
Mr Ian **Porter**	Executive Director of Corporate Affairs	no interests declared	No	No	No	No		01/11/2016	current	01/07/2022	12/07/2023	
	Board Attendee ICB											
	Audit Committee, attendee											
	Procurement Oversight Group, voting member											
	Remuneration Committee, attendee											
	Member of ICB Executive Management Team											
	System Management Board, attendee											
	Member of ICS Community Partnership Forum											
Mr John **Hooton**	Board Attendee ICB		no	yes	no	direct		01/07/2022	current	06/07/2022	06/07/2023	
		Barnet Borough Coiuncil	yes	no	yes	direct	Chief Executive	01/02/2017	current	06/07/2022	06/07/2023	
		Live Unlimited Charity (no 1176418)	no	yes	no	direct	Chair of Trustee	01/03/2018	current	06/07/2022	06/07/2023	
Dr Jonathan **Levy**	Board Attendee ICB		yes	yes	no	Direct		01/07/2022	current	04/07/2022	08/09/2022	
	Member of ICB Quality and Safety Committee	James Wigg and Queens Crescent Practices	Yes	Yes	No	Direct	GP Partner	15/11/2015	current	10/09/2019	08/09/2022	
	Chair of ICB Integrated Medicines Optimisation Committee	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	08/09/2022	
		Kentish Town South Primary Care Network	Yes	Yes	No	Direct	Practice is a member of PCN	10/09/2019	01/07/2019		08/09/2022	
		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	08/02/2021	08/09/2022	
		Camden Health Partners	Yes	Yes	No	Direct	Shareholder in GP Federation	15/11/2016	current	10/09/2019	08/09/2022	
Dr Simon **Caplan**	Board Member ICB		yes	yes	no	Direct		01/07/2022	current	04/07/2022	10/07/2023	
	Member of ICB Audit Committee	Fernlea Surgery	Y	Y	Y	Direct	Partner	1990	current	26/01/2021	10/07/2023	
	Member of ICB Strategy and Development Committee	NCL GP Providers Alliance	no	Y	Y	Direct	Board Member	01/05/2022	current	04/07/2022	10/07/2023	
	Chair of Medicines Clinical Reference Group	Jewish Care (National charity)	no	Y	Y	Direct	Member of Clinical Governance Committee	2010	current	26/01/2021	10/07/2023	
		Federated4Health	no	Y	Y	Direct	Practice is a member	2016	current	26/01/2021	10/07/2023	

		Welbourne PCN	no	Y	Y	Direct	Practice is a member	01/06/2020	current	26/01/2021	10/07/2023	
		NHSE & I (London region) Medical Directorate	Y	Y	Y	Direct	Senior Clinical Advisor NHSE & I	01/04/2020	current	26/01/2021	10/07/2023	
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	11/07/2023	
		General Practice Providers Alliance (GPPA)	Yes	Yes	No	direct	Chair	2022	current	11/07/2023		
		UCL Health Alliance	Yes	Yes	No	direct	Director	03/04/2023	current	11/07/2023		
		Gemini Health	Yes	Yes	No	indirect	Director	Aug-17	current	27/01/2016	11/07/2023	
		Enfield Healthcare Cooperative	Yes	Yes	No	indirect	Co Chair and Executive Director	Sep-17	current	27/01/2016	11/07/2023	
		Enfield One Ltd	Yes	Yes	No	indirect	Director			27/01/2016	11/07/2023	
		White Lodge Medical Practice Ltd	Yes	Yes	No	indirect	Director	2009	current	27/01/2016	11/07/2023	
		Equity Health LLP	Yes	Yes	No	indirect	Director	Nov-08	current	27/01/2016	11/07/2023	
		Enfield Health Partnership Limited, Provider of community gynaecology service	Yes	Yes	No	indirect	Shareholder 5%	Mar-13	current	27/01/2016	11/07/2023	
		Enfield Healthcare Alliance	Yes	Yes	No	indirect	Shareholder less than 5% (as White Lodge	2015	curremt	27/01/2016	11/07/2023	
		Local Medical Committee	No	Yes	No	indirect	member	11/09/2014	current	31/07/2023	11/07/2023	
		BEH MHT	No	Yes	No	indirect	spouse is a Pyschiatrist at Trust	27/01/2016	currrent	27/01/2016	11/07/2023	
		Evergreen Surgery	Yes	Yes	Yes	direct	Director	2007	current	27/01/2016	11/07/2023	
		NCL training Hub	Yes	Yes	Yes	direct	Clinical Lead	01/04/2022	current	12/12/2022	11/07/2023	
		NHSE	Yes	Yes	Yes	direct	GP Appraiser	2016	current	12/12/2022	11/07/2023	
		Enfield Borough Partnership Convenor	Yes	Yes	Yes	direct	Convenor	01/05/2023	current	11/07/2023		
		Enfield Health Partnership Limited (Federation)	Yes	Yes	Yes	direct	co-chair	mid 2020	current	12/12/2022	11/07/2023	
		Enfield Care Network	Yes	Yes	Yes	direct	Practice is a member of PCN	01/07/2019	current	08/05/2020	11/07/2023	
Kaya **Comer-Schartz**	Board Member attendee and Leader of Islington Borough Council	Islington Borough Council	yes	yes	yes	direct	Leader of the Council		current	14/12/2022	03/08/2023	
		Junction Ward - Islington Borough	yes	yes	no	direct	Councillor Representative, Labour		current	14/12/2022	03/08/2023	
Richard **Dale**	Executive Director of Transtion and Performance	No interests declared	No	No	No	No		03/07/2018	current	04/09/2019	24/07/2023	
	Member of Executive Management Team											
	ICB Board of Members, attendee											
	Finance Committee, attendee											
	Audit Committee, attendee											
	Strategy and Development Committee, attendee											
	Quality and Safety Committee, member											
	ICS Community Partnership Forum, member											
Sarah **Mansuralli**	Chief Development and Population Health Officer	No interests declared	No	No	No	No		07/11/2018	current	07/11/2019	07/07/2023	
	Member of Executive Management Team											
	Attend ICB Board of Members											
	Exec Lead for Strategy and Development Committee											
	Attend Finance Committee											
	Attend Procurement Oversight Group											
Sarah **McDonnell-Davies**	Executive Director of Place	No interests declared	no	no	no	no		20/06/2018	current	20/06/2018	14/07/2023	
	Member of Executive Management Team											
	Attend ICB Board of Members											
	Attend Strategy and Development Committee											
	Exec Lead for Primary Care Committee											
	Exec Lead for Integrated Medicines Optimisation Commmittee											
	attend other NCL / Borough related meetings as required											
Sarah **Morgan**	Chief People Officer Member of the Executive Member Team	Good Governance Institute	no	no	yes	Direct	Faculty member	01/12/2020	current	04/07/2022	06/07/2023	manage contributions in line with ICB guidance
	Attend Remuneration Committee											
	Attend Primary Care Committee											
	Member of People Board											
	Member of People and Culture Oversight Group											
	Member of rhe Strategic Development and Population Health Committee											
		Fresh Visions People Ltd Charity no 1091627	no	no	yes	Direct	Trustee / Director	22/04/2022	current	04/07/2022	06/07/2023	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
Becky **Booker**	Director of Financial Management Attendee of Audit Committee, Finance Committee	None	No	No	No	None	n/a	n/a	n/a	18/10/2017	20/10/2022	
Gary **Sired**	Director of System Financial Planning Attendee at ICB Finance Committee	none	n/a	n/a	N/A	N/A				16/10/2018	10/10/2022	

North Central London
Integrated Care Board

Draft Minutes
Meeting of NHS North Central London ICB Board of Members
25 July 2023 between 2pm and 4pm
Clerkenwell Room

Present:	
Mike Cooke	Chair, NCL Integrated Care Board
Frances O'Callaghan	Chief Executive Officer
Becky Booker	Director of Financial Management
Kay Boycott	Non-Executive Member
Dr Chris Caldwell	Chief Nursing Officer
Dr Simon Caplan	GP - Provider of Primary Medical Services
Cllr Kaya Comer-Schwartz	Leader, Islington Council
Richard Dale*	Executive Director of Performance and Transformation
Ian Davis	Chief Executive, Enfield Council
Usman Khan	Non-Executive Member
Sarah Mansuralli*	Chief Development and Population Health Officer
Sarah McDonnell-Davies*	Executive Director of Places
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
Sarah Morgan*	Chief People Officer
Ian Porter*	Executive Director of Corporate Affairs
Dr Jo Sauvage	Chief Medical Officer
Liz Sayce	Non-Executive Member
Paul Sinden	Managing Director, GP Provider Alliance
In Attendance:	
Alex Faulkes	Programme Director, Urgent and Emergency Care (Item 2.1)
Michelle Johnson	Deputy Chief Clinical Officer (Item 2.2)
Andrew Spicer	Head of Governance and Risk (Items 3.3 and 4.1)
Anna Stewart	Start Well Programme Director (Item 2.2)
Nicola Theron	Director of Estates
Apologies:	
John Hooton	Chief Executive, Barnet Council
Jinjer Kandola	Chief Executive Officer, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust
Mark Lam*	Chair, Royal Free Hospitals and NMUH
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Dr Alpesh Patel*	Acting Chair, GP Provider Alliance
Phill Wells	Chief Finance Officer
Minutes:	
Steve Beeho	Senior Board Secretary

* Standing Participant

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	Mike Cooke welcomed attendees to the Meeting.
1.1.2	Apologies had been received from John Hooton, Jinjer Kandola, Mark Lam, Dr Jonathan Levy, Dr Alpesh Patel and Phill Wells.
1.2	**Declarations of Interest relating to the items on the Agenda**
1.2.1	Mike Cooke invited Members to declare any interests relating to items on the agenda.
1.2.2	There were no additional declarations of interests or gifts and hospitality.
1.2.3	The Board of Members: • **NOTED** the requirement to declare any interests relating to the agenda; • **NOTED** the Declaration of Interests Register and the requirement to inspect their entry and advise the Board Secretary of any changes; • **NOTED** the requirement to record any relevant gifts and hospitality on the ICB Gifts and Hospitality Register.
1.3	**Minutes of the NCL ICB Board of Members Meeting on 9 May 2023**
1.3.1	The Board of Members **APPROVED t**he minutes as an accurate record.
1.4	**Matters Arising**
1.4.1	Sarah Mansuralli noted with regards to the 'open' action relating to mental health breaches (action 11) that a report on mental health had recently been presented to the Integrated Care Partnership (ICP). It was agreed that it would be helpful to circulate this to Members and a decision would be taken in due course as to whether a further report should be brought to the November meeting.
1.4.2	There were no additional matters arising.
1.4.3	The Board of Members **NOTED** the Action Log.
1.4.4	Action: Sarah Mansuralli to circulate the mental health slides presented to the ICP on 11 July 2023.
1.5	**Update from the Chair**
1.5.1	Mike Cooke had no particular updates on this occasion.
1.6	**Report from the Chief Executive Officer**
1.6.1	Frances O'Callaghan provided an overview of the report, highlighting the following points: • NCL Trusts continue to be affected by the ongoing industrial action, particularly GOSH and UCLH. She thanked staff for their continued professionalism and commitment during this challenging period. Discussions have taken place with NHS England about the significant amount of work that has been cancelled which is impacting on patients, as well as having a financial impact due to the reduced activity. On a more positive note, putting the strikes to one side, NCL as a system is overperforming against its activity targets which is a tribute to the hard work of all concerned • The ICB Organisational Change Programme is now formally underway. She thanked everybody involved for their participation, including the support provided by partners. Although this is inevitably a difficult period for staff, the whole process has been received far more favourably by staff than other previous reorganisations that she had experienced, which is a testament to the work of Sarah Morgan and her team • NCL involvement in the SPROCKET (Systems and Process Redesign and Optimisation at Childhood Key Events and Transitions) project was welcomed. Maximising the ICB and ICS's research interface will through a population health lens will be a key part of the way forward for NCL

	• Good progress has been made in increasing the number of patients with a severe mental illness who have had a comprehensive annual physical health check • The excellent work of system nursing staff was recognised at the recent Burdett Nursing Awards – the NCL Learning Hub's Nurse Education team won the Digital Health award and the Enfield Integrated Learning Disability Service Community Nurses at Barnet, Enfield and Haringey Mental Health NHS Trust were successful in the Learning Disability category.
1.6.2	The Board then discussed the paper, making the following comments: • Assurance was given that following the delegation of the management of primary care complaints, the ICB will take account of any learning. As part of this, the first analysis report will be presented to the Quality and Safety Committee in the autumn • Assurance was given that the ICB is mindful of the need to ensure that staff with protected characteristics are not disproportionately disadvantaged during the reorganisation. A huge amount of work has taken place to minimise any potential negative impact, led by Sarah Morgan's team, and the situation will remain under review.
1.6.3	The Board of Members **NOTED** the Report.
2.	**STRATEGY AND BUSINESS**
2.1	**NHS 111 Integrated Urgent Care Contract Award**
2.1.1	Sarah Mansuralli introduced the paper, highlighting the following points: • The procurement was designed to achieve greater integration of 111 services with primary care and London Ambulance Services (LAS) through a single contract which consolidated the various components that have developed over time. In addition, the ICB was seeking improved value for money and quality improvements. Other enhancements secured through the process include the move to a national telephony platform which facilitates queue management and the ability to send text messages • Extensive patient and stakeholder engagement was undertaken as part of the procurement • The Board is being asked to formally approve the awarding of the contract to the preferred provider, North Central London Alliance, which is a partnership of LAS and the London, Central and West Unscheduled Care Collaborative (LCW). The contract is worth approximately £19m per annum and it is proposed that it will run for five years.
2.1.2	The Board then discussed the paper, making the following comments: • It was confirmed that the ICB is planning for mobilisation from November and there is time for any contingency planning which may be needed. Subject to the outcome of today's decision, a formal letter will be sent to the preferred provider • Assurance was given that there has been strong clinical engagement throughout the process, given the amount of interfaces which arise from the service. The procurement offers significant opportunities for integration and innovation within the urgent care pathway. A number of required innovations have been built into the contract specification and there will be the ability to add further innovations to the contract as part of the annual review process as circumstances evolve • It was noted that many of the 111 pathways are based on algorithms and it is therefore likely that developments in Artificial Intelligence (AI) will start to feature in this area over time. However, clinical scrutiny will remain a fundamental part of this pathway • Assurance was given that the ICB's digital strategy which is in development will both seek to optimise the potential of digital innovation while also ensuring that greater inequalities are not created as a by-product • It was further noted that in light of patient feedback, the provider will be required to work with specific communities who currently find it difficult to access this service.
2.1.3	The Board of Members: • **APPROVED** the announcement of the North Central London Alliance (LAS & LCW partnership) as the preferred supplier following the end of the successful procurement

	• **APPROVED** the commencement of contract negotiations with the parties, noting that LAS will be the lead for the contract and LCW will be a named subcontractor. • **APPROVED** the delegation of the signing of the contract to the Chief Executive Officer and Chief Finance Officer for the NCL ICB at the end of the successful contract negotiations, noting that any material matters will be escalated to the NCL ICB Executive Management Team and reported to the NCL ICB in due course. • **NOTED** that currently the timeline for contract signature and mobilisation enables the new service to commence on 4 November 2023 as planned.
2.2	**Start Well Update**
2.2.1	Sarah Mansuralli introduced the paper, highlighting the following points: • The Case for Change published in June 2022 highlighted a range of areas where there were variations in equity, outcomes and patient experience in Neo-Natal, Maternity, Children and Young People's Services • Although various identified improvements could be delivered by potentially reorganising services, it was also recognised that there was a range of things which could be done outside these programmes, while also taking into account the wider health inequalities in NCL • The report therefore sets out some of the achievements to date in this area, including progress in implementing the virtual ward, introducing Hospital at Home access for NMUH and increasing access to perinatal mental health services across NCL in line with prevalence • Work on the Options Appraisal is ongoing, with a growing focus on the Integrated Impact Assessment, working closely with service users and patients.
2.2.2	The Board then discussed the paper, making the following comments: • It was noted that the audit of still births in Haringey is currently underway. It is recognised that black women generally receive a much poorer experience of maternity care in NCL and England in general. It is imperative that this is not normalised by virtue of it being a national issue and that the momentum of the audit is maintained • It was confirmed that the second stage of the analysis is due to be completed in September. A similar audit of maternal deaths during the perinatal period has also been commissioned, using the same methodology • It was questioned whether there are other determinants of inequalities which should be considered, such as early screening or ability to attend follow-ups because of childcare or employment issues. Assurance was given that this feedback on the need to look at factors beyond the NHS in terms of health improvement will be taken up when the audit is brought to the Quality and Safety Committee for consideration • The suggestion for practical action across the partnership was welcomed. The development of the Family Hubs across NCL will be helpful in this regard. Integrating services around community hubs will also help to cascade and reinforce messaging relating to early intervention in a variety of settings • It was highlighted that the broad measures in the Performance Report around emergency care, electives and cancer do not differentiate between adults and children to the size of the latter cohort. More detailed data will be provided in a future iteration of the report. It was further noted that the Urgent Care Review which has been commissioned is in response to the high levels of paediatric emergency attendances, so it would be helpful to track this as part of the same piece of work.
2.2.3	The Board of Members **NOTED the** update on the Start Well programme.
2.3	**2022-2023 Equality Information Report**
2.3.1	Sarah Morgan noted that the Board was being presented with a suite of HR-related papers which would be introduced in two parts, taking items 2.3, 2,4, 2.5 and 2.6 together first. In addition to approving these reports, the Board was also being asked to endorse the proposal that the ICB (and the ICS as part of that) to become an anti-racist organisation. She highlighted the following points:

	• The Equality Information Report is for 2022/23, although technically the data covers the period from 1 July 2022 onwards as that was the date when the new organisation was 'stood up' • The ICB is a nascent organisation with an ambitious equalities agenda. Key developments to date include the development of the Population Health and Integrated Care Strategy and being the first ICB to appoint a Non Executive Member (Liz Sayce) as Wellbeing and Inclusion Guardian on the Board, which signals the importance that the ICB places on this work • The approach to Equality Impact Assessments (EQIAs) has been refreshed and strengthened, as borne out by the strong EQIA element in the recent 111 procurement • The Staff Networks have curated an excellent series of events and awareness training, some of which have been taken up across London • Performance against the Workforce Disability Equality Standards (WDES) shows that the relative likelihood of non-disabled staff being appointed in comparison to disabled staff is 0.68 times higher • Identified areas for improvement include career progression, recruitment processes and senior posts reflecting the local population. Rather than wait for the completion of the organisational change programme to finish, work to address these will begin over the summer, including the introduction of de-biasing recruitment practices, such as diverse panels for all interviews that take place as part the organisational change programme implementation. Each panel will include an inclusive recruitment champion to ensure the panel follows best practice • The ICB will be participating in the Mayor of London's Workforce Integration Network anti-racism programme from September 2023, along with GOSH and the Royal Free This programme focuses on the five most under-represented communities in London.
2.3.2	The Board then discussed items 2.3, 2.4, 2.5 and 2.6, making the following comments: • The decision to become an avowedly anti-racist organisation was welcomed as the data underlines the importance of this. However, it will be important at the same time to maintain a focus on the other protected characteristics • It was noted that research shows that focusing on race also entails focusing on intersectionality. The fact that all staff networks now have an executive champion will give this work added weight and ensure that the organisation is held to account • The latest staff survey results revealed reduced satisfaction about the opportunity for flexible working and more thought will need to be given to this issue as the new organisation is 'stood up' • Assurance was given that the overhaul of recruitment processes will result in a very different approach to the one currently in place and there will be a programme of staff training to embed this. For example, assessing "previous experience" in job descriptions is often misunderstood as referring to academic qualifications, which has the effect of disadvantaging groups of people. There will be a national piece of work to address this • Due to the nature of systemic racism, embarking on an anti-racist journey is an important but difficult thing for an organisation to do. Endorsing this proposal is not something that should be done lightly as it will be a challenging process • Although the commitment to improving recruitment processes was welcomed, it is important that this is reinforced by a commitment to providing equal opportunities for career development • It was highlighted that the Islington-based charity, Nafsiyat, which provides cultural competency training for the NHS and has a strong insight into local communities, might be able to provide support in this space • It was clarified that while the ICB has been approved to participate in the Mayor of London's Workforce Integration Network anti-racism programme, as it is a relatively small organisation in terms of being an employer, the ICB has opened this out to system partners, so colleagues from Moorfield, the Tavistock and Portman, UCLH and the shared services will be joining forces as part of a single grouping, whereas GOSH and the Royal Free will also be on the programme independently.

	• An anti-racism programme for Chief People Officers and Organisational Development colleagues is also being run, involving a significant number of people from across NCL who will then take this work forward across their organisations • It was highlighted that NCL wants to commit to being an anti-racist system for nursing and midwifery across the ICS as part of a London-wide approach, subject to the Board endorsing today's proposal for the ICB • It was noted that the equalities work will play an integral role in the implementation of the Population Health and Integrated Care Strategy in terms of supporting social and economic development and supporting communities to live well • Subject to the Board endorsing the proposal to be an anti-racist organisation and approving the Gender Pay Gap report, it will be important to consider how the implications of these decisions will be communicated to staff.
2.3.3	The Board of Members: • **APPROVED** and **ENDORSED** the recommendation of NCL ICB making a public commitment to becoming an anti-racist organisation and to participate in the associated work as required • **APPROVED** the 2022-2023 Equality Information Report.
2.4	**2022-2023 Workforce Race Equality Standards (WRES) Report**
2.4.1	The Board of Members **APPROVED** the 2022-2023 WRES Report.
2.5	**2022-2023 Workforce Disability Equality Standards (WDES) Report**
2.5.1	The Board of Members **APPROVED** the 2022-2023 WDES Report.
2.6	**2022-2023 Gender Pay Gap Report**
2.6.1	The Board of Members **APPROVED** the 2022-2023 Gender Pay Gap Report.
2.7	**NCL ICB Organisational Development (OD) Plan**
2.7.1	Sarah Morgan introduced the paper which also included the 2022/23 staff survey results. She highlighted the following points: • It is being recommended that the ICB takes a three year view on how it addresses the staff survey, WRES and WDES results, in light of it being a newly-formed organisation, with further updates on progress brought to future meetings, based on the indicators in the OD plan • The OD plan has been developed using the NHS Improvement Compassion and Inclusion Framework. It is recognised that there are cultural, capability and capacity issues which need to be addressed while 'standing up' the ICB and the framework will help to deliver this • The plan includes feedback from the Safe Space listening exercises and a variety of other sources. In light of feedback from the Engaging Our People Forum and the staff network Chairs, the planned values and behaviours refresh is being pushed back slightly as staff are currently undergoing the Organisational Change programme • Despite all the changes and challenges, the staff survey results show that staff are more likely to recommend the ICB as a place to work compared to the 2021 score. There was also a significant improvement in the support provided for staff who require reasonable adjustments • Areas for improvement identified by the survey include flexible working, career progression and responsiveness to clinical concerns.
2.7.2	The Board then discussed the paper, making the following comments: • It was noted that the staff survey results in London have historically been worse than other parts of the country, but recognising this should not be grounds for either defeatism or complacency. Nevertheless, it is important to acknowledge that the results for the ICB reflect a new organisation and this will present new opportunities for improvement going forward, as the population health approach fundamentally changes the nature of the organisation compared to its predecessor

	• Although there are understandable staff concerns about the implications of the planned reorganisation, there is also a lot of positivity about the changed focus of the ICB. While recognising the fact that NCL's geography presents a specific set of challenges, it will be important to use the staff survey results as an indicator of how the ICB is progressing as an organisation • Assurance was given in response to concerns about the survey results relating to wellbeing and autonomy that a key part of the response to this will be supporting managers to be able to lead teams well in the wake of the transition from a CCG to an ICB. Central to this will be staff having clear objectives and clarity of roles • It was noted that a significant minority of staff are declining to answer the questions regarding disability and sexual orientation. Discussions had taken place with the staff networks and Workforce information system provider the previous day about how to encourage people to report this and assurance was given that this will be taken forward • It was confirmed that the data can be filtered by directorate, grades and different characteristics and thereby enable the organisation to focus on particular areas. For example, it is hoped that the roll-out of the *Core Skills for Managers* training will strengthen middle management and in turn lift the organisation • It was acknowledged that in recent years the CCG under-invested in organisational development, so the OD priorities were welcome. It was highlighted that the latest staff survey had been conducted from September to November 2022, which was a challenging time as staff had just transitioned into the new organisation and running the next survey over the same months this year will coincide with another challenging period • It was suggested that the ICB should consider asking staff a series of 'pulse questions' to enable it to monitor equalities progress with greater regularity • The three year approach set out in the OD plan was welcomed and it was recommended that there should only be a limited amount of 'refreshing' over that period as the main focus will need to be on its implementation • It was suggested that there should be a separate discussion about the survey results relating to acting on concerns raised by patients or unsafe clinical practice and safety to speak up. It would be helpful to reflect on what is driving this and what the Board's leadership role and aspiration should be in this area • It was noted in response that a number of ICB staff provide care to patients and have access to the full complexity of their care and these staff are usually dealing with more complex cases, so it is possible that they are observing things which they consider unacceptable. Alternatively the results might emanate from commissioners who are hearing of things. At present the ICB does not have a clinical incident reporting system in place but this is in the process of being addressed • It was highlighted that the ICB had carried out a 'pulse survey' on health and wellbeing in the context of wanting to improve its Organisational Health offer and feedback from fora about staff feeling overwhelmed. As a result, more support is being put in place around things such as career transition and general wellbeing • It was noted that the Equalities Report shows that BAME staff in general have a poorer experience around career progression and there is still an amount of bullying and harassment from managers which needs to be addressed, although there has been a welcome reduction in the amount of bullying and harassment from patients.
2.7.3	Summing up the discussion, Mike Cooke noted that while it is clear that there is more work to do and the ICB is not yet the organisation that it aspires to be, there is a clear OD Plan at the heart of the way forward.
2.7.4	The Board of Members **APPROVED** the NCL ICB OD Plan.
3.	**OVERVIEW REPORTS**
3.1	**Integrated Performance and Quality Escalation Report**
3.1.1	Chris Caldwell and Richard Dale introduced the paper, highlighting the following points:

	• An analysis undertaken of the impact of the ongoing industrial action has demonstrated that it has had a significant financial impact on the ICB, as well as on what work can be carried out in hospitals, which affects in turn access and patient experience around delays and cancellations. However, there was no immediate negative impact on the experience of patients being treated in hospital during the strikes themselves, although it is acknowledged that any impact on outcomes may take time to become apparent. Dealing with the effects of the industrial action on patients has been particularly challenging for administrative and PALS staff and general morale has been adversely affected over this period • The ICB is also looking at how it records maternity performance as the system is having to close or reduce access to low-risk birthing facilities due to lack of staff, requiring colleagues to be moved into delivery suites • Primary care continues to deliver appointment numbers at a higher level than in 2021/22, although it is acknowledged that this does not always tally with the experience of residents who find access to be difficult, so further work is taking place to get to the bottom of this. Work continues on strengthening the digital infrastructure to support practices while also safeguarding against any potential digital exclusion • Progress continues to be made in reducing the number of mental health out of area placements. However, the target for Access Rates for Community Mental Health Services for Children Young People in NCL was not met, largely as a result of recruitment challenges, and a recovery plan is in place • Despite the industrial action, the number of long waiters has continued to decrease • Following performance improvements, the Royal Free is no longer being overseen under Segment 3 of the national System Oversight Framework • Despite the progress being made in various areas, the overall patient treatment list is continuing to grow due to an imbalance between demand and capacity. There is therefore a strong emphasis on Advice and Guidance to ensure that triaging is taking place early in the pathway and non-surgical support is being provided where appropriate • Excellent progress is being made in diagnostics – NCL has seen the largest reduction in the country since January in the proportion of patients waiting more than 6 weeks • Improvements have been made across NCL against the four hours Emergency Care Standard, although this is variable in places.
3.1.2	The Board then discussed the paper, making the following comments: • It was noted that the Mental Health presentation to the ICP mentioned previously under Item 1.4 set out the challenges in the urgent care pathways and the actions being taken. In particular, it highlighted the good work on out of area placements and the challenges around maintaining this (including recent Metropolitan Police initiatives) which are being addressed • There has been an exponential growth in demand for CAMHS ranging from 25-35% across NCL. This increase has occurred both during the pandemic and in its aftermath. Discussions are taking place at partnership level about what can be done to manage demand and address waiting times, while also ensuring that there is equitable access for those whose need is greatest, based on triage and assessment • It was suggested that it would be helpful for future Out of Area placements data to be presented year-on-year • It was questioned whether there was an opportunity for parts of the system to come together before winter to share key messages about keeping healthy. Assurance was given in response that the system is focused on winter planning across a broad range of work programmes, while recognising that there are a number of uncertainties to contend with. For instance, in the case of elective recovery it will be important to manage the trajectory of the backlog as well as the new referrals, while also being mindful of other potential pressures, such as new respiratory viruses. In primary care the ICB will be seeking to increase the uptake of Advice and Guidance to avoid people having to wait to be seen in outpatients and the focus on prevention through the Locally Commissioned Service for Long Term Conditions is supporting primary care capacity while also tackling wider determinants in a more person-centred way.

	• Various initiatives are also underway to alleviate pressures in acute trusts, such as the pre-dispatch pilot which is designed to ensure that the system is in a stronger position when activity starts to increase in a few months' time • It was noted that work around NMUH using the Inequalities Fund has resulted in community-based interventions in collaboration with the local authorities and the wider partnership which have had a significant impact on reducing repeat presentations by understanding and addressing the forces which drive them • The use of the digital waiting room' to enable people to access support while they are waiting for an appointment was highlighted as an example of parts of the system working together collaboratively to keep people 'waiting well'. It is also important to provide support in the community where people are likely to access it and there are models in place to help young people manage their conditions and become more self-supporting and resilient. The ability to navigate the self-help services has led to a number of people becoming peer supporters and advocates around good mental health and wellbeing. The Mental Health Support in Schools trailblazer is a good example of this partnership working but there is a need to expand the model to strengthen early intervention and prevention in non-stigmatising environments.
3.1.3	Mike Cooke observed that it is clear there is a lot of depth to the thinking which is taking place which Board Members would benefit from being more sighted on and it would therefore be helpful to receive more detail on winter planning via a presentation at the next Board Seminar. This would enable Members to receive assurance and help to ensure that there is a shared understanding of who is doing what in different areas.
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.
3.1.5	Action: Richard Dale to co-ordinate a presentation on winter planning for the Board Seminar on 19 September 2023.
3.2	**Finance Report**
3.2.1	Becky Booker introduced the paper, which set out the financial position for the ICS as a whole and in more detailed form for the ICB. She highlighted the following points: • The system is reporting a forecast out-turn in line with plan. However, there is an £8m variance at Month 2. The main driver behind this is the impact of the industrial action, particularly the under-delivery of elective activity. Month 3 figures show a further deterioration in the system financial position as the variance now stands at £17m • The national Elective Recovery Fund (ERF) target is being reduced by 2 percentage points which will be reflected in the individual commissioner and provider plans. Work on these will be undertaken in Month 4 • The maximum 'clawback' for ERF has decreased to 16%, which means that 84% of the ICB's ERF allocation is guaranteed. National ERF targets are expected to be achieved by the end of the year • The ICB continues to report a break-even position at Months 2 and 3, albeit this includes some challenging savings targets. Work is ongoing to mitigate the financial risks which have been identified. .
3.2.2	The Board of Members discussed the paper, making the following comments: • It was confirmed that any debts and outstanding invoices relating to the legacy CCGs had been transferred to the ICB as part of the transition • It was highlighted that much of the financial risk around medicines is due to external market forces which are beyond the ICB's control. Work is taking place with Trust Chief Pharmacists to compare and contrast drug costs and purchasing in order to take a more ICS-focused approach to expenditure as it is the second highest area of expenditure after staffing. The new Interim Chief Pharmacist is now in post and is familiarising herself with the system • It was further noted that as a result of inflation, the cost of new packages of Continuing Healthcare tends to be significantly higher than the ones which are being closed.

	• The development of the Medium Term Financial Strategy over the coming months will be integral to how the system addresses the underlying deficit.
3.2.3	The Board of Members **NOTED** the Finance Report.
3.3	**Board Assurance Framework (BAF)**
3.3.1	Ian Porter introduced the paper, highlighting the following points: • There are currently 12 risks on the BAF, 10 of which are system risks and two which are ICB-only • Two new risks have been added: *Failure to conduct timely Deprivation of Liberty Assessments on our NCL ICB-funded clients* and *Failure to deliver timely urgent and emergency care for the residents of NCL.* The latter is a new risk arising from two performance risks which have been closed following review (PERF25 and COMM14) • The scores for two risks *(Failure of the Integrated Care Board in effectively managing the risks of devolution for Dental, Optometry and Pharmacy Services from April 2023 onwards* and *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)* have decreased since the previous meeting • A deep dive of all risks is currently underway with Executive Directors and ultimately Board Committees and this work will be reflected in future BAF reports.
3.3.2	The Board of Members discussed the paper. It was agreed that despite the progress that has been made, the score for the risk relating to the devolution of specialist services (COMM22) should not be below the BAF threshold as it still represents a clear and present risk.
3.3.3	The Board of Members **NOTED** the Board Assurance Framework.
3.3.4	Action: Sarah Mansuralli and Ian Porter to arrange for the score for risk COMM22 to be reassessed so that it meets the BAF threshold.
4.	**GOVERNANCE**
4.1	**Governance Report**
4.1.1	Mike Cooke introduced the report which contained a summary of Members' feedback on the progress of the Board Committees and the work of the Board since the establishment of the ICB in July 2022. The feedback confirmed that although Members were initially uncertain about quite what to expect at the start of the ICB's journey, they are relatively pleased with how things have developed, while recognising that more progress needs to be made. In particular, there is an appetite for the Board and its Committees to get into an 'action and delivery' phase, especially around the population health agenda.
4.1.2	In addition to considering the review of Committee effectiveness, the Board was also being asked to approve a number of changes to governance arrangements, including some amendments to the ICB Constitution.
4.1.3	The Board then discussed the paper, making the following comments: • It was clarified that the Local Authority representatives on the People Board will be the Directors of Economic Regeneration and Adult Social Care at Camden Council. It was acknowledged that there is room for improvement in terms of obtaining a better spread of representatives from the five NCL Boroughs to ensure that their voices are heard and it was agreed that Sarah Morgan would consider further how best to address this • It was noted that one of the themes that emerged during the review of the Quality and Safety Committee's effectiveness was the respective emphasis on the core accountabilities of the ICB in relation to the services it commissions and residents' experience of the wider health and care system as a quality issue and the Terms of Reference are in the process of being amended to reflect this. This discussion raised the issue of the boundaries between this Committee and the responsibilities of other Committees and it was suggested that this point warranted further consideration

	• In response it was agreed that Committee Chairs would meet outside the meeting to discuss how best to support this piece of work, with Ian Porter's support • It was noted that Board Secretaries will discuss with Committee Chairs how they might want to take forward the feedback from members • It was highlighted that subject to the Board approving the proposed changes to the Constitution, these will then need to be approved in turn by NHS England.
4.1.4	The Board of Members: • **NOTED** the review of Committee effectiveness • **APPROVED** the revised Constitution • **APPROVED** the revised Scheme of Reservation and Delegation • **APPROVED** the NCL People Board Terms of Reference • **APPROVED**: o The Local Care Infrastructure Delivery Board Terms of Reference; o The amendments to section 18.1 of the Strategy and Development Committee's Terms of Reference; o The amendment to the ICB's Functions and Decisions Map; o The change of name of the Primary Care Contracting Committee to the Primary Care Committee and to reflect this change in all of the ICB governance documentation; • **NOTED** the arrangements for Integrated Medicines Optimisation Committee and the Clinical Reference Group.
4.1.5	Action: Sarah Morgan to review the diversity of Local Authority representatives on the People Board.
4.1.6	Action: Committee Chairs to meet to discuss how best to map Committee responsibilities to minimise any overlap.
5.	**ITEMS FOR INFORMATION AND ASSURANCE**
5.1	**Minutes of the Audit Committee Meetings on 21 March and 17 May 2023**
5.1.1	The Board of Members **NOTED** the minutes of the Audit Committee.
5.2	**Minutes of the Finance Committee Meetings on 4 April and 19 May 2023**
5.2.1	The Board of Members **NOTED** the minutes of the Finance Committee.
5.3	**Minutes of the People Board Meeting on 20 February 2023**
5.3.1	The Board of Members **NOTED** the minutes of the People Board.
5.4	**Minutes of the Procurement Oversight Group Meetings on 6 September and 21 November 2022, and 17 January 2023**
5.4.1	The Board of Members **NOTED** the minutes of the Procurement Oversight Group**.**
5.5	**Minutes of the Quality and Safety Committee Meeting on 7 March 2023**
5.5.1	The Board of Members **NOTED** the minutes of the Quality and Safety Committee.
5.6	**Minutes of the Strategy and Development Committee Meeting on 8 February 2023**
5.6.1	The Board of Members **NOTED** the minutes of the Strategy and Development Committee.
6.	**ANY OTHER BUSINESS**
6.1	There was no other business.
7.	**DATE OF NEXT MEETING**
7.1	7 November 2023 between 2pm and 4pm.

North Central London
Integrated Care Board

Draft Minutes
Annual General Meeting of NHS North Central London ICB
19 September 2023 between 4pm and 4.15pm
Clerkenwell Room

Present:	
Mike Cooke	Chair, NCL Integrated Care Board
Frances O'Callaghan	Chief Executive Officer
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
Sarah McDonnell-Davies*	Executive Director of Place
Ian Porter*	Executive Director of Corporate Affairs
Dr Jo Sauvage	Chief Medical Officer
Liz Sayce	Non-Executive Member
Minutes:	
Steve Beeho	Senior Board Secretary

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	Mike Cooke welcomed attendees to the Annual General Meeting (AGM) of North Central London ICB.
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 since its inception: • The ICB is a new statutory organisation which is significantly different to its predecessor. Its main focus is on population health, working closely with its provider, local authority and voluntary sector partners to reduce health inequalities and support the wellbeing of local residents, as well as people who travel into NCL to access services • Although it has been a challenging year, it has also been a rewarding one for people working in the ICB. The strong relationships that are being forged with local authority colleagues will be particularly important as the ICB continues to take shape and the leadership and support of Cllr Kaya Comer-Schwartz and John Hooton have been invaluable in this respect • The ongoing industrial action at hospitals is putting pressure on patients and staff as the backlogs continue to increase. Although the hard work of staff across the system to mitigate this was commended, it is important that this situation does not become "normalised" • The winter planning which is currently underway will build on the learning from recent years, while recognising that each winter presents a different set of challenges. There will be a strong emphasis in the planning on ensuring there is equitable access of resources in the north and south of the system, both in and out of hospital

* Standing Participant

	• The recent development of the Inequalities Fund is a strong demonstration of the ICB's commitment to reducing health inequalities. The Fund has supported a range of projects across the five Boroughs, including, for example, the ABC Parenting Group which delivers early years activities for parents and carers in Haringey and Enfield and the Mobile Health Bus in Camden which has improved the number of annual health checks for people with learning disabilities • As a further demonstrable example of good partnership working, there are now two community diagnostics hubs in NCL, in Wood Green and Finchley Memorial Hospital • The autumn vaccine programme, which has been brought forward this year, will build on the knowledge and partnership working developed in past campaigns, particularly with regards to engaging with seldom-heard communities • The hard work that has gone into the Organisational Change programme was commended, particularly the leadership of Sarah Morgan and the input from partners. It is recognised that the uncertainty will make it a challenging process for staff. The response to the consultation will be published shortly and it is hoped that staff will feel that the majority of their concerns have been addressed • NHS England recently published its assessment of the first nine months of the ICB's existence and this process will continue to be refined in future years. The positive assessment recognised the huge amount of work taking place to improve the health of local residents against a particularly challenging backdrop • The Board and the Executive Team are committed to change and the ICB has developed resilience in its first year, building on the legacy of the CCGs, while also being a different type of organisation.
1.3	**Annual Accounts 2022/23**
1.3.1	Phill Wells provided an overview of the 2022/23 accounting year: • There were two distinct accounting periods – the first quarter of the year concluded the operation of NCL CCG and the remaining nine months were accounted separately in accordance with the new organisation. Both periods ended with a full audit of the accounts produced and both periods had clear financial targets which needed to be met and also reflect the obligation to lead the system to a break-even point for the 2022/23 financial year • Three main targets were set by NHS England: to adhere to an overall expenditure limit within the CCG and ICB total allocations; to deliver the plan that the CCG and ICB set for themselves for the 12 month period; and a statutory obligation to spend only what was given as the running cost allowance for the financial year • The Annual Report and Accounts show that all three targets were met for both the CCG and the ICB. A 'clean' Audit Opinion was received for both sets of accounts • While meeting its targets the ICB also invested through the Inequalities Fund, as highlighted previously, and met the Mental Health Standard Investment Standard • The CCG final accounts for the first quarter of 2022/23 showed that it achieved a breakeven position. The ICB final accounts for the remaining three quarters show that it achieved a £25.8m surplus, which was £0.2m ahead of the target and equates to less than 1% of the annual CCG and ICB allocation • Just over half of the overall allocation was spent directly on the acute and integrated care providers within the system, approximately 15% was spent on Mental Health services and just over 10% was spent on primary care. Only 1% of the allocation was spent on running the organisation • The financial positions for the ICB and the NHS as whole in the current financial year are extremely challenging. The ICB is again required to deliver a balanced plan and a balanced year-end position across the system. This includes the ICB needing to deliver a surplus in order to off-set the planned deficits in other parts of the system • The ICB will continue to identify and deliver efficiencies across the entirety of the cost-base. One of the major challenges will be redesigning the ICB in order to meet the reduced Running Cost Allowance which will decrease by 30% by 2025/26 • Despite these challenges the ICB remains committed to delivering the best possible healthcare that it can.

1.4	**Questions from the Public**
1.4.1	There were no questions from members of the public.
1.4.2	Mike Cooke thanked everybody for attending and closed the meeting.

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 November 2023 - Action Log

On Agenda	
Needs Urgent Update	
In Progress	
Completed	

Meeting Date	Action Number	Action	Lead	Deadline	Update
7 February 2023	8	**Board Assurance Framework (BAF) Paragraph 3.3.5** To arrange for Board Committees to consider the appropriateness of the scores for the risks they lead on in the next round of meetings	Committee Chairs and Board Secretaries	September 2023	Comprehensive risk reviews were undertaken across several directorates over the summer with the overall outcomes being presented to the Executive Management Team on 5 October 2023. Depending on when the risk reviews in each area were completed risks have been/are being presented to committees and the overall outcomes of the risk reviews are being presented to the Audit Committee in November 2023. An update on this work is included in the BAF paper (item 3.3).

25 July 2023	13	**Matters Arising** **Paragraph 1.4.4** To circulate the mental health slides presented to the ICP on 11 July 2023.	Sarah Mansuralli	July 2023	The slide presentation was forwarded to Board Members on 26 July 2023.
25 July 2023	14	**Integrated Performance and Quality Escalation Report** **Paragraph 3.1.5** To co-ordinate a presentation on winter planning for the Board Seminar on 19 September 2023.	Richard Dale	September 2023	The Board received a winter planning presentation at its Seminar on 19 September 2023.
25 July 2023	15	**Board Assurance Framework** **Paragraph 3.3.4** To arrange for the score for risk COMM22 (relating to the delegation of specialist commissioning) to be reassessed so that it meets the BAF threshold.	Sarah Mansuralli and Ian Porter	October 2023	The risk score was considered as part of the latest round of risk reviews and it was agreed that, although it remains below the BAF threshold, the risk would be included in the BAF from November 2023 for Board oversight (item 3.3).
25 July 2023	16	**Governance Report** **Paragraph 4.1.5** To review the diversity of Local Authority representatives on the People Board.	Sarah Morgan	October 2023	Sarah Morgan has raised this issue with the five local authority Chief Executives to consider how best to address this challenge. Further discussions have also taken place with other local authority colleagues and the membership of the Supply Delivery Board has been extended to increase the reach across the five Boroughs. A People Board seminar is also being held in December and the invitation list has been widened for this as well.

25 July 2023	17	**Governance Report** **Paragraph 4.1.6** To meet to discuss how best to map Committee responsibilities to minimise any overlap.	Committee Chairs	November 2023	The Committee Chairs will be meeting on 14 November 2023 to discuss this.

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 November 2023

Report Title	Chief Executive's Report	**Date of report**	18 October 2023	**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. System Pressures and Winter Planning

2.1 The system continues to operate under significant pressure and continues to plan for winter. Although there has been a strong focus on planning, managing and escalating pressure caused by the industrial action and seeking to contain the resulting loss of activity, there has however been an impact on the system's longest waiting patient cohorts and active ongoing management is underway to ensure patients are kept informed and prioritised. Prior to strikes, NCL had delivered a 67% reduction to the number of patients waiting longer than 78 weeks for treatment (a reduction from 601 patients to 201). Since the beginning of this financial year, however, sustained industrial action has driven a 22% increase to this long waiting patient cohort (245 patients as of October 2023).

2.2 The number of patients spending more than 12 hours in Emergency Departments remains high, reflecting high occupancy and constraints relating to patient flows through hospitals. Demand for social and community care resources continues to exceed supply, resulting in delayed discharges. NCL is prioritising interventions that support improvements in this area, working with our Council partners. Significant efforts have been made over recent months to provide step-down bed capacity in community settings. Virtual ward capacity is increasing with senior medical cover from acute hospitals.

2.3 This work is a key contributor to improving the aggregate NCL performance against the A&E 4-hour performance target, which has dipped in recent months due to ongoing industrial action and flow pressures. Further work is still required to deliver the step change towards the national performance ambition of 76.0% of patients seen within 4 hours, by March 2024.

2.4 Other interventions are being prioritised, such as the effective use of short stay units to drive improvement. London Ambulance Service has trialled a 45-minute handover protocol, implementing intelligent conveyancing, cohorting and expedited handover arrangements.

2.5 In relation to cancer services, the NCL position against 62-day plans remains challenged. At the start of October 2023, there were 822 patients waiting over 62 days against a plan of 609. Despite this, progress has been made with delivering the system's cancer recovery plans. North Middlesex University Hospital was moved out of Tier 1 oversight in September 2023 as a result of reducing their 62-day backlog and improving Faster Diagnosis Standard (FDS) performance.

3. Improved access to expert sickle cell care

3.1 People living with sickle cell disorder (SCD) in North Central London will benefit from improved access to specialist, integrated community nursing care and timely pain relief when experiencing a crisis, thanks to new pathways and investment. This follows the recommendations in the wake of the All-Party Parliamentary Report, *No One's Listening* (November 2021), which investigated deaths and failures of care for patients with SCD in secondary care.

3.2 **NCL Community sickle cell, thalassaemia, and rare anaemia service**
This new service will provide specialist nursing care for people close to, and in their own homes. The service aims to keep patients well at home, provide access to early support when their condition deteriorates, and reduce the need to go into hospital. It will link up with primary care, social care, community care, and specialist care to integrate these aspects of patients' experience.

3.3 **New hyperacute service based at North Middlesex University Hospital (NMUH)**
NCL has also successfully bid to host one of the six hyperacute units (HAUs) funded by the National

Healthcare Inequalities Programme and NHSE. These units provide specialist treatment when people with sickle cell disorder (SCD) need it most, allowing them to bypass Emergency Departments in the event of a crisis. Our HAU will be at NMUH in Edmonton as postcode analysis showed the hospital is closest to where the majority of people with sickle cell disorder in NCL live. Funding of £1,182,364 has been awarded for a three-year pilot.

3.4 The enhanced service will mean that people experiencing a vaso-occlusive crisis will be able to contact a red cell specialist 24 hours a day, seven days a week, to determine the most appropriate treatment. Patients will be able to speak directly to clinicians who understand their condition and can provide effective pain relief via care from the NMUH haematology day unit, care in the community, a virtual ward, or attending an Emergency Department. This approach was developed with people living with SCD, who said that a hotline would provide better access to specialist help from healthcare professionals who know their circumstances and that care closer to home would reduce the need to travel.

3.5 Now that the funding for these new SCD services has been agreed, work has begun to recruit to posts and further develop operating policies, with services expected to launch by the end of 2023. Both the new community service and hyperacute unit at NMUH will be evaluated to inform future models of care for patients living with SCD.

4. Integrated Care Partnership update

4.1 The NCL Integrated Care Partnership (ICP) met on 3 October 2023, chaired by ICS Chair, Mike Cooke.

4.2 The ICP considered mobilisation of the NCL Population Health and Integrated Care Strategy, focusing on the contributions of our Borough Partnerships and NCL-wide programmes. The strategy is formed from priorities in each borough and each Partnership is now organising its activity around it, identifying gaps and agreeing where to accelerate to drive meaningful change. All areas within the Strategy are actively being progressed and the baseline position (in each borough and across NCL) is being established so we can evidence progress. Examples of work against key priorities were reviewed by the ICP with updates on children and young people with special educational needs and disability (SEND), work to improve the physical health of adults with severe mental illness (SMI), and early proposals to integrate work around heart health.

4.3 On SEND, Barnet has been selected as the lead authority for a two-year programme sponsored by the Department for Education and supported by NCL Councils and partners including the ICB and NHS providers. Approximately £6m will be provided over two years to test key national proposals locally. The objective is to redesign the system around the needs of children and young people to address barriers experienced on a daily basis and to improve outcomes and lived experience. The ICP strongly supported this work and the alignment of capacity to deliver it.

4.4 For adults with SMI, deep inequalities and complex issues underpin poor physical health outcomes. The ICB, UCLPartners, and other partner organisations are working to address this with coproduction via our Longer Lives Experts by Experience reference group, research and evidence, and professional input. This is supported by investment in services in boroughs, work with Primary Care at Neighbourhood level, enhancing Trust teams including with peer support, and strengthened voluntary, community and social enterprises community outreach. We exceeded the 2022/23 national target for annual health checks for people with SMI, with 13,322 health checks undertaken – quadruple the number two years ago. Health checks are a critical step in closing the gap in outcomes and supporting people effectively with risk factors and treatment for conditions such as heart disease, diabetes and cancer. Key outcomes include reduced premature mortality and improved quality of life.

4.5 The ICP also noted heart health is a major priority in the Strategy and there is an opportunity to come together around an integrated and preventative approach across NCL. Optimising outcomes will require dialogue with communities (healthy living, risk factors), detection (health checks, case-

finding – targeting resources at individuals or groups who are suspected to be at risk) and proactive integrated pathways for treatment. We are taking action now around hypertension treatment, with outcomes embedded in our recently launched Long-term Conditions model delivered by primary care with support from partners. The ICP will receive an update on the wider opportunity at its next meeting.

5. Launch of NCL Long Term Conditions model

5.1 On 1 October 2023, North Central London launched a new model of care for people living with long term conditions. The model builds on successful work by primary care teams over the past seven years and draws on wider evidence and best practice. It supports a consistent offer for patients with all 180 NCL GP practices signed up to embed and deliver the model.

5.2 To identify patients who can benefit, teams will have an initial focus on people with metabolic (heart disease, diabetes, chronic kidney disease, heart failure) or respiratory conditions (asthma, chronic obstructive pulmonary disease) registered with a GP in North Central London. Our population health management platform (Heatheintent) will support practices to identify people who will benefit.

5.3 Local clinicians, patient representatives, and wider system partners have worked closely together to develop and launch the model. It focusses on a proactive approach, offering each patient a planned intervention and support, with additional touchpoints for those living with more complex needs. Once a patient is identified, the clinician will take a holistic approach looking at their physical and mental health and wider wellbeing. Every patient will have an annual 'check and test' appointment that covers all diagnosed conditions, personalised care and support planning, and goal setting to help them set and stay on track with their own health and wellbeing goals. GP practices will use the full range of primary care roles, such as pharmacists, physician assistants, specialist nurse practitioners, and social prescribers to deliver the service.

5.4 The model also supports our commitment to reducing health inequalities, with practices using new tools to help them identify people who can benefit from this new approach and to track outcomes and identify health inequalities. Building on learning from the Covid vaccination programme, practices will also be encouraged to collaborate with local voluntary sector partners to tailor outreach and support to help close gaps in outcomes.

6. Developing an NCL Research Engagement Network

6.1 Health and care, academic and voluntary, community and social enterprise (VCSE) partners in NCL have been successful in a bid for £100,000 funding from NHS England and the Department of Health and Social Care to develop our own Research Engagement Network.

6.2 This is an important step towards meeting our statutory duties as an ICB to involve local communities and tackle health inequalities and will further diversity, inclusivity, and representation of our local populations in health research.

6.3 The three core aims in the development of our Research Engagement Network are to:

- improve research co-ordination between partners via a forum for VCSE and communities which will inform NCL's strategic aims and research priorities
- increase participation in research in our under-served communities, starting with a focus on two specific under-served communities. These are Black and inclusion health communities – by which we mean groups who are socially excluded and who tend to have poorer experiences of healthcare
- over the longer-term, to improve trust by making sure evidence leads to service change and enhanced experiences for communities, and feeding this back to communities

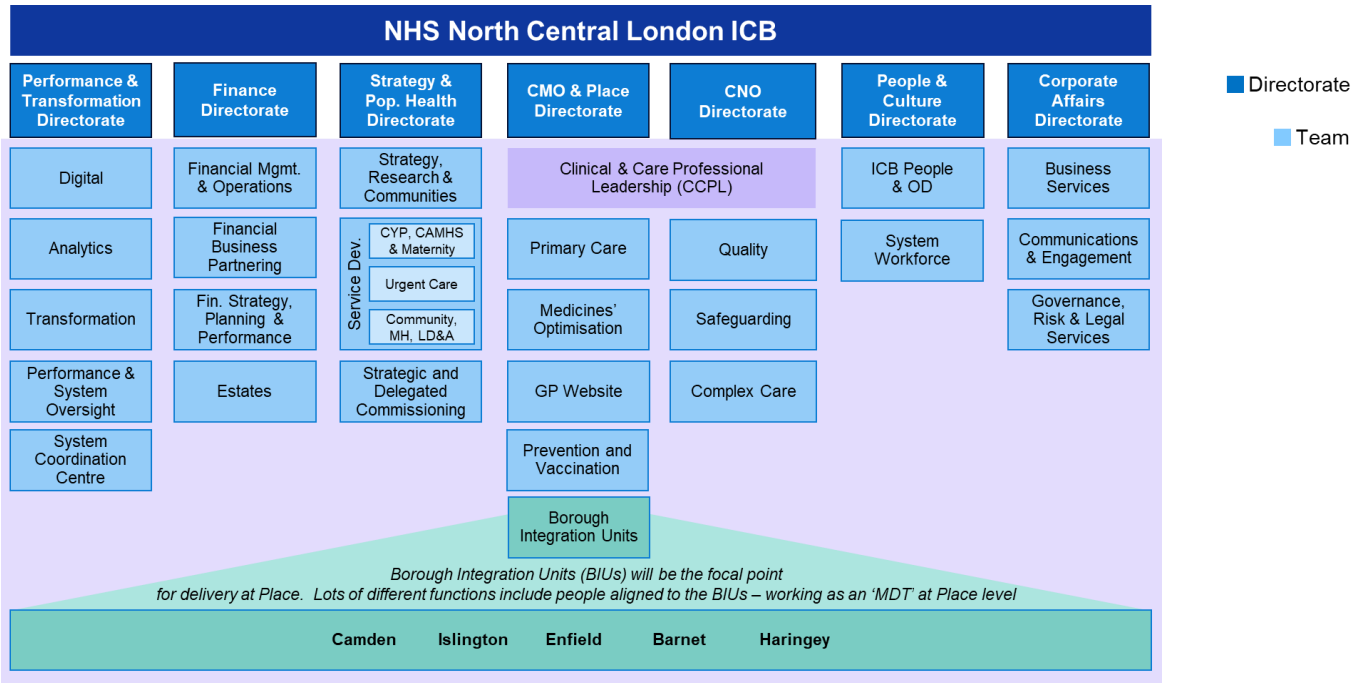
6.4 This work aligns with the ambitions set out in our Population Health and Integrated Care Strategy to tackle health inequalities by listening to our communities, taking shared responsibility for

breaking down barriers, and mobilising our system's world class improvement and academic expertise to become a learning system.

6.5 We will be working with ICS partners to undertake a robust approach to evaluation, recognising that, while the funding is for six months, we are aiming for long-term impacts through the continued development of the NCL Research Engagement Network. As well as monitoring research participation and awareness, our evaluation will focus on our engagement reach through the course of the programme as well as the insights from our local communities.

7. Organisational Change Update

7.1 The NCL ICB staff consultation on our proposed new structure concluded on 21 August 2023 and the consultation outcome was published on 28 September. The confirmed new structure is shown below.



7.2 There was a significant amount of thoughtful and helpful staff feedback during the consultation, which was carefully considered by Executives and which informed the design of the final structure. The main headline change was to create a new Chief Medical Officer (CMO) and Place directorate, moving the portfolio of the Executive Director of Place under the CMO. This reflects the importance of focusing on 'place' in our work, by which we mean local geographical areas, often based on local authority boundaries. It also supports the development of our Borough Integration Units and better connects our clinical and care professional leadership with primary care, medicines management, and our shift to more proactive prevention of ill health.

7.3 We also received approval from NHS England at the end of August, to run a Voluntary Redundancy Scheme (VRS) for our staff who are at risk. We are pleased to be able to offer our staff this choice and will open the window for the VRS at the end of October.

7.4 The next phase of our Organisational Change Programme will focus on the transition and implementation of the new structure and we will keep the Board updated on progress with this.

8. 2022/23 annual ICB assessment outcome

8.1 We have received the outcome of NHS England's assessment of our performance between 1 July 2022 – 31 March 2023 (our first nine months of operation). NHS England have acknowledged the range of work we are doing to improve the health of our residents. Examples cited include our engagement with partners and communities, the work we are doing in quality and safety, our ambitious Green Plan, our focus on health inequalities, and our progress delivering physical health

checks for people with severe mental illness. The assessment also makes some suggestions for areas we need to focus on more in the year ahead, and recognises that there remain challenges around the ongoing impact of the pandemic and the increase in waiting lists, similar to other ICBs across the country. The full assessment outcome letter is available on our website. It's a heartening reminder of all that we have achieved in our first nine months against a challenging backdrop – and my thanks go to all colleagues and partners for their efforts and contributions.

9. NHS IMPACT and developing our improvement approach

9.1 NHS IMPACT (Improving Patient Care Together) is a new national improvement approach supporting all NHS organisations to have the skills and techniques to deliver continuous improvement. The aim is to achieve demonstrable improvements in health outcomes and inequalities, quality of care, use of resources, and the retention and wellbeing of staff.

9.2 Building an improvement culture means making sure that every member of staff is encouraged and supported to improve the work they do every single day. This is a long-term vision, but we are all aware of the many pressing challenges which the NHS currently faces, including how we can best assure and improve patient and staff safety.

9.3 There is not a "one size fits all" model and there is no intention to propose a standard NHS improvement method. Trusts and systems are encouraged to innovate and to develop their own local approaches. However, evidence suggests the consistent adoption of five practices is critical:

- a shared purpose and vision which guide all improvement effort
- investing in people and building an improvement focused culture
- leaders at every level who understand continuous improvement and practise it in their daily work
- the consistent use of an appropriate suite of improvement methods
- embedding improvement into management processes so that it becomes the way in which we lead and run our organisations and systems

9.4 Locally, we have brought our organisations together to build an NCL community of practice around the current improvement resources we have across the system and begun work to understand what we do well and where we can work in new ways to be more effective. Across NCL ICS, boards will undertake a self-assessment to support the process of building improvement culture across the system.

9.5. Our local strategies and plans, including the NCL Population Health and Integrated Care Strategy, the organisational development plan, and work to design our new analytics function will be informed by this work.

Frances O'Callaghan
Chief Executive

18 October 2023

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 November 2023

Report Title	National Delivery Plan for Recovering Access to Primary Care – NCL approach	**Date of report**	5 October 2023	**Agenda Item**	2.1
Lead Director / Manager	Sarah McDonnell-Davies, Executive Director of Place	**Email / Tel**		sarah.mcdonnell1@nhs.net	
Board Member Sponsor	Sarah McDonnell-Davies, Executive Director of Place				
Report Author	Rebecca Kingsnorth & Adam Backhouse	**Email / Tel**		rebeccakingsnorth@nhs.net adam.backhouse@nhs.net	
Name of Authorising Finance Lead	Sarah Rothenberg, Director of Finance, Primary Care	**Summary of Financial Implications** Three National funding streams support delivery of this plan: • System Development Funding – held by the ICB. Local allocation of System Development Funding to support delivery is outlined in this plan. • Capacity and Access funding – already allocated to Primary Care Networks following submission of Capacity & Access Plans in Summer. • Transition and Transformation funding - allocated to support practice level engagement in the programme this year or next. Wider transformation funding managed by Primary Care GP IT, Digital and Workforce is being aligned to key goals and outputs in the Recovery Plan. The ICB invests in access to General Practice via core primary medical services contracts (GP practice 'core' contracts) and local enhanced services at practice, PCN and Borough level. Non recurrent Winter funding (where available) is also used to enhance capacity.		
Report Summary	The National Delivery Plan for Recovering Access to Primary Care is a major focus for NHS England (NHSE) and Integrated Care Boards (ICBs). Published late Spring, the plan aims to make it easier and quicker for patients to get the help they need from primary care. Access along with capacity, infrastructure and workload were the focus of most primary care transformation work pre-pandemic. COVID triggered rapid change over a short period of time to the General Practice operating model and changed				

	patterns of patient demand. Activity within General Practice in North Central London (NCL) has increased by on average 15% on pre-pandemic levels. The National and independently administered GP-Patient Survey provides excellent data on patient satisfaction with General Practice. Results for NCL show in 2020, on average 63% of respondents in NCL described their experience of making a GP appointment as 'very good' or 'good'. In 2023 this has dropped to 53%. In the same survey patients are asked whether their needs were met at their last general practice appointment. In 2020 on average 93% in NCL said 'yes'. In 2023 this is 89%. Whilst disappointing to see a decline, it shows General Practice has continued to work hard to meet patient expectations and is providing a high quality service. Nationally and locally it is recognised that experience of access and efficacy of access is critical to patients and to the reputation of General Practice. The national plan describes a model for "Modern General Practice Access" - incorporating better digital telephony, simpler online requests and faster navigation, assessment and response. It sets out 14 areas for improvement - behind each sits considerable work to transform ways of working within General Practice and at the interface between General Practice and other services. The ICB has been shaping its approach to working with Practices, Primary Care Networks (PCNs) and system partners in NCL to deliver the Access Recovery Plan. We have established a clear programme of work and have confidence in our ability to deliver. We are aligning existing transformation projects and priorities to optimise impact. We recognise we need to get to the root causes of the issues and see this as an opportunity to innovate and to work at individual practice level to make a positive impact for patients and the general practice workforce over time. The report sights the Board on national requirements, local priorities, key actions, our approach to change, resourcing, oversight, communication and key risks. This is a major programme of work at a time of considerable change for ICBs and NHSE. Funding streams have been aligned nationally to this work but there is no new investment. NHSE require ICBs to report progress at public Boards in October/November 2023 and again in February/March 2024. Additional detail was included in the October ICB Primary Care Committee reports.
Recommendation	The Board of Members is asked to **NOTE** the North Central London ICB response to the National Delivery Plan for Recovering Primary Care Access.
Identified Risks and Risk Management Actions	Delivery will support us to address key risks on the Board Assurance Framework and Primary Care Committee risk register. In particular, PERF28 *Failure of Primary Care patient access*. The ICB has developed a programme risk register. Key risks and mitigations are outlined in this report. A full risk register is available on request. The key risk is we deliver individual actions described in the plan but fail to support a consistent transition to the Modern General Practice Access model. This is mitigated by the approach being taken by the ICB.
Conflicts of Interest	It is noted that the Clinical Director for Primary Care for North Central London ICB is also a Board member of the General Practice Provider Alliance which may receive funding as part of developing the change support programme described in Section 4. This will be managed in line with the ICB Conflicts of Interest Policy.

Resource Implications	Delivery of this plan requires allocation of national funding as described, alignment of wider transformation projects and significant ICB capacity.
Engagement	Communications have been issued to all practices and a subset of practices have received targeted communications. There have been discussions with the Londonwide Local Medical Committee (LMC). The programme approach is being shaped by the ICB and providers via the GP Provider Alliance (GPPA). Our local programme offer includes support where changes to individual practice models need to be shaped with and communicated effectively to patients. We considered our overall approach with the NCL Community Partnership Forum in October. We are also part of a London wide project to undertake Deliberative Engagement with patients, stakeholders and frontline staff and plan to focus on key areas like access to inform our current work and future ambitions.
Equality Impact Analysis	A national Equality and Health Impact Assessment has been produced in relation to the national plan. A local Equality Impact Initial Screening Assessment has been produced to supplement this, focusing on our local implementation approach. Both are available on request.
Report History and Key Decisions	NCL ICB Executive Management Team received a report on this work in August 2023 and October 2023. The Primary Care Committee, Digital Board and Community Partnership Forum have also received reports on this work in October 2023.
Next Steps	Implementation against this plan will continue. An updated report will be submitted to the ICB Board in March 2024.
Appendices	Appendix 1: The patient journey under the Modern General Practice Operating Model

1 Background

Access to general practice is a major priority nationally and locally. Accelerated by the pandemic, new routes into general practice have been introduced and new modes of consultation offered. In addition to traditional telephone and reception routes, access options now include digital routes such as 'e-consult' (online forms), online appointment booking and online requests (e.g. for repeat prescriptions). Face to face appointments are offered alongside telephone appointments, video appointments and online advice. Appointments are also offered with a broader range of professionals from the general practice team.

These changes have been designed to support an improved response to patient need, improved patient experience and management of rising demand. For a period during the pandemic face-to-face contact with practices reduced in line with national guidance on infection prevention and control. During this time the use of telephone and online contact with patients increased rapidly to keep patients and staff safe.

Alongside this, activity within General Practice in North Central London (NCL) has increased by at least 15% on pre-pandemic levels. In some practices it has increased by as much as 30%. Practice registered lists have grown at a similar rate over the same period. More activity is being delivered by General Practice than ever before however:

- There is variation between practices in the way that changes have been implemented
- There is significant variation between practices within the GP-Patient survey results
- Patients and their carers do not always know how to best access the support they need
- Work to communicate these changes to patients and to support them to use digital channels has sometimes lagged behind the introduction of the technology itself
- Practices continue to experience unprecedented levels of demand following the pandemic and the extraordinary workload is impacting staff wellbeing.
- Practices are providing more appointments than ever before, but in general patients are reporting higher levels of dissatisfaction with access.

In July 2023 results of the annual National GP Patient Survey were published. Many practices in NCL perform very well against national averages. More still have shown significant improvement against 2022 results. However, there is significant variation across our 180 practices for example within NCL data, almost 70% of respondents indicated they had a "Good" overall experience of their practice – but responses vary significantly across our 180 practices from only 42% of patients to 95%, and in some responses there has been a widening of the gap between the most and least satisfied.

The national Delivery Plan for Recovering Primary Care Access (Access Recovery Plan / ARP) was published in May 2023. This is one of the major NHS Recovery Plans and requires implementation through until 2025. The plan aims to tackle the 8am rush and reduce the number of people struggling to contact their practice. It also aims to ensure patients know on the day, how their request will be managed.

The plan describes a model for *Modern General Practice Access* that focuses on better digital telephony, simpler online requests and faster navigation, assessment and response. There are 14 areas for action within the plan – all of which require considerable work to implement. In response, a programme has been established across the ICB, Primary Care Networks (PCNs) and GP Practices.

It is expected that patients will report improved experience through national tools such as the Friends and Family test and annual GP-Patient Survey. In NCL we will seek to understand progress ongoing through engagement with local providers, patient representatives and stakeholder groups. We will measure impact ongoing via GP appointment data, primary care workforce data and data relevant to the uptake and use of digital tools. Partners such as Healthwatch will be critical.

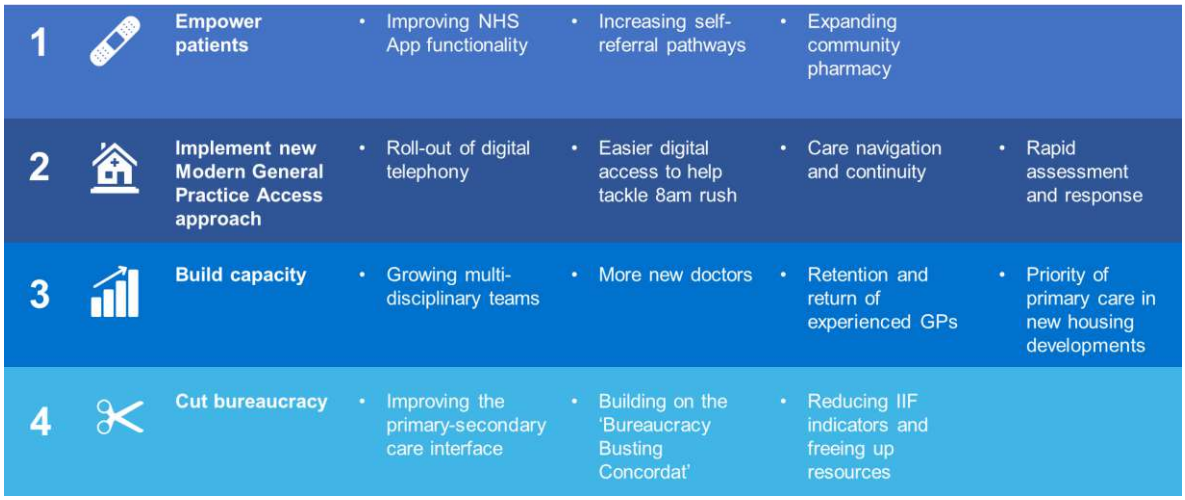
The Access Recovery Plan is one of a number of major strategies and programmes requiring input from General Practice. They also have a role in the Delivery Plan for Recovering Urgent and Emergency services, implementation of the Fuller Review, the mobilisation of the NCL Long Term Conditions Locally Commissioned Service and the Winter plan for 2023/24. All of this should have a positive impact but represents significant work and transformation and requires a supportive approach from the ICB.
This report summarises our work to date and our plans for the next 18 months. A more detailed paper has been considered by the NCL ICB Primary Care Committee and is available here[1]. We have confidence in our approach and ability to make a positive impact for patients and staff.

2 National requirements

The Access Recovery Plan incorporates actions for NHS England, ICBs, ICS partners, PCNs and individual Practices. There are fourteen areas for action aligned against four key aims:

1. **Empowering patients** to seek help in the most appropriate setting, and using digital means where preferred to contact their GP; enabling patients to use self-referral pathways for some services; expanding the range of services provided in community pharmacies;
2. **Modern General Practice Access** approach, using digital telephony, enabling digital access to free up phone lines throughout the day, increasing the level of care navigation and signposting of patients whose needs may be better met by other services, and introducing rapid assessment and response:
3. **Building capacity** by embedding new workforce, supporting local recruitment and retention of GPs and practice nurses, and national actions to train more new doctors and support estates through prioritisation of funding for primary care estate in Local Authority housing developments:
4. **Reducing bureaucracy** including at the interface of primary and secondary care e.g. referral and discharge from hospital care. This includes national actions to reduce bureaucracy and free up funding to focus on capacity and access.

Headline actions from the National Plan are included below:



Improving access requires practical work to implement new tools and approaches, but also a focus on supporting staff and patients through change. A national support offer for individual practices and PCNs has been put in place with universal, intermediate and intensive offers.

ICBs are expected to support practices or PCNs to sign up to these offers; undertake 'diagnostic' conversations with practices using a national tool (*the Support Level Framework*); administer transition & transformation funding to practices 2023-25); and provide hands-on support.

[1] Part-1-PCC-Papers-of-17-Oct-2023-v2.pdf (nclhealthandcare.org.uk) (Item 5.1)

3 ICB response

NHSE are monitoring delivery locally via NHS regional offices and direct engagement with ICBs. Demonstrable progress is being sought and the 2024 GP-Patient Survey will be an opportunity to review key indicators at all levels – individual practice through to system wide. We are making good progress locally and are **on track overall** in NCL with planning and delivery of the requirements. We are **confident in our approach** and are aligning with NHS England offers to PCNs and practices, but also **innovating locally**. Below we outline our work under each of the four key aims.

1) Empower patients

Increasing the use of the NHS App

This is focused on increased use of the NHS App by practices and patients. Work includes:

- Working with all practices to ensure patients can book and manage routine appointments via the NHS App by 31 July 2023 - although it should be noted that the number of appointments available via the App may be only a small proportion of the total appointments provided by a practice as there is also a significant focus on triage of requests prior to booking patients into an appointment.
- Ensuring from 31 October 2023 that all practices allow patients over the age of 16 access to new entries into the health record held by GP practices. This includes access to documents, free text and test results. National patient-facing communications have been issued to increase awareness of this.
- Ensuring all practices enable secure NHS App messaging to patients so that over time - for those patients using the App - this becomes the main source of information and contact from the practice, and that communications can be two-way.
- Encouraging ordering of repeat medications via the NHS App.

The ICB has a dedicated team led by a Clinical and Care Director for Digital implementing a programme of work to support these aims and wider digital developments. The implementation of national ambitions requires translation locally. Examples of the work being done includes:

- Training for Digital and Transformation Leads from Primary Care Networks (PCNs) on the features of the NHS App. In turn these leads can work with practices in their PCN and support them to make the necessary changes to their use of the NHS App;
- Guidance to practices on making health records available to their patients in a clinically safe way;
- Work with suppliers of text messaging tools for practices, so that messages can flow through the NHS App;
- Support to practices with their configuration of the NHS App for ordering of repeat medications.

Providing the option of self-referral into some community services

For some conditions general practice involvement is not necessary and self-referral can be a convenient option that also frees up practice time. NHS England selected seven services for which self-referral should be available by 30 September 2023. The deadline of end of September was met in NCL for four of these: Community musculoskeletal services; Community Podiatry; Community Equipment Services and Tier 2 weight management.

No London ICB yet has self-referral in place for all stipulated pathways in all boroughs. We are in dialogue with NHS England, via the NCL Adult Community Provider Transformation Programme, about the challenges with remaining pathways (Audiology, Wheelchair Services and Falls services). In most cases these will require changes to specifications, contracts and provider deliver models.

Expanding Community Pharmacy services

Community pharmacy is an essential part of the primary care landscape and offers people easy access to health services in the community. The range of services provided by community pharmacy has been

increasing over time. The Access Recovery Plan is a key opportunity to work with the sector following delegation of Dentistry, Optometry and Pharmacy (DOP) commissioning to ICBs in April 2023.

The Access Recovery Plan looks to Community Pharmacy to ease the pressure on General Practice. It is a source of support for patients with minor ailments and can provide a key role in proactive care and prevention. Early expansion of the role has seen oral contraception and hypertension casefinding (blood pressure checks) services rolled out. National negotiations are underway for a Common Conditions Service (CCS) focused on 7 clinical conditions, enabling pharmacies to assess patients and supply prescription-only medicines via Patient Group Directives.

NHS England is coordinating work to deliver IT and digital solutions that would help streamline referrals between General Practice and Community Pharmacy, provide access to relevant clinical information from the GP record and share structured updates into the GP patient record following a pharmacy consultation. In anticipation, and to maximise the benefit of these schemes, ICB leads are in discussion with NCL Local Pharmaceutical Committees and providers.

The hypertension service is currently offered by 219 / 298 NCL pharmacies (73%). The contraception service is currently offered by 71 / 298 NCL pharmacies (24%). There will be continued focus on increasing the number of pharmacies offering these services and increasing referrals from general practice for agreed pathways.

2) Implementing Modern General Practice Access

The Modern General Practice Access model is designed to reshape the patient journey, with a focus on improving the availability and use of digital telephony, enabling simpler online requests, and faster care navigation, assessment and response for patient queries and requests for appointments.

Digital telephony
Long call-waiting times or patients hearing the engaged tone when they call their practice occur when practices have analogue phone systems with a fixed number of lines and no call management system. As demand and practice list sizes have grown, the “8am rush” to book appointments cannot be handled by outdated practice telephony systems. The Access Recovery Plan requires all practices to move to digital cloud based telephony systems that can handle the volume of activity. These systems can handle multiple calls and include call-back functions so patients get a better experience.

The national requirement is that all practices on analogue telephony systems must be supported to transition to digital telephony by March 2024. **In NCL 92% of practices have already transitioned to digital telephony and the remaining 8% (14 practices) will have transitioned by March 2024.** There is considerable work to do at practice level to ensure the practice teams know how to most effectively use these systems, work with the usage data and reporting and reframe their operating models and appointment systems so the maximum benefit can be realised. New technologies such as this impact practice staff roles, workflows and require embedding into practice policies and ways of working. Staff require training and development as they begin to work with these tools. This needs to be coupled with support to patients and their carers.

Simpler online requests
While people will always be able to call their practice, the Access Recovery Plan aims to make online requests easy and ensure they are a dependable route, noting this works well for groups such as working age adults. NHS England is asking all ICBs to support practices and PCNs to consider the best digital tools available to enable online access.

NCL ICB was a forerunner in supporting practices to select high quality online consultation tools and these **are already in place across NCL practices.** As with telephony, effective use of this technology requires work at an individual practice level.

Faster navigation, assessment and response
An ambition of the Access Recovery Plan is to make it easier for people to contact their practice and to get a response the same day. Clinically urgent requests should be assessed same day and when the request is not urgent, an appointment - if needed - should be scheduled within two weeks.

Care navigation is central to this ambition. It is estimated that ~15% of current GP appointments could have been dealt with via a different route – including through self care, community pharmacy or other more appropriate local services. NHS England has invested in a National Care Navigation Training programme which uses the care navigation competency framework developed by Health Education England. This has been advertised proactively to all NCL practices and we are monitoring uptake and considering local training to augment the national offer.

3) Build capacity

Multidisciplinary teams and GP capacity
The shape of the general practice workforce has changed significantly over the past five years, with the introduction of new roles particularly via the Additional Roles Reimbursement Scheme (ARRS) at practice and PCN levels. This has seen Pharmacists, Physiotherapists, Physicians Associates, Nursing Associates, Mental Health practitioners and other clinical roles join the team. There has also been recruitment of non-clinical roles able to play a key role such as Social Prescribing Link Workers and Digital and Transformation Leads. The Primary Care Access Recovery plan places a focus on growing multidisciplinary teams as well as recruiting more doctors and retaining GPs within the workforce.

NCL ICB has initiatives in place that support this work aligned to the pillars of the NCL People Strategy (Supply, Development, Transformation) and the three key priorities of the NHS Long Term Workforce Plan - Train (grow the workforce), Retain (embed the right culture and improve retention), Reform (working and training differently). Action being taken locally includes:

- Supporting recruitment of ARRS staff by close working with ICB ARRS leads, the NCL Training Hub, PCNs, and analysis of PCN recruitment projections.
- Delivery of GP retention initiatives via Training Hub. This includes coaching and mentoring, newly qualified and mid-career fellowships, joint PCN and Training Hub recruitment of workforce and education leads for ARRS roles / specific PCN service specifications, development of multi-professional education;
- Introduction of a flexible staff pool, to develop an NCL pool of locums and connect them to practices with sessions to cover.
- Introduction of various primary care staff wellbeing initiatives, for example, General Practice Survival Toolkit, NCL Valued Awards, NCL Health and Wellbeing Champions Network.

We are tackling challenges in the embedding of larger and more diverse teams through this plan. Action includes use of System Development Funding to support supervision of staff, work between the estates team and primary care team to review practice space assessments and proposals for new developments and alignment of non-recurrent funding to one off set up costs linked to IT equipment and support for staff joining General Practice.

4) Cutting bureaucracy

The recovery plan asks ICBs to work with primary and secondary care providers to implement the recommendations of the Academy of Medical Royal Colleges (AoMRC) report on improving the primary / secondary care interface. The aim is to cut bureaucracy and reduce workload for practices whilst

improving the efficacy of key processes. NCL has developed core principles and four priorities which now require buy-in and support to embed. The local *Consensus* document is in the process of being ratified by the ICB, Trusts, the Provider Alliance and LMC, all of whom have been involved in its development:

- **Onward referrals:** if a patient has been referred into secondary care and need another referral for an immediate or related need, the secondary care provider should make this for them.
- **Complete care (fit notes and discharge letters):** providers of NHS-funded secondary care services should ensure that on discharge, or after an outpatient appointment, patients receive fit notes when required and where possible issued electronically. Discharge letters should highlight clear actions for general practice (including prescribing medications required).
- **Call and recall:** for patients under their care NHS trusts should establish their own call/recall systems for patients for follow-up tests or appointments.
- **Clear points of contact:** ICBs should ensure providers establish single routes for general practice and secondary care teams to communicate rapidly e.g. single outpatient department email.

The following challenges are being worked through:

- Quantifying the impact of improvements to the interface – lack of data necessitating manual audit or qualitative feedback
- Need for an overview of all pathway changes (A&G, shared care etc.) and the impact on general practice workload to enable a more strategic approach to resource, planning and training.

4 Approach to change

The actions outlined above are critical and require on-the-ground change at an individual practice level and across PCNs. This practical work must be underpinned by significant development and change management support, and undertaken in a way that generates positive impact for patients and staff.

Early engagement with NCL practices suggests three quarters are confident in their ability to embed the Modern General Practice model, but there is the possibility of a real step-change in access and experience of access, if this is recognised as a broader opportunity for transformation and development.

The NCL approach is underpinned by:

- Effective use of available information and data to understand the current position with regards to access and patient satisfaction at practice/PCN/Borough/System level - this is focused on analysis and interpretation of Access and the GP-Patient Survey data across multiple years and effort to understand the ‘root cause’ of any issues alongside provider teams.

- Support to practice leaders and frontline teams – the Recovery Plan is one of a number of significant transformation programmes within General Practice. This transformation work is happening in the context of more activity than ever before being delivered by General Practice. As an ICB we want to support, collaborate and enable practice teams and providers to lead and drive change.

- An approach from the ICB that is holistic – bringing together ICB Primary Care, Estates, GP IT, Digital, Workforce, Quality, Comms and others to shape and offer integrated practice level support, sequenced and managed for optimum impact.

ICBs have been asked to develop and roll out a support offer for local practices and support engagement in National programmes. Locally we have used data such as GP-Patient survey results, Quality &

Performance dashboard, usage data linked to digital tools, intelligence from teams within the ICB and other sources, to develop an initial understanding of the likely priorities practice by practice. This analysis is informing a 'hands on' support offer being developed with provider representatives, the Local Medical Committee (LMC) and General Practice Provider Alliance (GPPA). Examples of support might include:

- Support to practice managers and their teams to develop triage and signposting skills
- Support to practice managers and their teams to develop new administrative workflows to underpin the modern general practice operating model;
- Bringing in change management expertise from external organisations, including experts on primary care demand and capacity management and experts in the use of digital systems (for example cloud-based telephony systems);
- Working with local Patient Participation Groups (PPGs) and VCSE organisations to advise around the implementation of digital access routes in an inclusive and patient-friendly way;
- Support to fully embed digital access routes including encouraging patients to use the NHS app to book appointments, order prescriptions, and managing online consultations within the practice workflow.

The ICB's wider work is supporting this agenda. For example:

- The Communities team has undertaken considerable work on digital inclusion
- Estates and Primary Care are working closely to describe the estates requirement driven by the modern general practice access model and to secure capital and revenue to enable the model. Examples are:
    - NCL is one of the few ICBs to have top sliced the ICS capital allocation to prioritise primary care premises developments. This has supported 13 projects in 2022/23. We have focussed on priorities to improve the efficiency, affordability and quality of our estate, attracted additional funding and identified new ways of using NHS land to support wider workforce challenges. In 23/24 we are investing £8.9m across 6 prioritised local care projects
    - The Primary Care Patient Record Room Conversion Project has repurposed space used to store patient records at 20 sites, into clinical and clinical support spaces. Capacity for more than 370,000 additional appointments was provided for c. £2.4m with no additional revenue impact. A further phase of this work is underway.
- Work undertaken to deliver the People Strategy is support supply and retention of staff and the development of careers within General Practice
- Winter plans for 2023/24.

NHSE has developed a Support Level Framework - a diagnostic tool for structured conversations with practice teams to shape practice level plans and support offers. The National General Practice Improvement Programme is also available free to practices and PCNs.

National funding streams are being directed to the programme. Some National targets have been stood down with money reinvested. The most significant resource is via the System Development Fund (SDF), issued to health systems over the last few years to support:

- General practice transformation
- General practice workforce programmes
- General practice IT and estates programmes

For 2023-24 it is a stated aim in national guidance that this funding is invested in initiatives that will support practices and primary care networks (PCNs) to deliver the ambitions in the Recovery Plan and other primary care improvement programmes described in the guidance. For the first time a number of historically separate ring-fenced funding lines, have been pooled to give ICBs greater flexibility in

allocation of the funds - we have taken advantage of this to support the data driven MDT supported change management approach described earlier. This approach has been discussed with NHSE London and has received positive feedback. A breakdown of the SDF for NCL is provided in the full report submitted to the Primary Care Committee.

PCN funding was also aligned to initial Capacity & Access Plans which all in NCL developed and submitted successfully. Work is underway and includes: improving response rates for the friends and family test; developing processes for acting on patient feedback; improving practice websites and work with admin teams to improve appointment data. An average sized PCN will receive ~£200k over the course of the financial year, of which 70% will be paid directly via twelve monthly support payments, and 30% is an improvement payment, and is conditional on achievement. Practices are also to receive Transition and Transformation funding at around £13,000 per practice to support them to change their operating model. 50% of practices will receive this money and deliver in 2023/24 and 50% in 2024/25. Practices will, in addition, receive funding for completion of a Quality and Outcomes Framework (QOF) indicator focused on managing capacity and demand.

5 Communication

We are taking several actions in NCL to ensure that patients and the public are aware of the recent and upcoming changes to the general practice operating model, and to engage local patients and stakeholders in this programme of work. For example:

- A National Access Recovery campaign is due to launch to explain the evolving nature of primary care to the public. Running to March 2024 the campaign aims to increase public understanding of the changes, the benefits they bring and how he public can access support focused on digital access, the wider practice workforce and other care and support options.
- The ICB has developed its approach to disseminating the national materials and engagement with patient representative groups and the voluntary and community sector. We will focus on sharing messages through partner and stakeholder channels including traditional local media and digital platforms such as newsletters, websites and social media. We will localise materials using ICB clinicians and primary care staff as spokespeople to enhance the impact of the campaign. We will also work closely with our local voluntary and community sector groups drawing on trusted voices to support engagement.
- We have developed a practice-facing Directory of Services web page to support with care navigation
- We have commissioned along with other London ICBs and NHS England (London) a programme of deliberative engagement with the public to understand their expectations of primary care services and weigh this up with constraints such as workforce, estate, financial resources. We expect this to have a major focus on access and to inform our programme of work.

6 Oversight

The Access Recovery Plan has a high profile nationally and NHS England are convening a regular national meetings with ICBs and Regions to support two-way dialogue about delivery of this plan. We anticipate a further report to Board in February/March 2024.

The NCL ICB Primary Care Committee is evolving to oversee both the delivery of responsibilities delegated to us from NHSE (e.g. for management of the GP core contract and nationally directed enhanced services) and ICB priorities for General Practice (access, enhanced services, workforce). This will provide a route through which to monitor delivery and oversee the success of our approach locally. Technical digital work will also be tracked by the NCL Digital Board.

Day to day delivery is overseen by the Executive Director of Place supported by the wider ICB Executive Management Team, in particular the Chief Medical Officer and Executive Director for Performance & Transformation. Teams across the ICB are engaged in this work.

The ICB is working closely with providers and sector leads via its Primary Care Operations Group which includes members from the General Practice Provider Alliance (GPPA), PCN Clinical Directors and Londonwide LMCs and Local Pharmaceutical Committees (LPC).

We expect to see the impact on patient experience via the national GP Patient Survey, but this is an annual process and we need to be able to monitor progress and impact on a more regular basis. We will use improvement metrics and trajectories described at a very high level in Figure 3. Under each key area sits at least 2-3 metrics against which we are able to baseline and then monitor. This is described in the full report submitted to the Primary Care Committee.

	Short term	Medium term	Long term
Practice	Response to practice surveys about implementation of modern general practice		
	Agreement and tracking of local metrics attached to change management offers (practice specific)		
	Complaints data – number and theme, by practice/PCN/Borough coming into ICB following delegation of complaints process (baseline July 23)		
		Improvements in digital maturity	
		Patient experience reported via work with VCSE partners.	
			Patient survey results
PCN	Achievement of metrics in *capacity and access improvement plans.*		
System	Ongoing qualitative feedback from patients and system partners.		
		Review of variation in appointment, workforce and digital datasets.	
			Patient survey results

7 Key risks

Delivery of the Access Recovery Plan will support us in addressing key risks on the Board Assurance Framework (BAF) and Primary Care Committee Risk Register. *Failure of Primary Care patient access* (PERF28) is one of 3 risks meeting the PCC threshold. This longstanding risk is being refreshed by Committee but recognises reducing levels of patient satisfaction with their ability to access an appointment and the diverting practice capacity to meet this demand for access. It should be noted that the Committee sees a linked risk – the risk this reduces time available for proactive care and long-term condition management.

To support the Recovery Plan a programme risk register has been developed. Key risks and mitigations are outlined below. The full risk register is available on request:

- We deliver the individual actions described in the plan but fail to support a consistent transition to the Modern General Practice Access model → This is mitigated by the data-driven approach to target change support and the holistic approach to support being taken by the ICB.
- We deliver the individual actions described in the plan but fail to offer sufficient capacity for change management and development at practice level, or sustain this over a period to secure practice team engagement and embedding of new ways of working → This is partly mitigated by the segmentation of practice need and the alignment of support via a 'case management' approach and sequencing

alongside practice teams and any external suppliers. Additional resources would be of benefit and will be sought and aligned where available.

- We are unable to track or demonstrate quantifiable impact on primary care access at system level → This risk is reduced through use of a range of metrics to understand impact ahead of the 2024 GP Patient Survey
- Risk that sustained work on digital inclusion is needed for the Modern General Practice Access model to be effective and impact patient experience → This is partly mitigated by work in NCL led by the ICB Communities team to understand digital exclusion locally and the communities and populations most affected.
- The National Additional Roles Reimbursement Scheme (ARRS) does not provide sufficient resource to cover the estates, IT or supervision requirements for these roles putting pressure on General Practice leaders and ICB budgets → we are supporting where possible through work with NCL Training Hub and development funding for PCNs. This has been raised with NHSE via Primary Care, Digital and Estates routes and they continue to refine the scheme.
- The availability of funding (capital and revenue) to support modern general practice estate → NCL has taken proactive steps to allocate capital to General Practice and support schemes that free up space for example the digitisation of patient records. The 24/25 Capital allocation will be a further opportunity. Increased capital partly (although not fully) mitigates pressure on estates revenue budgets.

8 Conclusion

The Primary Care Recovery Plan is clear and focused and the ICB has a strong approach underpinning its delivery. It is evident from this report and the full report submitted to the Primary Care Committee that the plan requires a complex range of actions at Practice, PCN and System level. NCL has clear plans and is making progress against hard deliverables and key deadlines. Actions are being taken to address areas of challenge. We are thinking about the root cause of the challenges the plan seeks to address and looking through a quality improvement lens in the way we are designing support packages. We are aligning our wider work locally and innovating. Practices and PCNs in NCL have demonstrated their commitment to this plan to date.

Access to General Practice is a complex system challenge, one that has been impacted by the pandemic, rising demand, rapid roll out of technology, a changing workforce and factors driving up activity and productivity. Patient experience of access is at the heart of this plan and our work with partners including Healthwatch, the VCSE, patient groups and professionals within practices who are the first point of contact for most (Receptionists, Administrators, Practice Managers, Navigators) will be critical to the overall success of this programme.

The ICB Primary Care Committee will support oversight of this programme, and its wider work to consider the NCL ICB approach to, and ambitions for, patient access will shape its delivery 2023-2025. The Board is expected to receive a further report in February/March 2025. This supports our reporting and accountability to NHS England.

The Board is asked to **NOTE** the North Central London ICB response to the National Delivery Plan for Recovering Primary Care Access.

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 November 2023

Report Title	Mental Health Update	**Date of report**	18 October 2023	**Agenda Item**	2.2
Lead Director / Manager	Sarah Mansuralli, Chief Strategy and Population Health Officer, NCL ICB	**Email / Tel**		Sarah.mansuralli@nhs.net Tel: 07557319123	
Board Member Sponsor	Jinjer Kandola, ICS Chief Executive Lead for Mental Health				
Report Author	Lauretta Kavanagh, Programme Director for Mental Health, Learning Disability and Autism	**Email / Tel**		lauretta.kavanagh1@nhs.net	
Name of Authorising Finance Lead	Not applicable	**Summary of Financial Implications** Previous Board of Members update in September 2022: the Board supported the proposed approach to investment and Year 1 priorities and 3 year investment plan.			

Report Summary

This report provides an update on Mental Health services in North Central London including the collective action we need to take to respond to some enduring challenges, as well as the progress so far on implementation of the NCL Mental Health "Core Offer". The paper also details a number of strategic opportunities and risks on the horizon, outlining the actions the system is taking, or needs to take in response.

Key system challenges facing mental health services, recommended actions, as well as opportunities and risks on the horizon

- The pandemic and cost of living crisis have contributed to **need rising by an estimated third in recent years in NCL**, especially among young people. Rates of probable mental health conditions have increased among 17-19 year olds from 1 in 6 to 1 in 4 and only one in three people with mental health needs accesses mental health services.The workforce challenges we face mean that we are unlikely to be able to meet this challenge through traditional service expansion alone. This is demonstrated by the 10,000 people on our community mental health waiting lists awaiting triage. In line with our "Core offer" and Population Health and Integrated Care Strategy, we need to **collectively accelerate service improvement and transformation through digital enablers, workforce innovation and greater integration**, so that we **serve more people earlier**.
- There continue to be opportunities to **strengthen integration between physical and mental health services** and **reduce fragmentation**. An example of how we will deliver the former is through our **"Longer Lives**

Strategic Delivery Plan'" which will be **delivered by local borough partnerships** and lead to services working increasingly together to increase life expectancy, reduce ill-health and advance health equalities for adults with severe mental health illness. The ICB will work with partners to set out **how we best can respond to the fragmentation and capacity risks** and case for change within **community CAMHS services**, exploring opportunities and potential benefits of increasing vertical integration.

- Local mental health providers are facing **persistent industrial action**, which has compounded local waiting list challenges and affected staff morale and resilience. Providers are working to **safeguard our workforce** through plans that promote **well-being and retention**.
- NCL is responding to the Metropolitan Police Commissioner-initiated rapid **rollout of Right Care, Right Person (RCRP)** which reduces police involvement in mental health emergencies from 1 November. Significant work is taking place at London, NCL and place levels between partners to implement and optimise our mitigation plan, in line with work being coordinated by London's Joint Mental Health and Policing Group. This includes focused work on **shared approaches to welfare checks** (with the responsible agency taking them on instead), **transportation and handovers at health-based places of safety**.
- **Workforce shortages are the key rate limiting factor to improving and expandng NHS mental health services**. Our NCL NHS Mental Health workforce increased by +6.4% in 22/23, but there is increased reliance on bank and agency staff. Joint work is being taken forward via our **NCL People Plan** and part of the solution to meeting rising need is through mental health sector engagement in **workforce supply, development and transformation.**
- The Strathdee Review recommendations and new mental health inpatient commissioning framework will mean that we need to **review the configuration of adult acute inpatient services** to optimise length of stay, flow and sustainable staffing levels for rising demand. This is in addition to current **work with partners to help ensure people are discharged in a timely way to suitable alternative services** to meet their needs, such as complex inpatient rehabilitation and intensive supported accommodation.

"Core Offer" Implementation Progress

In September 2022, the ICB Board of Members signed off the implementation approach for the Mental Health "Core Offer", which aims to secure consistent and equitable services for all services in North Central London, in line with our Population Health and Integrated Care Strategy. As part of this implementation, further planned recurrent investment of £25m was agreed by 24/25, in addition to the c. £400m baseline expenditure that providers received in 21/22.

In line with the "Core Offer" and NHS Long Term Plan, mental health services have made progress in expanding and starting to transform models of care.

- Work is taking place within neighbourhoods across NCL to **transform community mental health services**, in a way that is wrapped around primary care services – with integrated input from social care and the voluntary sector for people with severe mental health problems;
- Capacity has increased in A&E alternatives for people in a mental health crisis through our work on **crisis houses and crisis cafes**;

	• While workforce remains the greatest rate limiting factor to improving and expanding NHS mental health services, there has been a **6% increase in our NHS provider workforce** between June 2022 and June 2023; with progress in expanding adult community services, Think 111*2, Perinatal and CYP home treatment teams as particular successes; and • In 2023/24, Mental Health services across NCL intend to recruit to 219 additional posts. While most services specified in the "core offer" are in place across NCL, there is **significant work required in order that services can sustainably meet intensity and access requirements**. Benefit realisation will continue to be monitored by regular updates to the NCL Mental Health Programme Board, including through our Mental Health Outcomes Framework.
Recommendation	The Board of Members is asked to **NOTE** and discuss the content of this report including areas on the horizon and proposed management actions to identified strategic risks.
Identified Risks and Risk Management Actions	**Risk:** The announcement by the Metropolitan Police Commissioner regarding the roll out of **Right Care, Right Person** (RCRP) reduces police involvement in mental health emergencies, meaning that without mitigation planning there may be an underlying resilience risk to the mental health crisis pathway. **Management action:** Significant work is taking place both at London, NCL and place level between partners to implement and optimise our mitigation plan in line with the work being coordinated by London's Joint Mental Health and Policing Group. This includes focused work on shared approaches to welfare checks (with the responsible agency taking them on instead of the police), transportation and handovers at health-based places of safety. **Risk:** There is a significant risk that providers will struggle to secure sufficient additional capacity within a context of rising community need due to underlying challenges with **mental health workforce supply and retention**. **Management action:** The Mental Health programme is playing an important role within implementation of our NCL People Strategy and contributing actively to delivery planning on workforce supply, development/transformation through relevant sub-committees. There are a range of initiatives providers are implementing to improve well-being and retention of staff within organisations. **Risk:** There is risk that **fragmentation and capacity challenges in CAMHS** service provision will mean local children and young people with mental health conditions do not access timely mental health care. This is crucial because mental health conditions are affecting an increasing number of CYP, suicide is the leading cause of death in young people and most lifelong mental health problems begin in childhood. **Management action:** The ICB has provided additional investment in CAMHS services at a faster rate of growth than for other health care areas across NCL. NCL CAMHS providers are collaborating around shared opportunity areas including through a joint performance management group. In addition, the ICB will work with partners to set out how we best can respond to the fragmentation and capacity risks and case for change within CAMHS services, exploring opportunities and potential benefits of increasing vertical integration.
Conflicts of Interest	Not applicable.
Resource Implications	Not applicable – Mental Health is an established workstream within the ICS.

Engagement	Not applicable – occurs through the Mental Health programme in line with our statutory duties for service change and as part of joint codesign with experts by experience.
Equality Impact Analysis	An EQIA was completed on the Mental Health “Core Offer” as part of its approval.
Report History and Key Decisions	Not applicable.
Next Steps	It is proposed that the Board of Members be provided with a further update in 12 months time and management actions relating to strategic risks and horizon scanning will be progressed through the NCL Mental Health Programme and relevant ICB committees (as applicable).
Appendices	Not applicable.

North Central London
Integrated Care Board

Mental Health Update

ICB Board of Members

7th November 2023

Collective action is required to meet some enduring and systemic challenges facing local mental health services

Nationally, only one in three people with a mental health need access services. The pandemic and cost of living crisis have contributed to **need rising by an estimated third** in recent years, especially **among young people**. Our enduring workforce challenges mean that NCL is unlikely to meet this need by traditional service expansion alone, e.g., there are currently 10,000 people waiting for triage by our community mental health services. In line with our Core Offer implementation and Population Health & Integrated Care Strategy, we need to **accelerate service improvement and transformation through digital enablers, workforce innovation and greater integration**, so that we serve more people, earlier, and have better reach to underserved groups.

As part of our approach, **we need to strengthen integration between physical and mental health services** and **reduce fragmentation**. This is a priority within our ICS population health approach, including through our **'Longer Lives' strategic delivery plan.** This plan will be **delivered through local borough partnerships** and improve life expectancy, reduce ill-health and advance health equalities for adults with a severe mental illness.

23/24 has been a challenging year and local mental health providers have faced significant challenges keeping services safe through **persistent industrial action**, which has compounded local waiting list challenges and **affected staff morale and resilience**. We need to continue to **safeguard our workforce through the actions providers have in place to facilitate well-being and retention**.

NCL is responding to the Metropolitan Police Commissioner-initiated relatively fast **rollout of Right Care, Right Person (RCRP)** which reduces police involvement in mental health emergencies from 1 November. Significant work is taking place at London, NCL and place levels between partners to implement and optimise our mitigation plan, in line with work being coordinated by London's Joint Mental Health and Policing Group. This includes focused work on **shared approaches to welfare checks, transportation and handovers at health-based places of safety**.

Workforce shortages are the key rate limiting factor to improving and expandng NHS mental health services. Our NCL NHS Mental Health workforce increased by +6.4% in 22/23, but there is increased reliance on bank and agency staff. Joint work is being taken forward via our **NCL People Plan** and part of the solution to meeting rising need is through mental health sector engagement in **workforce supply, development and transformation.**

Preventive and public health services for mental health continue to be key, however operate within national funding constraints. From 2018–19 to 22–23, the local authority public health grant had a real-terms reduction of 6%. We need to work together on prevention and to obtain best value from the funding we do have.

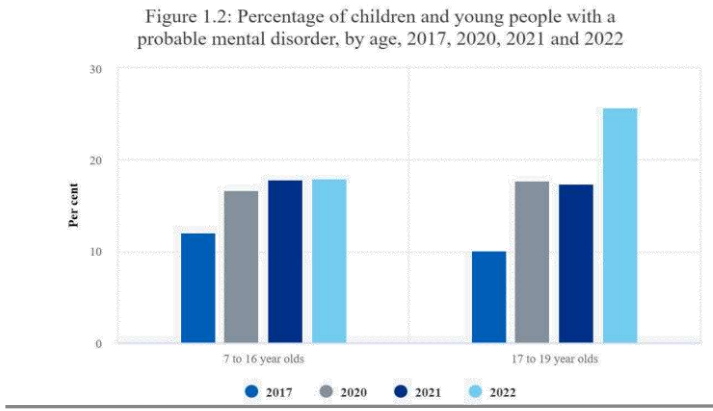
As part of system working, mental health needs to be everyone's business if we are to meet the challenge of increasing need and realise the opportunities that working together in partnership can bring

There is rising mental health need in our communities and a growing community mental health active caseload

Need is rising both nationally and locally

- **Mental health need among children and young people has increased** locally and nationally since the pandemic, with rates of probable mental health conditions increasing to 1 in 6 for 7–16-year-olds and 1 in 4 for 17-19 in 2022.
- This is a key statistic given that **lifelong mental illness starts before the age of 14 in a third** and by 18 years in almost half of individuals.
- Only **1 in 3 people with mental health need access mental health services** - across Children and Young people (CYP) and adults - demonstrating the 'mental health treatment gap'.

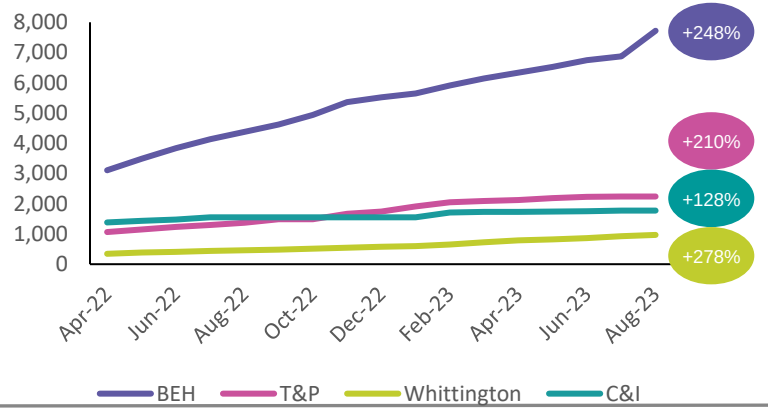
% CYP with a probable MH condition by age



The number waiting for a first response is large but stable, however the active community mental health services case load has doubled since April 2022

- Given the significant **number of adults and CYP waiting with no contact** (10k in August 23), increasing access to treatment continues to be a system priority.
- There is variation in performance against access targets, with underperformance for access in CYP and over performance for access in adults.
- The active caseload for community mental health services (adults and CYP) has increased by over 200% since Apr 2022.

Adult and CYP active caseload* by provider



We also have some evidence of increased complexity/acuity among people being seen in mental health services

- We are observing evidence that **complexity/acuity among those referred is rising**.
- For example, in April 2023, 64% were in the **NHS Talking Therapies high intensity pathway**, whereas this increased to 71% in September.
- Also, 7 in 10 **admissions for acute inpatient mental health care were under the Mental Health Act** signalling that acuity is high.
- This indicates a need to focus on ensuring that there is **sufficient capacity and resilience to meet the levels of demand and complexity** in ways that provide appropriate treatment, care and support to meet people's needs.
- Providers are already working together to explore **collaborative transformation opportunities** in CAMHS (Child and Adolescent Mental Health Services) and NHS Talking Therapies for anxiety and depression.

*Active case load definition: number of people who are open for assessment, treatment and care

Delivering the Mental Health Core Offer will help ensure consistency and equitable outcomes for residents….

Previous Board of Members update in September 2022 provided an overview and update on the progress of the Mental Health review including areas of focus during Year 1; Outlined the benefits that implementing the Core Offers will bring, including for population health improvement; Board supported the proposed approach to investment and Year 1 priorities

Overview of the programme to date:

Baseline review

- A **case for change for mental health services** across NCL was developed based on baseline analysis of data, service mapping and stakeholder interviews.

Core Offer for mental health services

- A **mental health core offer outline** was developed for different age segments of the population and specifications were drafted for each care function of the core offer, including **coordinating functions.**
- The purpose is to **address the inconsistency of service provision** across NCL by setting out a commitment to the NCL population of the support they can expect to have access to.

Funding timeline

- This model sets out affordability using the **MHIS and SDF* funding**. This reflects the strong alignment between delivery of the MH core offer programme and MH Long Term Plan.
- The model requires the MH system to work together and identify **productivity and efficiency savings** to support core offer investment plans as MHIS/SDF funding on its own is insufficient.

Benefits realisation

- We have developed a **Mental Health Outcomes Framework**, aligned to NCL's Population Health Strategy, which will enable us to measure the degree of change a patient experiences and to understand if the Core Offer is meeting the needs of NCL population
- **Patient outcomes will be measured** by validated tools such as Dialog+ using paired scores.

In addition to the £c.400m baseline expenditure in 21/22, further planned recurrent investment of £25m was agreed by 24/25:

£millions (cumulative)	22/23	23/24	24/25
Source of Funding			
MHIS Investment Pot	2.5	5.4	10.9
Service Development Fund	8.6	4.3	4.3
Productivity	-	3.0	5.2
MH Bed Day Reduction	-	2.3	4.7
Total Funding	11.1	15.0	25.1

Actual additional investment and recruitment in 22/23 – 23/24:

22/23	23/24
• *CYP rec. investment*: **£2.6m**	• *CYP rec. investment*: **£5.7m**
• *Adult rec. investment*: **£8.5m**	• *Adult rec. investment*: **£11.1m**
• *Recruitment*: NHS Mental Health workforce has increased by **+6.4%** in 22/23, but increased reliance on bank and agency	• *Recruitment*: If all 219 planned net additional posts are recruited to by year end, that would be a **+4%** increase in the MH workforce this year.

Investment to date is in line with the MHIS target and SDF allocation for targeted mental health investment.

*Mental Health Investment Standard and Service Development Fund

….and the expansion and transformation of services is well underway

North Central London
Integrated Care Board

EXPAND

Increased access to existing mental health services and established new services

Increased access to existing mental health services. For example:

- Increased capacity within A&E alternatives: Crisis Houses and Crisis Cafes
- Performance of treating urgent cases of CYP Eating Disorders have improved (75% in Q1 23/24 compared to the 44% during the same period last year).
- Investment and support from clinical network from Primary and Secondary care has seen performance meet the target in 22/23.
- Perinatal access for 2000 expectant women and new parents in 23/24
- 20k CYP will access NHS mental health services in 23/24
- 40k to access NHS Talking Therapies in 23/24
- SMI (severe mental illness) Adult Community and Core MH Teams will see 21k people with SMI
- Expanding all CYP MH crisis core functions to 24/7 response in 23/24 to meet the NHS Long Term Plan ambitions

Established several new services. For example:

- Supported NCL residents through Suicide Prevention and Bereavement
- Implemented new services including CYP Eating Disorder (ED)
- Launch of new centralised section 136 hub for North London
- Establishment of 16 Mental Health Support Teams in education settings

&

TRANSFORM

Transforming models of care, including improving quality and timeliness of care received

Transforming models of care. For example:

- In the last 12 months (Jun-22 to Jun-23), there has been a **6.0% increase in the provider mental health workforce** in NCL.
- Progress in recruitment is particularly strong for Adult Community Services, Think 111, Perinatal services and CYP Home Treatment Teams
- **Adult Community Transformation** - Transformed Community Mental Health Services wrapped around Primary Care, integrated with social care and voluntary and community sector for patients with a SMI.

Improving quality and timeliness of care received:

- Meeting **Core 24 Mental Health Liaison Service Standards** and the delivery of and **relocation of MH Crisis Assessment Service**
- Performance remains **consistent in meeting both the emergency response time (4-hour) and the 24-hour target** for assessments conducted by the Crisis Resolution and Home Treatment teams
- We have developed a **Mental Health outcomes framework for NCL**
- Significant work has been done to **improve the timeliness of people beginning to receive help within 4 weeks from referral**.

Adults/older people Core Offer services are in place, however significant optimisation is required to meet intensity and access requirements….

Sector	Service		In place	Further optimisation required
Primary Care MH	Early intervention and prevention support		X	Potential delivery plan requires scoping and consideration
	NHS Talking Therapies for anxiety and depression (IAPT)		✓	Access and in-pathway treatment waiting times
Secondary Mental Health Services	Perinatal service		✓	Data reporting improvement
	Core Community Mental health	Core Community Mental Health	✓	Improve AARS / primary care MH workers coverage across neighbourhoods
		Early Intervention Psychosis	✓	Achieving 95% Level 3 NICE concordance
		Eating disorder services	✓	Data reporting improvement
		Rehabilitation	Partial	Reduce variation between neighbourhoods in coverage
		Personality disorder / Complex emotional needs service	✓	Balance consistent and equitable core offer delivery; and define the early intervention pathway
		Individual Placement and Support (employment)	✓	Data reporting improvement
		Physical health checks for people with SMI	✓	Optimise through local implementation of NCL ‘Longer Lives’ at place
	CMHT / Intensive Services for Older People		✓	Joint work with partners
Secondary Crisis Mental Health Services	NCL mental health crisis line		✓	Integrated with Think 111*2
	Place of safety provision		✓	Optimise ways of working in line with RCRP including ensuring geographic equity
	Crisis resolution and home treatment		✓	Review intensity of Home Treatment Offer
	Psychiatric Liaison		✓	-
	Mental Health Crisis Assessment Service (MHCAS)		✓	Improve direct walk-ins and conveyance levels
	Acute inpatient MH services (Psychiatric Intensive Care Unit)		✓	Capacity, length of stay and optimising therapeutic input
	Crisis houses		✓	-
	Crisis cafes		✓	Optimise in line with evaluation outcome
	Care Home Liaison support		Partial	Consider further integration of mental health resource into EHCH* services
Other	Neurodevelopmental diagnostic and treatment service		✓	Access and treatment waiting times
	Dementia community and memory clinics		✓	-
Coordinating Functions	Coordinating Functions (Central point of access, trusted holistic assessment, care coordination and case management)		Partial	As part of planning for 24/25, the gap analysis will be refreshed as a system

*Enhanced Health in Care Homes

….this further optimisation is also required within children and young people Core Offer services

Sector	Service	In place	Further optimisation required
Primary Care MH	CYP Early intervention and prevention offer	Partial	Enhance provision in Barnet, Enfield and Haringey
	Mental Health Support Teams (MHST) in schools	✓	Increase coverage of education settings
Secondary Mental Health Services	Early years service and family services (0-5 years)	✓	Utilise maturity tool to identify service development priorities
	CAMHS community core teams (included integrated front door)	✓	Clinical model standardisation and workforce optimisation
	Targeted Services (e.g. for looked after children or care leavers)	✓	Reduce geographic variation across NCL and utilise social prescribing
	Community eating disorders service	✓	Achieve waiting time standards; review ARFID (avoidant and restrictive food intake disorder) and eating difficulties service
	Integrated MDT for complex needs	Partial	Review of adequacy in coverage and output
	Young Adult (16-25)	Partial	Utilise maturity tool to identify service development priorities
	Adolescent assessment and intensive interventions inc. psychosis	✓	Review of clinical model efficacy across NCL
Secondary Crisis Mental Health Services	NCL Crisis Line	✓	Integrate with Think 111*2
	Mental health Crisis Hubs	✓	Implementing the recommendations from Crisis Hubs Evaluation
	Mental health intensive home treatment	✓	Complete mobilisation of service across NCL
	Multidisciplinary mental health liaison to acute A+E and CYP medicine	✓	-
Other	Specialist intellectual disability, autism and ADHD pathways	✓	Reduce fragmentation of service provision, and waits
Coordinating Functions	Coordinating Functions (Central point of access, trusted holistic assessment, care coordination and case management)	Partial	As part of planning for 24/25, the gap analysis will be refreshed as a system

There are opportunities to integrate tiers of service delivery, including within CAMHS, and strengthen integration with physical health/social care

1. DELIVERING MENTAL HEALTH CORE OFFER

Inpatient Mental Health Services

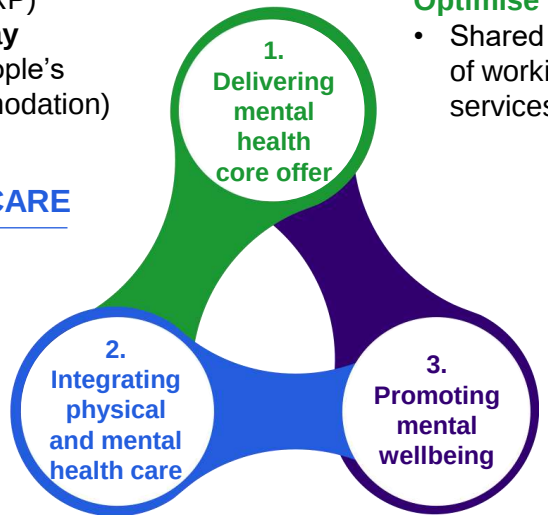
- **New MH inpatient commissioning framework**
- **Reviewing configuration of inpatient services** to optimise length of stay, flow and sustainable staffing levels for rising demand for inpatient care, and deliver the Strathdee Review recommendations while accommodating impact of further policy initiatives (RCRP)
- Shared focus with partners on **reducing long lengths of stay** (including improving suitable alternative services to meet people's needs, e.g., complex rehab and intensive supported accommodation)

Existing service access, wait times and quality improvement

- **Improvement in waiting times**; new standards in development for UEC and all age community mental health; measuring outcomes in mental health; services audited as delivering NICE concordant care

Optimise vertical integration

- Shared ICB and Provider consideration of change in our system's capacity and ways of working to deliver change and make transformation happen for example in services such as **increasing vertical integration in community CAMHS**



2. INTEGRATING PHYSICAL AND MENTAL HEALTH CARE

Longer Lives

- **Optimise through local implementation of NCL 'Longer Lives' at place**: Improving life expectancy, reducing ill-health and advancing equalities for adults with severe mental illness, including through annual health checks

Population segmentation and risk stratification across both physical and mental health

- Exploring common or SMI as entry conditions to LTC LCS*
- Including a mental health component in NCL's population segmentation

Mental Health Core Offer for rough sleepers

- Developing our NCL **Core Offer for rough sleepers** on the basis of NICE guidelines and building on the learnings from the pilot in Camden - providing integrated health and social care services for people experiencing homelessness

3. PROMOTING MENTAL WELLBEING

Prevention Concordat for Better Mental Health

- NCL commitment to the **Prevention Concordat for Better Mental Health** would promote evidence-based planning and commissioning to increase the impact on reducing health inequalities

Suicide prevention

- Understand **public health priorities/actions** and agree collective response to national suicide prevention strategy 2023-2028
- Application of **NCISH (National Confidential Enquiry into Suicide and Safety in Mental Health) evidence and IMV (Integrated Motivational – Volitional) model** of suicidal behaviour to practice in NCL

Promote public awareness

- **Collaborating with Local Authority** Public Health teams to promote public awareness on sustaining mental wellbeing
- Increase public understanding of NCL direct access MH services

*Long Term Conditions Locally Commissioned Service

There are several strategic risks on the horizon that we are managing

#	Description	Management
1	**Mental Health workforce supply and retention:** There is a risk that due to shortages in clinical / professional roles within mental health services, providers struggle to secure sufficient additional capacity within a context of rising demand. There is also risk to deterioration of staff well-being and retention given rising pressures from industrial action and winter pressures.	(i) A recruitment sitrep is in place to track delivery by investment scheme against the core offer specifications at ISG; (ii) Leveraging the NCL work on workforce strategy via the workforce supply, development and transformation sub-committees by nominating provider representation in these groups to plug into wider workforce initiatives (iii) Provider initiatives to improve well-being and retention of staff within organisations. (iv) Trusts have robust winter plans and plans in place to minimise the impact of industrial action and winter planning, however there is recognition of the cumulative impact of industrial action on staff morale and ability to meet demand.
2	**Right Care Right Person implementation:** 24-May letter from Met Commissioner to health and care partners advised RCRP implementation which will significantly reduce police involvement in mental health emergencies, requiring both health and LA services to adapt and strengthen their own approaches to supporting people in mental health adversity at a time of significant capacity constraints.	(i) National implementation guidance for health and social care is expected to be published in the autumn (ii) A London wide implementation plan has been developed and sub-groups established to focus on a) communications b) data c) policy and legal framework and d) workforce and training. These groups are also looking at opportunities to develop and agree polices once for the region. There will also be ongoing monitoring and reporting of progress against this plan to the London Mental Health Board. (iii) A series of NCL Roundtable discussions are being held among senior NHS and LA leaders and Metropolitan Police Service Borough Commanders. (iv) North London MH Partnership is progressing an action plan aligned to the London's, which NCL is heavily involved in shaping and borough partners are working together on local responses to issues such as welfare checks.
3	**Fragmentation and capacity in CAMHS service provision:** There is a risk that local children and young people with mental health conditions do not access the timely, good quality mental health care: • Mental health conditions are affecting an increasing number of CYP • Suicide is the leading cause of death of YP • Most lifelong MH problems start in childhood	(i) 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 (ii) The Mental Health Core Offer for children and young people is comprehensive, relevant and clear, with a view to consistent and equitable support reaching CYP across NCL (iii) NHS CAMHS Providers are collaborating around potential shared improvement areas (iv) We will work with partners to set out how we best can respond to the fragmentation and capacity risks and case for change within CAMHS services, exploring opportunities and potential benefits of increasing vertical integration (v) Joint CAMHS performance management is being strengthened
4	**Meeting rising levels of need and promoting access to services:** Including waiting times, taking a pop health approach, equity access ratios.	(i) Further strengthen our approach to meeting rising levels of need and promoting access as part of our 24/25 planning round, in line with the ICB's population health and integrated care strategy and Core Offer (ii) This includes providing appropriate support for people with neuro developmental conditions. (iii) This core offer has been agreed for MH and is intended to achieve equitable outcomes for all parts of the population, including people and communities who are underserved.

The next steps the Mental Health programme is taking are detailed as follows:

NHS North Central London Integrated Care Board

23/24 Q3

- **Delivery of 23/24 schemes**, including recruiting against 219 additional posts
- Mental health Trusts and borough partners in NCL to develop and mobilise local **RCRP action plan** aligned to the London implementation plan
- Focus on reducing **inpatient long lengths of stay** and hospital flow through winter
- **Incorporate and represent MH estate in ICS system-wide infrastructure strategy** by Dec 23
- **New initiatives** include 12-hr breach policy, Think 111*2 first, 136 hub, rapid response
- Refresh **Experts by Experience** voices in programme delivery
- Refresh plan for **zero Out of Area Placements**

23/24 Q4

- **MHCAS** to move to permanent location
- Update adult MH community specialist service models and wider pathways
- Work with partners to set out how we best can **respond to the fragmentation and capacity risks** and **case for change within CAMHS services**, exploring opportunities and potential benefits of increasing vertical integration
- Agree **priorities for further core offer investment in 24/25** planning round, taking into account the need to further **expand and transform service delivery**.
- ICP Committee to create a **prevention concordat** for NCL and based on that sign up to national
- Progress 4 week wait target and DIALOG+ rollout
- Develop an Advancing Mental Health Equalities (AMHE) action plan for NCL

24/25 H1

- Sign-off and mobilise additional mental health investment for 24/25
- Regular reporting against NCL Mental Health **Outcomes Framework**
- Implementation of NCL '**Longer Lives**' strategic delivery plan at place
- Include MH conditions in LTC LCS and as in NCL's population segmentation
- Patient and Carers Race Equalities Framework (PCREF)

24/25 H2

- Ensure **optimisation of all mental health core offer services** by April 25
- Launch our NCL **Core Offer for rough sleepers**
- Focus on **Productivity** and Value for Money challenges

It is proposed that the Board of Members will be provided with a further update in 12 months time. Management actions relating to strategic risks and horizon scanning will be progressed through the NCL Mental Health Programme and relevant ICB committees (as applicable)

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 November 2023

Report Title	Integrated Performance and Quality Report	**Date of report**	18 October 2023	**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	Liz Sayce, Non-Executive Member Dr Chris Caldwell, Chief Nurse				
Report Author	Alex Cox, Director of Performance (Interim) Deirdre Malone, Director for Quality (Interim)	**Email / Tel**		alex.cox2@nhs.net deirdre.malone@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 and quality indicators against national and locally agreed targets relating to acute, mental health, community and primary care services. Areas of progress: • NCL are seeing steady improvements in patient flow and the reduction of the number of inappropriately placed mental health out of area patients (OAP) when compared to the same period last year. There are a number of programmes underway, such as the use of integrated discharge teams, that are reducing reliance on this bed provision. The latest data for August				

	2023 shows 442 OAPs recorded, which is a significant reduction on the August 2022 value of 668. • In respect of the NHS England (NHSE) National Cancer Programme, North Middlesex were officially moved out of Tier 1 oversight in September 2023, in recognition for reducing their 62-day pathway backlog and improving FDS performance. • The proportion of patients waiting over 6 weeks (backlog) for a diagnostic test has improved and stabilised in recent months, the net impact of increasing capacity, improving productivity, and stable demand. NCL successfully delivered the objective of the national 'Optimisation Month' initiative with a 12% reduction in diagnostic long waits between December 2022 and March 2023, in line with the National NHS initiative. Further work is underway to ensure the system remains on track to achieve the national backlog ceiling of 5% by March 2025. • NCL has made significant progress during 2023 towards eliminating the number of long-waiting patients on elective care waiting lists, with a 56% reduction of validated 78-week waiters since January 2023, to 174 as of the end of August 2023. Further reductions across all cohorts remains a priority but will be managed in the context of the adverse impact of recent industrial action. The ICB continues to lead a collaborative approach to recovering all patient backlogs as quickly as possible. • NCL general practice continues to deliver significant appointment volumes, and at an aggregate level, practices are consistently meeting the national expectation that 90% of primary care appointments are booked within 2 weeks. Further to this, 52% of NCL patients received a same day appointment, which is above the national average of 44% recorded for August 2023. Ongoing challenges and further work: • Access to community mental health services for Children & Young People (CYP) in NCL fell short of the March 2023 target (>23,000) by 30% due to staff shortages in services. With 2023/24 investment in community services including plans to recruit additional staff, improvements in performance are expected during the year. • Cancer performance is challenged across NCL for both Operating Plan metrics (62-day backlog and the Faster Diagnosis Standard) – ongoing industrial action has continued to impact services adversely. The NCL Cancer Alliance is leading a transformation programme to improve services offered to NCL patients, and this includes the optimisation of capacity through the development of an alternative pathway for breast pain, delivering waiting list initiatives to support the recovery of gynaecology services, and also streamlining access through measures such as one stop clinics and sonography training to reduce repeat scans. • Aggregate NCL performance against the A&E 4-hour had been above trajectory for the beginning of 2023 but has dipped in recent months due to ongoing industrial action and flow pressures - the latest position for September 2023 shows performance of 69.7% against a plan of 73.8%. Further work is still required to deliver the step change towards the national performance ambition of 76.0% of patients seen within 4 hours, by March 2024.

	• The number of patients spending more than 12 hours in EDs remains high, reflecting high occupancy and constraints relating to patient flows through hospitals. Demand for social and community care resources continues to exceed supply, resulting in delayed discharges. NCL is prioritising interventions that support improvements in this area such as effective use of short stay units and in some cases redesigning the capacity and use of the 'hot floor' at our most challenged sites. Significant efforts have been made over recent months to provide step-down bed capacity in community settings. Virtual ward capacity is increasing with senior medical cover from acute hospitals.
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: • STR9: Failure to Deliver the 2023/24 ICB CIP (Cost Improvement Plan including elements of Transformation Programmes) (Threat). • PERF5: Failure to deliver Cancer 62-day waiting time standard (Threat). • PERF7: Failure to manage patient flow during heightened periods of pressure, including winter, Easter and other Bank Holidays (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 once the work on the NCL Outcomes Framework is complete.
Appendices	Full dashboards for measures, and a glossary of terms used in this report are set out in the appendix for reference.

NHS
North Central London
Integrated Care Board

NCL ICB Integrated Performance & Quality Report

October 2023

Authors: 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:

- NCL system response to industrial action (slides 3 and 4)
- Primary Care (slide 5)
- Mental Health Services (slide 7)
- Community Health Services (slide 8)
- Urgent and Emergency Care (UEC) (slide 9)
- Planned Care – Electives & Diagnostics (slide 10), Cancer Services (slide 11)

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 12)
- North Middlesex Hospital (slide 12)
- Tavistock and Portman (slide 13)

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 2023/24 NHS Priorities and Operational Plan, which was submitted to NHSE in May 2023. NCL ICB are monitoring activity against the trajectories set in this plan taking account of the risks posed by ongoing industrial action. This also includes the further collaborative work with providers to deliver compliance against elective activity targets, to improve bed capacity to secure A&E performance improvement trajectories, and the efficient use of mental health beds to reduce the reliance on out of area beds.

Dashboards for performance and quality measures are included in the appendix for reference. These are used alongside regular performance reports to track and support improvement through ICB committees and system forums.

The ICB's approach to quality and performance management is designed to complement the 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 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 plans.

NCL System Response to Industrial Action (1/2)

North Central London
Integrated Care Board

Overview

Industrial action has continued across the NHS during 2023, with junior doctors taking action for 5 consecutive days in July (13th to the 17th), 5 more in August (11th to the 14th) and a further 3 in September (20th to the 22nd). Additionally, consultants have also taken action in July for 2 days (20th and the 21st), August for 2 days (24th and 25th) and then September for 2 more (19th and 20th). The latest strike took place for 72 hours in October 2023 covering the 2nd to the 5th and involved both consultants and junior doctors once more. As with previous strike action, this encompassed stoppage of non-emergency activity inclusive of night shifts and on-call duties, with the only scenarios excluded from the action being a potential major incident or a mass casualty event. Junior doctors in GP training practices have also been part of the industrial action, although GPs were expected to maintain patient access on strike days. Industrial action in September 2023 overlapped between the two staff groups for the first time, meaning that "Christmas Day" arrangements had to be maintained across services for these periods - elective activity was postponed in order of clinical priority.

Key NCL System & Provider Actions

A consistent approach to prepare for the strikes has been in place for all time periods affected, with the NCL system supporting a collective consideration of mitigations for hospital sites with the highest risk of gaps in rotas for critical areas.

Elective activity was stood down ahead of the strikes, with a focus on prioritising the provision of critical services including EDs. Multi Agency Discharge Events (MADE) continued in the lead up to strike action, focusing on reducing occupancy and facilitating discharges, with the overall aim of halving the number of beds occupied by medically optimised patients. ICU transfer services remained, but heralded bookings from NHS 111 to EDs were suspended. The London Ambulance Service provided EDs and UTCs with key support requirements when needed.

The provision of critical services was prioritised, covering crisis services, places of safety and A&E psychiatric liaison support in EDs. Consultants covered gaps during junior doctors' strike days, and services minimised outpatients and community appointments to release capacity. Additional community support was provided to bed management meetings alongside engagement with Local Authorities, to enable escalation and support for the rapid approval of placements.

Providers also operated incident coordination centres to support the delivery of services, with command-and-control structures inclusive of executive oversight, to manage proceedings and any escalations. This was supported by a system operations coordination centre as part of the real time management of services through all strike periods, which was managed via the System Coordination Centre overseen by an ICB Director and Executive lead in-hours and out-of-hours. Furthermore, regular touchpoints at Bronze, Silver and Gold level were set up across the ICS, with the NCL Clinical Advisory Group (CAG) set up to advise on any emerging clinical service change or service closure that may have been necessary. During the strike periods experienced, there were no escalations to CAG.

NCL System Response to Industrial Action (2/2)

North Central London
Integrated Care Board

Primary Care/NHS 111
Practices focused on same day urgent care activity, while there was also increased NHS111 call handler and GP out of hours capacity laid on. Primary Care bridging services provided additional capacity in each borough, which was a universal offer for all practices and NHS 111.

Community Providers
Providers reduced consultant cover in the anticipation that they would be recalled to support acute providers. Clinical directors supported wards including undertaking follow ups from ward rounds, while bed occupancy was reviewed with consultant led decisions on acuity to ensure the timely release of bed capacity. Providers also bolstered urgent community response capacity, including additional support for Silver Triage services alongside the maximisation of virtual ward capacity.

Impact of Industrial Action on Quality
Providers are reviewing any potential cumulative impact of harm on patients resulting from cancelled appointments and delays to treatment during the periods of industrial action to date. This work is supported by the quality team within the Chief Nursing Officer's Directorate working collaboratively with the ICBs Chief Medical Officer.

Overview of Primary Care

North Central London
Integrated Care Board

General practice continues to deliver significant appointment volumes, and at an aggregate level, practices are meeting the national expectation that 90% of primary care appointments are booked within 2 weeks. This data does not include evening and Saturday appointments provided by Primary Care Networks (PCNs) through the national enhanced access specification, or those provided by borough-based GP hubs, both of which contribute to both the volume of available appointments. NCL ICB continues to explore ways to improve the depth and timeliness of primary care reporting to make visible the work that primary care in NCL does on behalf of residents. This is being overseen by the Primary Care Committee.

Both NCL ICB and primary care providers are focusing their attention on responding to the requirements of the national GP Access Recovery Plan. This will require a system response to maximising digital and infrastructure offers for practices, and ensuring the right pathways are in place with community services and local pharmacies.

- Practices are being supported to move towards the 'modern general practice' operating model by ICB primary care and digital teams. They will be able to access a share of the national transition and transformation funding over the next 18 months to help them make the transition to this new way of working.
- PCNs are all delivering local Capacity and Access improvement plans, which will focus on improving patient experience, demand and capacity management, and ensuring accurate recording of activity.
- NCL ICB is working to deliver system-wide access improvement priorities (e.g., developing capacity in community pharmacies and the introduction of new self-referral pathways into community services) to support primary care. NCL ICB is working with system partners to design a comprehensive change management offer for general practice which will make use of data and insight to target support where most needed. A full report on access improvement work will come to the board in November 2023.

The NCL-wide locally commissioned service focuses on the identification and management of long-term conditions launched on October 1st, 2023. The service has an emphasis on personalised care planning and continuity of care for those who will most benefit. The service launch is accompanied by ongoing mobilisation support and training for practices, and in the first 6 months practices are likely to be asked to target improvements in key outcomes for people with hypertension or diabetes. 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 '23	Jul '23	Aug '23
Core primary care appointments	669,071	628,233	627,875
% same day appointments	50%	51%	52%
% appointments within 2 weeks	90%	91%	91%

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 – including health checks and care plan implementation, patient experience, CQC ratings and complaints
- Activity – appointments provision and uptake of various primary care support services
- Workforce – clinical and administrative FTE, uptake of the Additional Roles Reimbursement Scheme (ARRS)

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

Developing Quality Governance Processes Across Primary Care

North Central London Integrated Care Board

The NCL Population Health and Integrated Care strategy aims to move towards a system that works and learns together. Members of the Primary Care Committee and Quality and Safety Committee held a developmental session in September 2023 to explore how NCL colleagues can align quality and governance processes across the system.

Stakeholders reflected on how NCL would create a sustainable environment for new ways of working to deliver on NCL ambitions, and become a learning system through quality improvement and research by:

1. Adopting a quality improvement approach to gather insights across the system through the implementation of the Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LfPSE).

2. Collaborating with academic partners and forums to enable better understanding of the local challenges facing NCL, and allocating resources to respond to the needs of the local population.

3. Using this evidence to inform research priorities.

PSIRF fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement, with the framework replacing the Serious Incident framework from Autumn 2023. It will embed patient safety incident responses within a wider system of improvement, prompt a cultural shift towards a systematic response to patient safety, and does not mandate investigation as the single method to learning from incidents. There are opportunities to use other methods such as multidisciplinary team debriefs, huddles and after-action reviews, as appropriate.

The implementation of the PSIRF and LfPSE means that NCL can collect better data on themes about incidents that occur in Primary Care. Members of the Local Management Committee (LMC) attended the development session and intend to support Primary Care colleagues with the implementation of LfPSE. The Assistant Director for Quality, and members of the LMC will meet up to take this forward over the coming weeks.

The Performance and Quality dashboard was discussed at the Primary Care Committee in October 2023, and the team will work with the analytics and borough based Primary Care teams to delve into the data to understand the 2022/23 GP Patient Survey data, from an access and patient experience perspective.

Overview of Mental Health Services

North Central London
Integrated Care Board

Access to first treatment for Talking Therapies (IAPT) continues to be significantly challenged with August 2023 performance at 14,565 – this is below the rate required to achieve the Q2 2023 target of 22,174. Key drivers of under-performance relate to workforce recruitment and retention, coupled with a reduced number of trainees allocated to services. Providers continue their recruitment and staff wellbeing campaigns, commissioning capacity from voluntary care and digital providers, as well as increasing outreach to BAME and other protected groups, to improve performance. August 2023 data shows the recovery rate at 49% (target 50%), 6-week wait performance at 88% (target 75%) and 18-week waits above target at 99% (target 95%).

For Q1 2023, NCL failed to meet the target of 578 Out of Area Placements (OAPs), however performance shows significant improvement compared to Q1 2022. In Q2 2023, performance is currently off plan, with 442 bed days in August 2023 alone. In order to reach the Long-Term Plan target of zero OAPs by the end of 2023/24, a ten-step discharge plan based on a quality improvement approach is being implemented in NCL, with stated aims to reduce patients' mean length of stay (LOS) and improve patient flow with a focus on three key processes: pre-admission, inpatients, and discharge.

Access rates for community mental health services for Children & Young People (CYP) in NCL fell short of the 2022/23 target by 30%. By Q1 2023/24, NCL had achieved 81% of the target, with gradual increases since January 2023. CAMHS vacancy and retention rates, support teams' functions in schools not meeting access metric definitions, and patient data capture, all contributed to underperformance. With 2023/24 investment in community CAMHS relating to access, data capture and recruitment, performance is expected to continue to improve.

Memory services in NCL are developing plans to ensure delivery against the Dementia Diagnosis Rate national ambition of 67% is maintained throughout 2023/24. NCL is currently reporting at 67.9% for August 2023.

NCL is on track to meet the Q1 2023/24 CYP target in reducing inpatient episodes for people with a Learning Disability/Autism. CYP performance improved due to achieving 100% in Care, Education and Treatment Reviews (CETR) for Q1 2023 - this has reduced the average LOS from 11 months to under 5 months. Adult inpatients (ICB) have seen a 19% increase in admissions since Q4 2022/23, indicating increasing awareness and recognition of autism within NCL. Specialist Residential Service patients had legally required restrictions in place until Q4 2022/23, and this has impacted the average LOS and CETR compliance in NCL for ICB admissions.

	June '23	July '23	Aug '23
IAPT Access (YTD) *[23/24 Q2 Target: 22,174; 23/24 Y/E Target: 44,350]*	9,045	11,915	14,565
OAPs *[23/24 Target: 0]*	638	275	442
CYP MH Access (12MR) *[Q1 23/24 Target:16,822; Q2 23/24 Target: 18,075]*	16,595	16,655	TBC
Dementia Rate *[Diagnosis Target: 67%]*	68.0%	67.9%	67.9%
	Q3 22/23	**Q4 22/23**	**Q1 23/24**
LD/Autism Inpatients (ICS) *[Q1 23/24 target: 23]*	18	22	25
LD/Autism Inpatients (NHSE) *[Q1 23/24 target: 17]*	17	18	18
LD/Autism Inpatients(<18yrs) *[Q1 23/24 target: 8]*	9	5	5

Overview of Community Health Services

North Central London
Integrated Care Board

The percentage of CYP waiting 18 weeks or less reduced to 67% in August 2023 against the local agreed target of 66%, while the number of CYP waiting over 52 weeks increased by 109 when compared to the previous month. It is recognised in the system that there are long waits for some areas of children's services - autism and therapy services contribute to over 50% of the total waiting list. Following the Community Services Review and the development of the NCL core offer, the key CYP workstreams that are prioritised for transformation in 2023/24 are neurodiversity (autism), community paediatrics, nursing and therapies services. Progress and development of these programmes are being monitored at the NCL CYP Transformation Group each month.

Referral rates into CYP Community therapy services continue to be high. Numbers waiting have increased for a range of reasons including sustained high referrals, demand continuing to exceed available capacity and a reduction in provision following the end of non-recurrent recovery funding in 2022/23. New recurrent investment into outer London boroughs and transformation projects aim to improve capacity, reduce the numbers waiting and reduce referrals in the longer term.

The number of CYP waiting for formal autism assessments has seen an exponential increase in demand. As a result, waiting lists remain at unsustainable levels and the demand–capacity gap continues to widen. To improve capacity and reduce waiting times, an additional 970 assessments have been commissioned for NCL patients, with 570 provided by the NCL Neurodevelopment Assessment Hub, and 400 by the private provider Healios. This activity is scheduled to be delivered by the end of March 2024.

In August 2023, the 18-week waiting time compliance for adult community services reduced to 85% from a referral – there is not currently a locally agreed target for delivery in NCL. However, there was a reduction to 24 cases waiting over 52 weeks, when compared to July 2023. At the Whittington, the MSK waiting list has increased in recent months. A contributing factor is an internal pathway change, with referrals now sent directly for an MSK triage clinical assessment so adding to the waiting list, rather than being discharged back to the GP. Mitigating actions include Super Saturdays, extra bank shifts, and the GetUbetter-supported self-management tool being implemented. CNWL are undertaking additional validation work on podiatry waiting times which should be completed in Q3 2023, and this is likely to reduce the numbers currently reported.

	June '23	July '23	Aug '23
Waiting Times % <18 weeks (CYP) *[23/24 Target: 66%]*	69%	70%	67%
Waiting Times >52 weeks (CYP)	198	266	375
Waiting Times % <18 weeks (Adults)	86%	86%	85%
Waiting Times >52 weeks (Adults)	28	30	24

Overview of Urgent & Emergency Care Services

North Central London
Integrated Care Board

Attendance numbers to NCL EDs reduced over the summer with 5,000 fewer attendances than the average of the prior 3-month period. Despite the reduction in ED attendances, the acuity of inpatient cases and associated bed congestion led to long waits with 4-hour performance not meeting current trajectories. All NCL providers continue to work towards achieving their Operational Plan trajectories to meet the national ambition of 76% 4-hour performance by March 2024. The number of patients waiting 12 hours remains high within NCL sites and a focus for improvement.

During recent months there has been a trial of the LAS 45-minute ambulance handover protocol, where intelligent conveyancing, departmental cohorting and expedited handover arrangements have been implemented across NCL. In early August 2023 there was a significant improvement in the proportion of handovers occurring within 45 minutes from 81% to 92%. Notably there was a significant reduction in the longest handover cases as seen from May 2023 (613) to August 2023 (117). This improvement has also provided a benefit for ambulance response category 1 and 2 times. This has been due to implementation of a new handover protocol across London.

Covid-19 case numbers and associated occupied beds have been rising across London - in NCL they rose from around 50 occupied acute beds in late July 2023 to a peak of 122 on September 12th 2023, although they are slowly reducing again. The rise in cases is related to the Omicron variant and not the new BA.2.86 variant first detected in the UK on August 18th 2023. The impact of the new variant is not yet known, and the autumn vaccination programme has been brought forward as a mitigation to this.

Performance for NHS111 remains challenged despite call numbers reducing to 30,944 for August 2023, the lowest value over the last 12 months. Performance in call answering failed to improve with an average waiting time of 4 minutes and 2 seconds in August 2023. There remains bi-weekly regional demand and capacity meetings to review workforce needs and recruitment and retention initiatives.

There are plans underway focus on increased use of Same Day Emergency Care and Urgent Community Response in a bid to reduce demand on EDs, and to increase virtual ward beds to improve flow, and subsequently reduce waits to be seen. Volumes for 12-hour ED delays for patients with mental health needs remains around 200 per month, and this is mainly due to a lack of local beds - further work is being undertaken to improve supported discharge and bed flow to improve this.

	July '23	Aug '23	Sept '23
A&E 4-hour Waits *[23/24 national target – 76%]*	73.8%	72.7%	69.7%
A&E 12 Hours in Department* [From a decision to admit]	1,078	1,493	1,387
Ambulance Handover Delays (>60 minutes) *[Occasions over 60 mins]*	210	117	124
NHS 111 – Calls Abandoned *[National target <5%]*	10.8%	14.3%	TBC
Long Lengths of Stay (>21 days) *[23/24 Target – 455]*	548	566	565

**NCL 12 hour waits data from time of arrival at ED, is undergoing further validation and will be provided in future reports.*

Overview of Elective & Diagnostics Services

North Central London
Integrated Care Board

Recurrent industrial action (IA) has had a significant impact on elective capacity since March 2023. This sustained loss in capacity has continued to impact the NCL long waiting patient cohort clearance rate. Displaced cancer and urgent pathways have continued to be prioritised following strike action, ahead of complex then routine electives. It is estimated that NCL lost 5,000 elective cases and 35,000 outpatient appointments due to strikes held through Q2 2023, equating to approximately a 20-30% in elective activity, and a 10-20% reduction in outpatients, on each day with IA.

Prior to IA, NCL had reported a 60% reduction in the 78ww cohort between September 2022 and March 2023. However, this has been impacted adversely by sustained IA since March 2023, and the number of patients waiting longer than 78 weeks for treatment has now increased. NCL is forecasting a September 2023 month end position of 209 patients waiting longer than 78 weeks for treatment. The majority of these long waiting patients are attributed to capacity constraints in urology and complex paediatric services across the sector.

Elective activity levels continue to exceed the 2019/20 baseline. Key NCL interventions to reduce waiting times remain in place and cover:

- Referral optimisation – GP referrals to be managed appropriately first time.
- Improving productivity – theatre utilisation, outpatient clinics, and adopting clinical best practice pathways.
- 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 – reducing inequity in access through sharing of resources and redistribution of demand. Implementation of the National Digital Mutual Aid System (DMAS) and the Patient Initiated Mutual Aid Digital System (PIDMAS).

For diagnostics, NCL remains the top performing ICS in the country, reporting that 11.4% of patients were waiting more than 6 weeks (backlog) in August 2023. NCL System performance remains ahead of both the London regional average and the Nationally mandated ambition to date for 2023/24.

Recovery plans are being implemented by providers with support from NCL ICB and the ICS Diagnostic Programme, aimed at transforming services and increasing capacity, including the establishment of Community Diagnostic Centres. The system remains on track to achieve the national ambition of no more than 5% of patients waiting over 6 weeks by March 2025.

	July '23	Aug '23	Sept '23
RTT Waiting List *[23/24 Target – 259,133]*	267,358	269,450	*277,664**
RTT 65ww *[23/24 Target – 0]*	1,611	1,964	*2,277**
RTT 52ww *[23/24 Target – 3,088]*	7,717	7,748	*8,686**
Electives YTD *[Inpatients + Day Cases]*	109.8%	111.0%	TBC
Outpatient FU YTD *[Excluding OPPROC]*	105.5%	107.3%	TBC
Diagnostic Waits > 6 weeks	9.6%	11.4%	*13.5%**
Diagnostic Activity *[% OF 2019/20)*	107.6%	106.4%	*110.4%**

** Based on provisional data, subject to further validation*

Overview of Cancer Services

North Central London
Integrated Care Board

In respect of the NHSE National Cancer Programme, North Middlesex were officially moved out of Tier 1 oversight in September 2023, in recognition for reducing their 62-day pathway backlog and improving Faster Diagnosis Standard (FDS) performance.

Overall, performance of NCL cancer services remains variable. Challenges in the diagnostic phase of pathways continue to adversely impact the number of patients waiting 62 days or longer, which stands at 822 across NCL in the latest data for October 2023. This is an underperformance of 213 against the plan of 609. Across NCL, the latest October 2023 backlog position is driven by skin (220), urology (206) and lower GI (128) patients. For the FDS, only North Middlesex, Whittington and Moorfields are currently meeting their trajectory. The NCL Cancer Alliance has recently agreed funding to support a number of innovations led by Trusts across NCL, that will help deliver faster diagnosis and improve timely access to treatment, and patient experience.

The NCL Cancer Alliance is leading a transformation programme aimed at:

- Optimising capacity through the development of an alternative pathway for breast pain.
- Delivering WLIs to support gynaecology recovery (an additional 2,810 appointments will be delivered in 2023/24).
- Streamlining access, such as one stop clinics and sonography training to reduce repeat scans.
- Implementing Teledermatology services within suspected skin cancer services, in line with national guidance.
- Reducing radiotherapy backlogs and improving 31-day subsequent radiotherapy performance.

Skin at UCLH is the most challenged pathway, due to high demand, capacity lost to strikes, and the retirement of the MDT coordinator. UCLH have developed a recovery plan, including additional capacity using existing staff, the independent sector (IS) to deliver additional 2ww and procedure clinics, and analysing the impact of a Teledermatology pilot.

Although 31-day subsequent radiotherapy performance has improved at Royal Free and UCLH, there is still further work required to meet the standard. Mitigations include temporary increases in treatment capacity via Trusts extending operating hours, the transfer of Whittington's urology patients requiring radiotherapy from Royal Free to UCLH, exploring the utilisation of the IS to provide additional capacity, and the development of proposals to install additional LINACs.

To tackle the recurring administrative workforce shortages which adversely impact on waiting list management, providers are undertaking detailed analyses of their establishment to improve their understanding of any potential gaps. Industrial action has continued to impact cancer services. ICB analysis informs that approximately 65,364 cancer outpatient appointments have been lost as a result of strikes from February to August 2023.

	Jul '23	Aug '23	Sept '23
Cancer Waits 62-Day Backlog *[23/24 Target - 515]*	691	763	802
Cancer Diagnosis Standard (FDS) *[23/24 Target – 75%]*	71.2%	69.7%	TBC *Data is reported 6 weeks in arrears*

NCL Providers (as of Oct 8th, 2023)	Cancer Backlog as % of Waiting List
University College London	15.0%
Royal National Orthopaedic	14.5%
Royal Free London	7.5%
North Middlesex	6.2.%
Whittington Health	5.8%
England Average	**9.2%**

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. Exit criteria for 2023/24 for RFL relate to UEC, cancer and finance. The Trust is no longer in SOF3 for RTT in view of the significant progress during 2022/23 in reducing long waits.

Progress across the 3 UEC metrics has been reported in year, although August and September 2023 were challenging due to the impact of the ongoing industrial action. A&E 4-hour performance has been above trajectory for 5 of the 6 months in 2023, while 12-hour waits in ED have shown a similar pattern. Data quality issues in relation to 12-hour waits and their reporting each month have now been resolved. Trust focus has remained on short stay unit capacity (CDU and AAU) to increase flow and ease pressures on ED. Ambulance handover times have also shown good performance, and <30 minutes waits have met targets for 4 of the 6 months reported so far this year. Cohorting patients and improving flow have had a positive impact.

Cancer performance against SOF3 exit criteria, shows the 62-day backlog is reducing, although not yet meeting the agreed trajectory - 342 versus a plan of 319 for September 2023. 104-day waits are also reducing and are ahead of trajectory (121 versus 124) for September 2023. FDS improvements have been seen, although performance remains below the agreed trajectory for August 2023.

Gynaecology services remain a challenged area, however funding from the Cancer Alliance enabled additional hysteroscopy sessions to be carried out at weekends from September 2023. System-wide discussions continue regarding the impact of staff shortages on access to radiotherapy.

North Middlesex University Hospital (NMUH)

SOF3 arrangements are also in place with NMUH. Exit criteria for 2023/24 have been agreed across UEC and cancer, and mirror the metrics established for RFL trajectories to enable peer support.

For cancer, in recognition of the significant progress made on the 62-day backlog and FDS performance, it has been agreed by NCL ICB and the NHSE regional team that NMUH will move from Tier 1 to Tier 2. The weekly performance oversight meetings have been reduced and now take place on a monthly basis - the usual overall monthly performance meetings remain in place. The latest performance reported against the cancer exit criteria shows that NMUH are ahead of trajectory in all three areas – for September 2023, the 62-day backlog has reduced to 82, with 104-day waits down to 44. FDS performance is above trajectory at 70.2% against a plan for August 2023 of 68.7%.

UEC performance against the exit criteria metrics remains below agreed trajectories in recent months for 2023, although improvements have been made in all areas. Work is underway to incorporate a primary care front-of-house model to support further improvements required to meet the March 2024 A&E 4-hour target of 76%.

The NMUH ‘Go for Flow’ programme is focussing on 3 key areas – increasing discharges by midday (this is happening in surgery but needs to be extended to medicine), ensuring patients are streamed to the right place (‘right patient, right place’), and reducing delays when discharging to community services or the local authority. Delivery on the ambulance handover target has shown improvement despite a dip in September 2023 - physical capacity constraints and periods of high demand on ED continue to provide a challenge.

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 development of plans aligned to exit criteria and agreed milestones. The domains covered by the exit criteria are set out below. The oversight mechanisms includes a monthly executive group focussed on performance and improvement chaired by the ICB Executive Director of Performance and Transformation and an Oversight board chaired by NHS England.

The monthly T&P SOF Performance and Improvement meetings work alongside the SOF Oversight Board arrangements to deliver operational performance support and provide regular updates to the SOF Oversight Board.

Finance – delivery of the 2023/24 planned deficit of £2.5m is key and will be reliant on the identification and delivery of recurrent cost improvement programmes (CIPs) to achieve balance. A clear approach to deliver CIPs will be required alongside a plan to address potential improvements in financial governance, previously highlighted by Internal Audit.

Service Performance – this will focus on achievement against wating time requirements, that will be supported by service improvement plans with a focus on CAMHs. This domain will also cover work on the Gender Identity Development Service (GIDS), with oversight of T&P work to manage clinical and operational challenges whilst it remains within its control, and then the support for the transfer of services to the new service model. Improvement of the Gender Identity Clinic (GIC) productivity through pathway redesign will also feature within this domain, and focus on the mitigation of clinical risk within the service.

Care Quality – CQC recommendations will sit within this domain, alongside the updated T&P quality framework, ensuring adequate oversight of these actions.

Leadership and Governance – the new T&P Exec team now in place will look to demonstrate strengthened leadership and governance at Board level and throughout the organisation, alongside strengthened governance processes across the Trust. CQC 'Well-led' recommendations are to be implemented and monitored.

As part of the SOF 3 process, NCL ICB is working closely with partners across NCL to mobilise peer support across the other areas of the SOF exit criteria.

Appendices

Appendix 1 – NCL Balanced Scorecard

North Central London
Integrated Care Board

NCL ICS Level Scorecard (17-10-23)

	Key Performance Indicator	Target	Reporting Period	Current Performance	Trend	Year-End Forecast	Notes
ICS Finance	Bottom line (YTD)	(£51.3m)	YTD M5	(£80.9m)		(£0.0m)	*The YTD variance is mainly driven by industrial action impact (£15.4m), ERF under-performance (£6.7m) and CIP shortfall net of other benefits (£7.5m). FOT is set at plan*
	Efficiency delivery (YTD)	£84.9m	YTD M5	£65.3m		£275.9m	*Providers are currently behind on CIP delivery but forecasting to be on plan.*
	Agency Spend (YTD)	£40.8m	YTD M5	£48.0m		£97.1m	*YTD overspend on agency against 23/24 plan and a straight line extrapolation would indicate that NCL will exceed the 23/24 NHSE agency cap.*
	Capital (YTD)	£44.2m	YTD M5	£50.0m		£195.7m	*Overspend at M5 due to the phasing of the capital programme. We are undertaking a deep dive re-forecasting exercise during M6.*
	Cash (YTD)	n/a	YTD M5	£788.4m		£726.7m	*YTD cash position is a net £75m decrease in cash balances. This is equivalent to a net decrease of 6 days of cash in hand, from 56 to 50 days cash in hand.*
	ERF			(£6.7m)			*Underperformance driven by industrial action*
Performance & Quality	Ambulance handover delays	5% > 30min	w/e 15/10/23	32.2%	Steady		*The NCL position has seen improvements overall since Dec-22. All sites have seen improvements in the last month since the joint 45 min handover trial with LAS. However there has been an increase in 30 min delays at some sites. NMUH remain the most challenged site in NCL followed by BH, and whilst both use cohorting for escalation, there are often times when ambulance numbers exceed capacity.*
	A&E 4-Hr Performance	Oct '23 >75.6%	w/e 15/10/23	68.5%	Steady		*WH remains the most challenged NCL site. All providers submitted 2023/24 Operating Plan trajectories that met the national ambition to achieve the 76% target by Mar 2024.*
	Over 12 Hrs in ED	tbc	w/e 15/10/23	907	Steady		*Numbers remain high, but whilst performance has fluctuated there is an overall improved position when compared to Dec-22. BH remain the most challenged site in NCL with 15% of their attendances delayed. Data quality issues have been flagged with providers in order to assure consistency of reporting in NCL.*
	Long Length of Stay (21 Days+)	Oct '23 <512	w/e 15/10/23	603	Steady		*The NCL value has gradually increased since Aug-23. The overall NCL position has remained relatively steady over the past few weeks.*
	Elective Activity (% of 19/20)		YTD M5	111.0%	Steady		*Value represents NCL provider aggregate*
	Total Waiting List Size	Oct '23 <259,978	w/e 08/10/23	279,727	Declining	off target	*Overall the NCL waiting list size has been progressively declining. Largely driven by growth in urology and dermatology specialties in recent weeks.*
	RTT 65ww	Oct '23 <1,874	w/e 08/10/24	2,342	Declining	off target	*The Oct-23 position has been impacted by further strikes with sustained waiting list growth seen to routine and less clinically urgent waits. Recent trends suggest that NCL is unlikely to clear all 65ww by Mar-24, forecasting over 200 breaches by year end. Escalation meetings have been set up with trusts to alleviate pressures.*
	Cancer Backlog	Oct '23 <609	w/e 08/10/23	822	Steady	off target	*The NCL backlog position is largely driven by skin (220), urology (206), and lower GI (128) patients. NMUH and WH are currently meeting their trajectory.*
	Cancer Backlog - % of PTL	6.4%	w/e 08/10/23	9.0%	Steady	off target	
	Diagnostic % >6 weeks	Oct '23 <10.5%	w/e 08/10/23	12.8%	Improving		*NCL has come under pressure in terms of performance during the latest rounds of industrial action, with incremental rises in Aug and Sept-23, however, there has been some recovery in Oct-23*
	MH - IAPT Access	M5 YTD - 18,479	YTD M5	14,565	Steady		*Underperformance seen across all NCL boroughs*
	MH - Out of Area Placements	Q2 - 392	YTD M5	442	Steady		*Numbers of Out of Area Placements is exceeding anticipated target at both BEH and C&I.*
	CAMHS Access	Q2 (12MR) - 18,075	M4 (12MR)	16,655	Steady		*NCL underperformance of CYP MH access is due to lower reported levels than nationally projected, of the MHST function 1activity.*
	Never Events	0	Sept '23	0			*Represents NCL trusts' total count*
	Serious Incidents	n/a	Sept '23	21			*Represents NCL trusts' total count*
	HCAI - *C.Diff*	12 month rolling - 297	Aug '23	326			*Represents NCL ICB total cases*
	HCAI - MRSA	12 month rolling - 0	Aug '23	17			*Represents NCL ICB total cases*
Efficiency/ Workforce	WTE Substantive Staff v Plan	Op Plan	M5	-0.5%			*Values are based on the 2023/24 Operating Plan submission*
	Vacancy Rate	n/a	M5	10.9%			*UCLH, NMUH & WH are above the NCL 10.9% average*
	Sickness Rate	c4%	M2	4.3%			*NCL sickness rates have remained steady over previous reporting periods.*
	Theatre Productivity	85%	4 wks to 10/09/23	78.3%			*Value represents 'capped utilisation' - national average is 77%*
	Daycase as a % of Elective	85%	July '23	84.8%			*MEH, NMUH, RFL and WH are currently meeting the target.*
	Outpatient FU Reduction	75%	YTD M5	107.3%			*All NCL providers are over the 75% target YTD*

Appendix 2 – NCL Mental Health Dashboard (1/2)

North Central London
Integrated Care Board

North Central London ICS - Mental Health LTP/ICS Trajectories (Monthly)		TARGET 22/23 - Q2	2022/23	TARGET 22/23 - Q3	2022/23			TARGET 22/23 - Q4	2022/23			TARGET 23/24 - Q1	2023/24			TARGET 23/24 - Q2	2023/24	
			September		October	November	December		January	February	March		April	May	June		July	August
Summary of Monthly Measures	IAPT access	21,300	16,900	31,950	19,590	22,570	24,805	42,600	27,740	30,515	33,715	11,088	2,990	6,055	9,045	22,175	11,915	14,565
	IAPT recovery rate	50.0%	49.0%	50.0%	53.0%	52.0%	51.0%	50.0%	50.0%	52.4%	52.0%	50.0%	47.0%	51.0%	49.0%	50.0%	47.0%	49.0%
	IAPT first treatment 6 weeks finished course rate	75.0%	85.0%	75.0%	83.0%	83.0%	83.0%	75.0%	84.0%	83.0%	84.0%	75.0%	85.3%	85.0%	87.0%	75.0%	87.0%	87.5%
	IAPT first treatment 18 weeks finished course rate	95.0%	98.0%	95.0%	97.0%	97.0%	97.0%	95.0%	98.0%	98.2%	98.0%	95.0%	98.0%	98.0%	99.0%	95.0%	98.0%	99.1%
	CYP access - One contact	17,474	15,695	19,221	15,645	15,570	15,570	23,291	15,755	16,035	16,275	16,822	16,345	16,405	16,595	18,075	16,655	TBC
	Dementia diagnosis rate 65+	70.0%	68.4%	71.0%	TBC	TBC	TBC	73.0%	TBC	TBC	TBC	67.0%	66.3%	67.2%	68.0%	67.0%	67.9%	67.9%
	EIP entering treatment - treatment received <2wks	60.0%	79.0%	60.0%	84.0%	80.0%	83.0%	60.0%	75.0%	74.0%	72.0%	60.0%	69.0%	69.0%	78.0%	60.0%	77.0%	TBC
	Number of inappropriate OAP days (YTD by quarter)	323	1,198	822	294	905	1,847	2,270	762	1,232	1,556	578	218	413	638	392	275	442
	1 hour response time %	95.0%	96.1% (BEH)	95.0%	91.1%	91.8%	93.2%	95.0%	92.1%	94.5%	94.7%	95.0%	96.8%	96.8%	97.2%	95.0%	95.8%	96.3%
	24 hour response time %	95.0%	96.5% (BEH)	95.0%	90.8%	91.4%	94.1%	95.0%	94.3%	95.5%	96.2%	95.0%	98.2%	96.8%	95.5%	95.0%	97.1%	97.1%
	Women accessing perinatal mental health (PMH)	2,002	930	2,002	905	865	830	2,002	775	820	750	275	351	498	612	550	TBC	TBC

Appendix 2 – NCL Mental Health Dashboard (2/2)

North Central London
Integrated Care Board

North Central London ICS - Mental Health LTP/ICS Trajectories (Quarterly)		2022/23								2023/24			
		TARGET 22/23 - Q1	Q1	TARGET 22/23 - Q2	Q2	TARGET 22/23 - Q3	Q3	TARGET 22/23 - Q4	Q4	TARGET 23/24 - Q1	Q1	TARGET 23/24 - Q2	Q2
Summary of Quarterly Measures	Children and young people (CYP) eating disorders - urgent	95%	43.6%	95%	54.1%	95%	57.1%	95%	75.0%	95%	75.0%	95%	TBC
	Children and young people (CYP) eating disorders - routine	95%	25.4%	95%	27.2%	95%	28.1%	95%	34.0%	95%	84.0%	95%	TBC
	People accessing individual placement and support (IPS)	285	308	570	400	855	494	1,141	767	355	331	711	TBC
	Severe mental illness - physical health check (SMI-PHC)	10,142	8,567	10,909	8,949	11,677	10,342	12,445	13,322	13,498	11,388	13,674	11,008
	Adult Community Access	16,795	15,200	17,825	14,985	18,555	14,945	19,887	14,805	16,627	14,910	18,248	TBC
	Learning disabilities - annual health checks	12.4%	17.0%	29.4%	37.4%	49.2%	59.5%	75%	90.3%	12%	15.7%	29%	34.7%
	Learning disabilities - adult inpatients (ICS Commissioned)	26	27	24	20	22	18	22	22	23	25	23	TBC
	Learning disabilities - adult inpatients (NHSE Commissioned)	19	16	19	18	16	17	16	18	17	18	16	TBC
	Learning disabilities - CYP inpatients	5	6	5	8	5	9	5	5	8	5	7	TBC

Appendix 3 – NCL Acute Dashboard

North Central London
Integrated Care Board

NHS NCL ICB - Selected Acute Services		2022/23							2023/24				
		September	October	November	December	January	February	March	April	May	June	July	August
UEC	*4-Hour AE performance target*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*70.1%*	*70.5%*	*71.9%*	*72.7%*	*73.8%*
	4-Hour AE performance	68.6%	66.5%	67.1%	61.8%	69.8%	67.7%	68.4%	71.3%	70.6%	72.8%	73.8%	72.7%
	12 hour waits	1,309	1,722	1,484	2,003	2,031	1,653	1,586	1,054	1,614	1,343	1,078	1,493
	LAS handovers	6,058	5,815	5,943	5,332	5,993	5,648	6,451	6,589	6,381	6,111	7,099	7,082
	Ambulance handovers 30 min+	2,392	2,453	2,259	2,441	2,272	2,011	2,542	2,183	2,191	2,065	1,894	1,996
	Ambulance handovers 60 min+	783	1,008	866	1,251	837	720	889	589	753	613	210	117
RTT	*New RTT pathways (clockstarts) plan*	*57,639*	*57,788*	*58,686*	*49,012*	*55,305*	*54,398*	*54,751*	*52,262*	*60,400*	*58,575*	*58,005*	*58,678*
	New RTT pathways (clockstarts)	58,004	61,870	63,712	50,549	61,568	59,707	69,287	55,756	63,559	64,858	62,169	61,821
	RTT incompletes plan	*249,050*	*248,613*	*247,659*	*248,886*	*248,766*	*248,614*	*247,754*	*259,555*	*261,219*	*261,938*	*261,127*	*260,675*
	RTT incompletes	248,517	251,186	252,172	254,630	251,934	255,892	259,535	262,516	264,929	267,490	267,358	269,450
	52+ waits plan	*5,454*	*5,462*	*6,729*	*6,468*	*7,311*	*7,580*	*7,186*	*5,962*	*6,624*	*6,392*	*6,088*	*6,297*
	52+ waits	7,285	7,090	7,095	6,699	6,152	6,162	6,289	6,710	7,048	7,170	7,717	7,748
	65+ waits plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*2,379*	*2,728*	*2,473*	*2,365*	*2,526*
	65+ waits	2,350	2,205	1,985	2,026	1,798	1,593	1,231	1,250	1,391	1,527	1,611	1,964
Diagnostics	*Imaging plan*	*56,591*	*57,123*	*58,799*	*53,323*	*58,371*	*55,206*	*57,740*	*48,306*	*54,129*	*51,967*	*52,436*	*52,435*
	Imaging activity	62,108	60,390	64,524	54,979	63,316	61,216	68,236	57,313	63,721	67,854	64,511	63,917
	Endoscopy plan	*4,298*	*4,277*	*4,437*	*3,911*	*4,210*	*4,215*	*3,966*	*4,004*	*4,481*	*4,167*	*4,604*	*4,197*
	Endoscopy activity	3,784	3,416	3,939	2,976	3,757	3,647	4,651	3,889	4,036	4,489	4,194	4,073
	Total diagnostic 6+ weeks	4,857	3,473	3,366	4,237	4,754	3,232	3,503	4,596	4,467	4,447	3,997	4,534
	Total diagnostic 6+ weeks achievement	87.7%	90.8%	91.6%	88.8%	88.1%	92.2%	91.3%	88.5%	89.4%	89.4%	90.4%	88.6%
Cancer	*62+ backlog plan*	*518*	*769*	*702*	*636*	*563*	*521*	*488*	*748*	*725*	*701*	*679*	*651*
	62+ backlog	866	915	753	884	782	656	665	752	742	723	691	763
	104+ waits plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*340*	*346*	*324*	*307*	*291*
	104+ waits	358	362	320	349	340	342	345	341	330	345	355	332
	28-day FDS plan	*75.0%*	*75.0%*	*75.0%*	*75.0%*	*75.0%*	*75.0%*	*75.0%*	*69.8%*	*72.1%*	*72.2%*	*74.3%*	*75.1%*
	28-day FDS achievement	71.6%	69.7%	69.8%	69.8%	65.4%	72.6%	73.1%	69.9%	66.9%	68.0%	71.2%	69.7%
Beds	*Average G&A beds occupancy plan*	*94.3%*	*93.6%*	*94.6%*	*93.1%*	*93.5%*	*93.9%*	*93.9%*	*95.8%*	*95.4%*	*95.3%*	*95.7%*	*95.4%*
	Average adult G&A beds occupancy	94.9%	95.1%	94.9%	93.8%	95.3%	94.9%	94.6%	91.8%	92.6%	92.4%	89.5%	90.4%
	Average adult CC beds occupancy plan	*78.9%*	*79.5%*	*78.9%*	*78.4%*	*80.0%*	*80.0%*	*79.5%*	*79.8%*	*79.3%*	*79.8%*	*80.3%*	*79.7%*
	Average adult CC beds occupancy	76.5%	79.3%	82.4%	82.5%	82.5%	79.0%	80.9%	78.6%	82.4%	77.0%	79.6%	81.8%
	Length of stay 21+ plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*541*	*548*	*529*	*520*	*516*
	Length of stay 21+	554	559	528	504	577	566	576	591	578	553	548	566

Appendix 4 – Glossary of Terms and Abbreviations

North Central London
Integrated Care Board

Serious Incident	Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff for organisations are so significant or the potential for learning is so great, that a heightened level of response is justified
Never Event	Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers
VTE Risk Assessment	Venous Thromboembolism Risk Assessment completion rate
HCAI	Healthcare Acquired Infection
CDiff	Clostridium difficile infection
MRSA	Methicillin-resistant Staphylococcus Aureus
FFT	Friends and Family Test – the FFT asks people if they would recommend the services they have used and offers a range of responses
SHMI	Summary Hospital-level Mortality Indicator - The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there
12 Hour Breach	The number of patient attendances to the Emergency Department spending over 12 hours from arrival to being transferred, admitted or discharged
Mixed Sex Accommodation	The number of occurrences of unjustified mixing in relation to sleeping accommodation
SOF	System Oversight Framework
Out of Area Placement (OAP)	An inappropriate OAP occurs where patients are sent out of area because no bed is available for them locally
RTT	Referral to Treatment – the length of time (in weeks) that a patient is waiting from referral for a non-emergency consultant-led treatment, to start of treatment.
UTC	Urgent Treatment Centre - GP led centres that offer appointments booked via NHS 111 or through a GP referral, which are an alternative to A&E for common/minor ailments.
MADE	Multi Agency Discharge Event – brings together resource to support patient flow, unblock delays, and simplify complex discharge processes.
ED	Emergency Department
PCN	Primary Care Network - GP practices working with local community, mental health, social care, pharmacy, hospital and voluntary services in groups
CQC	Care Quality Commission - independent regulator of health and social care in England
VCS	Voluntary and community sector
PTL	Patient Tracking List - a list of patients who need to be treated by given dates in order to start treatment within specified waiting times set out in NHS guidance.
SDEC	Same Day Emergency Care

NHS
North Central London
Integrated Care Board

North Central London ICB
Board Committee Meeting
7 November 2023

Report Title	Month 6 Finance Board Report	**Date of report**	18 October 2023	**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** NCL ICS is reporting a £87.6m deficit at Month 6 representing an adverse variance of £30.7m against the YTD plan. Without the impact of industrial action there would be a favourable variance at Month 6 of £2.7m. The ICB reports a year to date (YTD) and forecast breakeven position against plan.			
Report Summary	The System submitted a final 2023/24 balanced plan on 17 May 2023. As part of this the ICB submitted a surplus plan of £10.6m. The reported surplus position is required to ensure the overall System can report a breakeven position. However, the ICB plan is subject to the achievement of a number of challenging targets including full achievement of the ICB's efficiency target, £25.6m and additional pay vacancy and non-pay running cost efficiencies of £4.5m and £0.7m respectively. The plan also assumed full mitigation of a substantial risk profile, currently £53.7m as at Month 6 (risk adjusted). For Month 6 (September 2023) the ICB reports a year to date (YTD) and forecast breakeven position against plan. There are forecast adverse variances reported within Non-Acute and is mainly driven by Hospital Discharge pressures (£3.4m) and staffing & support pressures (£0.4m) reported within Continuing Care, CIP slippage of £1.8m reported within Prescribing, and increased activity within Audiology and Gynaecology Services reported within Community (£0.7m). Acute reports a forecast adverse variance of £2.4m and is driven by increased activity within Independent Sector. All forecast pressures are offset by the release of non-recurrent measures reported within Other Programme Services. The ICB reports a balanced risk position at Month 6.				

	The ICS reports full achievement of this year's efficiency targets at c£229.5m. The ICB efficiency target is £25.6m and as at Month 6 forecasts c23.6m against this target, leaving c£1.9m currently underachieved. The unachieved efficiency is mitigated by use of non-recurrent benefits to ensure the ICB reports a breakeven position against plan. Unachieved efficiencies impacts on the underlying financial position (ULP) of the ICB, which adversely impacts on the 2023/24 financial planning
Recommendation	The Board of Members is asked to **NOTE** the contents of this report.
Identified Risks and Risk Management Actions	Total risks have been identified as c£80.5m, which has been risk adjusted to c£53.7m based on the likelihood of risks materialising. The ICB reports a fully mitigated risk position for Month 6. However, within this the ICB reports a net risk position of c.£23.7m, which will need to be addressed via an in-year recovery programme. The use of non-recurrent mitigations to cover recurrent risks will impact on the ICB's underlying financial position, adversely affecting the ICBs starting position in 2024/25. NCL ICS is reporting a net system risk of c.£70m at Month 6, mainly relating to contractual issues, efficiency delivery and additional costs such as winter pressures. The system risk position will be reviewed again at Month 6 in light of reported YTD performance.
Conflicts of Interest	This paper was written in accordance with the Conflicts of Interest Policy.
Resource Implications	The ICB has a net risk position of £23.7m, requiring an in-year recovery programme. If non-recurrent measures are used to mitigate recurrent spend, this will impact the ICB's underlying position and the opening plan for 2024/25.
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.

NHS
North Central London
Integrated Care Board

Month 6 Finance Board Report

September 2023

Contents Page

North Central London
Integrated Care Board

NHS
North Central London
Integrated Care Board

NCL ICS Financial Position 23/24 – Month 6 (Sep'23)

NCL ICS M6 Financial Position

North Central London
Integrated Care Board

NCL ICS is reporting a £87.6m deficit at Month 6 representing an adverse variance of £30.7m against the YTD plan. Without the impact of industrial action there would be a favourable variance at Month 6 of £2.4m.

M6 Financial Position Overview - Revenue

Year to date

- NCL ICS reported a YTD deficit of £87.6m at Month 6 which is adverse to plan by £30.7m.

	NCL M5 – M6 YTD variance		
	M5	M6	Movement
	£'m	£'m	£'m
System adverse variance	**(29.6)**	**(30.7)**	**(1.1)**
Adverse variance explained by IA	**(31.8)**	**(33.1)**	**(1.4)**
Comprised of:	-	-	-
Direct IA costs	(12.1)	(14.7)	(2.6)
Other IA costs	2.5	6.1	3.6
ERF under performance (due to IA)	(22.1)	(24.5)	(2.4)
Favourable variance excluding IA	**2.1**	**2.4**	**0.2**
Comprised of:	-	-	-
ERF (excluding IA impact)	9.6	9.3	(0.3)
CIP shortfall and other	(7.5)	(6.9)	0.5

- Of the system adverse variance of £30.7m at Month 6:
  - Issues relating to Industrial action comes to £33.1m.
  - This means that excluding the impact of Industrial action there would be a favourable variance at Month 6 of £2.4m.
- Of the adverse variance increase of £1.1m between Month 5 and Month 6:
  - Costs relating to issues relating to Industrial action have increased by a net £1.4m.
  - Excluding issues relating to Industrial action there is a favourable movement of £0.2m.

	M6 Year to date			M6 Forecast Outturn			Straight-line Run Rate		
Organisation	YTD Plan (17th May submission)	YTD Actual	YTD Variance	Annual Plan (17th May submission)	Forecast Outturn	FOT Variance	23/24 M5 Straight-line Run Rate	23/24 M6 Straight-line Run rate	Improvement/ (Deterioration)
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Trust Total	(62.1)	(92.9)	(30.7)	(10.6)	(10.6)	(0.0)	(204.7)	(185.7)	19.0
NCL ICB	5.3	5.3	0.0	10.6	10.6	-	10.6	10.6	(0.0)
System Total	**(56.8)**	**(87.6)**	**(30.7)**	**0.0**	**0.0**	**(0.0)**	**(194.1)**	**(175.1)**	**19.0**

Year to date (Contd)

- The favourable variance excluding Industrial action is understated because CIP delivery has also been affected because of leadership and operational focus on Industrial Action management. However, this is difficult to quantify.

Forecast outturn at Month 6

- The NCL system FOT remains in line with plan with all organisations within NCL reporting a forecast outturn unchanged from plan.

23/24 Run rate position at Month 6

- There is an improvement in the straight-line run rate for most providers between M5 and M6.

Risk at Month 6

- NCL is reporting a net system risk of c.£70m at Month 6, mainly relating to contractual issues, efficiency delivery and additional costs such as winter pressures. The system risk position will be reviewed again at Month 7 in light of reported YTD performance.

NCL ICS Month 6 Financial Position (cont.)

North Central London
Integrated Care Board

Month 6 Financial Position Overview (cont.)

Capital position at Month 6

- Providers are reporting YTD overspends of £8.1m across the NCL capital programme at Month 6. The adverse variance is mainly driven by delays in deliveries due in 22/23 at UCLH and phasing of the 23/24 plan at RFL and WHIT.
- On national programmes, providers are reporting underspends of £6.5m driven mainly by the St Pancras transformation and delays in digital diagnostic programmes.
- FOT for the ICS programme is underspend by £1.9m due to a transfer of capital allocation to Primary care in the ICB, i.e. the ICS capital programme is being fully utilised.
- The national programme is forecasting an overspend of £6.6m, however this is presentational only. This relates to spend being forecasted against schemes which do not yet have a plan set in the Provider Finance Return (PFR) while awaiting MoUs to be finalised.

Provider efficiency savings at M6

- The 23/24 plan for NCL providers assumes delivery of £82.2m of efficiency savings by Month 6.
- As of Month 6, providers were reporting YTD savings of £63.4m which is behind plan by £18.8m and represents delivery of 27.6% of the total savings requirement for 23/24 which is 22.8% behind the Month 6 YTD plan.
- All providers are currently behind on CIP delivery at Month 6.
- All providers in NCL are forecasting full delivery of their respective savings programmes for 23/24.
- While the annual plan assumed c.80% of CIP to be delivered to be recurrent in nature, at Month 6 c.60% of CIP delivered to date is recurrent. A change of 20% in recurrent CIP delivery has an adverse impact of £46m on a full year basis, adversely affecting the opening plan position for 24/25.

Provider agency at M6

- Agency is overspending at Month 6 by £8.7m. A straight-line extrapolation of the Month 6 usage comes to £113.9m which would exceed the £104.1m system target. This is also higher than the 22/23 spend on agency of £111.6m.

	M6 ICS Capital Programme					
	YTD Plan M6	YTD Actual M6	YTD Variance M6	Annual Plan 23/24	FOT 23/24	Variance 23/24
Organisation	£'m	£'m	£'m	£'m	£'m	£'m
ICS Capital Programme	58.3	66.4	(8.1)	195.7	193.8	1.9
National Funding	62.3	55.8	6.5	108.3	114.9	(6.6)

	M6 Efficiency Savings							
	Efficiencies YTD				Efficiencies FOT			
Organisation	M6 Plan YTD	M6 Actual YTD	M6 Variance YTD	M6 Variance YTD	M6 Plan FOT	M6 Actual FOT	M6 Variance FOT	M6 Variance FOT
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Total provider efficiencies	82.2	63.4	(18.8)	(22.8%)	229.5	229.5	(0.0)	0.0%

	M6 Agency								
	M6 Year to date				M6 FOT				
Provider Agency Cap	YTD Plan £'m	YTD Actual £'m	Variance £'m	Variance %	YTD Plan £'m	YTD Actual £'m	Variance £'m	Variance %	23/24 M6 Straight-line Run rate £'000
Total Provider Agency Spend	48.2	56.9	(8.7)	(18.0%)	93.6	97.1	(3.5)	(3.7%)	113.9
System level agency cap					104.1				

NHS
North Central London
Integrated Care Board

NCL ICB Financial Position 23/24 – Month 6 (Sep'23)

Month 6 Summary Position

North Central London
Integrated Care Board

Month 6 Summary Position

Background

The System submitted a final 2023/24 balanced plan on 17th May. As part of this the ICB submitted a surplus plan of £10.6m. The reported surplus position is required to ensure the overall System can report a breakeven position.

However, the ICB plan is subject to the achievement of a number of challenging targets including full achievement of the ICB's efficiency target, £25.6m and additional pay vacancy and non-pay running cost efficiencies of £4.5m and £0.7m respectively. The plan also assumed full mitigation of a substantial risk profile, currently £53.7m as at Month 6 (risk adjusted).

Month 6 (September 2023)

For Month 6 (Sep'23) the ICB reports a year to date (YTD) and forecast breakeven position against plan.

The forecast adverse variances reported within Non-Acute is mainly driven by Hospital Discharge pressures (**£3.4m**) and staffing & support pressures (**£0.4m**) reported within Continuing Care, CIP slippage of **£1.8m** reported within Prescribing, and increased activity within Audiology and Gynaecology Services reported within Community (**£0.7m**). The Acute forecast adverse variance of **£2.4m** is driven by increased activity within Independent Sector. Forecast pressures are offset by the release of non-recurrent measures reported within Other Programme Services.

Summary financial position (£m)

	YTD			Full Year		
	Bud	Actual	Var	Bud	FOT	Var
	£m	£m	£m	£m	£m	£m
Revenue Resource Limit	**1,761.3**	**1,761.3**	**0.0**	**3,500.8**	**3,500.8**	**0.0**
Acute	859.7	860.5	0.8	1,706.3	1,708.7	2.4
Non-Acute	822.8	823.8	1.1	1,638.2	1,644.6	6.3
Other Pgrm Services	38.8	37.0	(1.8)	77.6	67.7	(9.9)
Running Costs	14.3	14.0	(0.3)	27.1	28.1	1.1
COVID-19 Costs	20.5	20.7	0.2	41.0	41.0	0.0
Total Operational	**1,756.0**	**1,756.0**	**(0.0)**	**3,490.2**	**3,490.2**	**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	**1,756.0**	**1,756.0**	**(0.0)**	**3,490.2**	**3,490.2**	**0.0**
Surplus / (Deficit)	**5.3**	**5.3**	**0.0**	**10.6**	**10.6**	**(0.0)**

Month 6 Summary Position (cont.)

North Central London
Integrated Care Board

Month 6 Summary Position

Key points to note

The below summarises the reported **YTD** and **FOT** variances. A detailed variance analysis is available on slide 11 for YTD and slide 12 for FOT.

Year to date (YTD)

Below are the key adverse variances reported Month 6:

- **£2.0m** reported within Continuing Care driven mainly by Hospital Discharge pressures,
- **£1.0m** reported within Acute driven by increased activity within Independent Sector,
- **£0.9m** reported within Primary Care Prescribing due to slippage in the achievement of this year's CIP target,
- **£0.4m** reported within Community due to increased activity within Audiology and Gynaecology Services.

The above has been offset by the favourable position reported within Dental, Ophthalmic & Pharmacy due to baseline dental performance being lower than budget (**£2.2m**) but is expected to breakeven for the full year. A favourable position is also reported within Other Programme Services due to the release of non-recurrent measures to ensure the ICB is able to report a breakeven position against plan (**£1.8m**), and within Running Costs mainly due to underspends reported against budgets reported within Corporate Affairs (**£0.3m**).

Forecast Outturn (FOT)

Below are the key adverse variances reported Month 6:

- **£3.8m** reported within Continuing Care due to pressures within Hospital Discharge (£3.4m) and staffing & support pressures (£0.4m),
- **£2.4m** reported in Acute driven by increased activity within Independent Sector,
- **£1.8m** reported within Primary Care Prescribing due to slippage in the achievement of this year's CIP target,
- **£1.1m** reported within Running costs due to slippage against this year's staffing efficiency target. The running cost budget is lower than the allocation received so although the ICB reports an adverse variance against budget, the ICB is reporting a favourable variance against the allocation,
- **£0.7m** reported within Community due to increased activity within Audiology and Gynaecology Services.

The above has been offset by the release of non-recurrent measures reported in Other Programme Services to ensure the ICB reports a breakeven position against plan.

Month 6 Summary Position (cont.)

North Central London
Integrated Care Board

Month 6 Summary Position

Pay

The below tables summarises the Month 6 pay position split between Programme and Running Cost. The YTD position is a favourable variance of £0.3m.

The favourable forecast pay variance of £1.6m is mainly due to the ICB holding vacancies. Included in the figures is the pay vacancy efficiency target of £4.5m (Running Cost £2.6m and Programme £1.9m). The use of Income/Non Pay budgets relates to funding coming from Hospital Discharge (£1.3m).

The current pay forecast assumes that all vacancies are held to the end of the financial year. This may change if future recruitment is undertaken

Running/Programme	Budgeted WTE	YTD Budget	YTD Actual	YTD Variance (Fav)/Adv	Annual Budget	Forecast Outturn	Forecast Variance (Fav)/Adv	Use of Income and Non Pay budgets	Revised Forecast Variance incl. Income/Non Pay (Fav)/Adv
	WTE	£000	£000	£000	£000	£000	£000	£000	£000
Running	272	11,560	11,811	252	21,576	22,783	1,207	0	1,207
Programme	535	19,481	18,884	(596)	38,961	37,456	(1,506)	(1,321)	(2,826)
	807	**31,041**	**30,696**	**(345)**	**60,537**	**60,239**	**(299)**	**(1,321)**	**(1,619)**

Month 6 Summary Position (cont.)

North Central London
Integrated Care Board

Month 6 Summary Position

Efficiencies

To deliver the 2023/24 financial plan the ICB is required to deliver £25.6m of recurrent efficiencies. The efficiency forecasts currently stands at c£23.6m against this essential target, leaving c£1.9m currently underachieved. The unachieved efficiency is mitigated by use of non-recurrent benefits to ensure the ICB reports a breakeven position against plan. Unachieved efficiencies impacts on the underlying financial position (ULP) of the ICB, which adversely impacts on the 2023/24 financial planning.

Use of Non-Recurrent Funds

During 2023/24 planning the ICB committed the use of c£15m of non-recurrent funding in order to achieve a breakeven position for the system as a whole. As at Month 6 the level of non-recurrent support that we expect to use has reduced to c£8.3m, which is reported within risks. The use of non-recurrent measures to support recurrent expenditure will adversely affect the ICBs underlying position. We are working with all budget holders to maximise the use of recurrent solutions.

Risks & Mitigations

Total risks have been identified as c£80.5m, which has been risk adjusted to c£53.7m based on the likelihood of risks materialising.

The ICB reports a fully mitigated risk position for Month 6. However, within this the ICB reports a net risk position of c£23.7m, which will need to be addressed via an in-year recovery programme. The use of non-recurrent mitigations to cover recurrent risks will impact on the ICB's underlying financial position, adversely affecting the ICBs starting position in 2024/25.

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	Actual	Variance	
	£m	£m	£m	
Allocations				
In year allocations	1,761.3	1,761.3	0.0	
Total Allocations	**1,761.3**	**1,761.3**	**0.0**	
Expenditure				
Acute	877.7	878.7	1.0	**Adverse Variance:** Due to increased activity within Independent Sector
Non-Acute				
Mental Health & LD	219.4	219.4	0.0	
Delegated Commissioning	148.9	148.9	0.0	
Community Services	179.9	180.3	0.4	**Adverse Variance:** Due to increased activity within Audiology and Gynaecology Services.
Primary Care	23.4	23.5	0.0	
Primary Care - Prescribing	102.7	103.6	0.9	**Adverse Variance:** Due to slippage in achievement of this year's CIP target
Primary Care - Dental, Ophthalmic & Pharmacy	78.3	76.1	(2.2)	**Favourable Variance:** Due to baseline dental performance being lower than budget, expected to breakeven for the full year
Continuing Care	70.1	72.1	2.0	**Adverse Variance:** Due to Hospital Discharge pressures, and staffing & support pressures
Total	**822.8**	**823.9**	**1.1**	
Other Programme Services & Running Costs				
Other Programme Services	41.2	39.4	(1.8)	**Favourable Variance:** Due to the release of non-recurrent measures to enable the ICB to report a breakeven position
Running Costs	14.3	14.0	(0.3)	**Favourable Variance:** Mainly driven by underspends within the Corporate Affairs
Total	**55.5**	**53.4**	**(2.1)**	
Total Expenditure	**1,756.0**	**1,756.0**	**(0.0)**	
Surplus / (Deficit)	**5.3**	**5.3**	**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	3,500.8	3,500.8	0.0	
Total Allocations	**3,500.8**	**3,500.8**	**0.0**	
Expenditure				
Acute	1,742.4	1,744.8	2.4	**Adverse Variance:** Due to increased activity within Independent Sector
Non-Acute				
Mental Health & LD	438.9	438.9	0.0	
Delegated Commissioning	290.9	290.9	0.0	
Community Services	359.8	360.5	0.7	**Adverse Variance:** Due to increased activity within Audiology and Gynaecology Services
Primary Care	46.9	46.9	0.0	
Primary Care - Prescribing	205.4	207.3	1.8	**Adverse Variance:** Due to slippage in achievement of this year's CIP target
Primary Care - Dental, Ophthalmic & Pharmacy	156.2	156.2	0.0	
Continuing Care	140.2	143.9	3.8	**Adverse Variance:** Due to Hospital Discharge pressures, and staffing & support pressures
Total	**1,638.3**	**1,644.6**	**6.4**	
Other Programme Services & Running Costs				
Other Programme Services	82.4	72.6	(9.9)	**Favourable Variance:** Due to the release of non-recurrent measures to enable the ICB to report a breakeven position
Running Costs	27.1	28.1	1.1	**Adverse Variance:** Due to slippage against staffing efficiency targets. The running cost budget is lower than the allocation received so although the ICB reports an adverse variance against budget, the ICB is reporting a favourable variance against the allocation
Total	**109.5**	**100.7**	**(8.8)**	
Total Expenditure	**3,490.2**	**3,490.2**	**0.0**	
Surplus / (Deficit)	**10.6**	**10.6**	**(0.0)**	

Month 6 Risks & Mitigations

North Central London
Integrated Care Board

Risk Summary

Directorate	Risk value Month 6 £'000	% RAG rating	Rag Rating	Risk value adjusted Month 6 £'000	Comments
RISKS					
Continuing Healthcare Team	20,965	70%		14,733	Discharge to access (D2A), uplift pressures and activity/price exceeding plan, and non delivery of efficiency targets
Acute - Variable Element of Block Contract	12,500	80%		10,000	Increased costs within High cost drugs and devices
Primary Care - Prescribing	19,090	47%		8,891	Risk of growth increasing to London average, and non delivery of efficiency targets
Acute Other	6,623	93%		6,175	£4.5m additional cost for LAS, Increased activity in Independent sector £0.9m, Termination of Pregnancy (TOPS) tariff changes £0.5m, and non delivery of efficiency targets £0.3m
Change Management Programme	7,000	80%		5,600	Includes transition costs and potential redundancies
Non-Recurrent funds	8,272	50%		4,136	Identified planning gap
Primary Care	3,762	66%		2,493	Potential pressures within GPIT & Systems for licences, and non delivery of efficiency targets
Other	2,335	70%		1,635	VOID cost pressures and non delivery of efficiency targets
TOTAL RISKS	**80,547**	**67%**		**53,663**	
MITIGATIONS					
Mitigations identified	(33,068)	91%		(29,972)	
TOTAL Mitigations	**(33,068)**	**91%**		**(29,972)**	
NET RISK POSITION	**47,479**	**50%**		**23,691**	
Mitigations required	*(47,479)*	50%		*(23,691)*	
REPORTED RISK POSITION	**0**	**0%**		**0**	

Month 6 Risk Position

Total risks have been identified as c£80.5m, which has been risk adjusted to c£53.7m based on the like likelihood of risks materialising.

Over half of the risk adjusted value sits within Acute services and Continuing Healthcare (CHC). The Acute risks mainly centre around High-Cost Drugs & Devices, as well as unbundled diagnostics (c£10.0m) and pressures within the LAS contract (c£4.5m). The CHC risks centre around D2A, uplift, and activity/price pressures.

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 c£30.0m. This leaves the ICB with a net risk position of c£23.7m, which will need to be covered via an in-year recovery programme.

North Central London
Integrated Care Board

Financial Accounts

Appendices

Appendix 1 - Income & Expenditure
Appendix 2 - Cash Flow Statement
Appendix 3 – Block Contracts

Appendix 1 - Income & Expenditure

	2023/24 In-Month AP6 - SEP 23			2023/24 Year to Date AP6 - SEP 23			2023/24 Annual Forecast			2022/23 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	(1,129)	(1,129)	0	(6,772)	(6,772)	0	(13,545)	(13,545)	0	0	0
Education, training and research	0	0	0	0	0	0	0	0	0	0	0	0
Non-patient care services to other bodies	0	(1,755)	(1,755)	0	(10,470)	(10,470)	0	(20,877)	(20,877)	(60)	(18,898)	(18,958)
Other Contract income	0	32	32	0	(106)	(106)	0	(219)	(219)	(1,062)	(3,977)	(5,040)
Other non contract revenue	0	819	819	0	(5,754)	(5,754)	0	(12,814)	(12,814)	0	0	0
Total Operating revenue	**0**	**(2,033)**	**(2,033)**	**0**	**(23,103)**	**(23,103)**	**0**	**(47,454)**	**(47,454)**	**(1,122)**	**(22,875)**	**(23,997)**
Operating Expenses	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Expenses												
Perm E/ees - Salaries and Wages	1,365	1,875	3,240	8,294	11,698	19,992	14,958	21,671	36,630	13,841	16,299	30,139
Perm E/ees - Social Security Costs	165	248	413	1,015	1,518	2,533	2,717	4,161	6,878	1,552	2,162	3,714
Perm E/ees - Em/er Contribs to NHS Pension	188	324	512	1,122	2,003	3,125	2,831	4,336	7,167	3,274	2,634	5,908
Perm E/ees - Apprenticeship Levy	17	0	17	129	0	129	259	0	259	135	0	135
Perm E/ees - Termination benefits	0	0	0	0	0	0	0	0	0	387	0	387
Other E/ees - Salaries and Wages	127	183	310	1,160	2,792	3,953	2,079	5,099	7,178	2,027	4,281	6,307
Total Gross employee expenses	**1,861**	**2,631**	**4,492**	**11,722**	**18,011**	**29,732**	**22,844**	**35,268**	**58,112**	**21,215**	**25,375**	**46,590**
Other Operating Expenses												
Services from other CCGs and NHS England	0	3	3	33	62	95	79	130	209	40	15	55
Services from foundation trusts	0	110,066	110,066	0	642,756	642,756	0	1,277,492	1,277,492	0	946,446	946,446
Services from other NHS trusts	0	97,217	97,217	0	554,106	554,106	0	1,105,618	1,105,618	0	817,952	817,952
Purchase of healthcare from non-NHS bodies	0	27,186	27,186	0	198,686	198,686	0	392,489	392,489	0	296,026	296,026
Purchase of social care	0	575	575	0	3,453	3,453	0	6,906	6,906	0	5,131	5,131
Chair and Non Executive Members	26	0	26	158	0	158	198	0	198	188	88	276
Supplies and services – clinical	0	132	132	0	792	792	0	1,584	1,584	0	1,194	1,194
Supplies and services – general	123	598	721	814	19,040	19,854	2,322	32,114	34,436	2,625	17,371	19,996
Consultancy services	5	312	317	0	312	312	0	0	0	0	1,230	1,230
Establishment	10	273	283	165	1,568	1,732	431	3,843	4,274	567	2,926	3,493
Transport	0	0	0	1	(0)	0	0	0	0	1	1	3
Premises	18	218	236	127	2,339	2,466	313	4,144	4,457	343	2,503	2,846
Depreciation	84	0	84	505	0	505	908	0	908	726	0	726
Audit fees	20	0	20	120	0	120	240	0	240	224	0	224
· Internal audit services	24	0	24	119	0	119	217	0	217	129	0	129
· Other services	0	0	0	0	0	0	0	0	0	26	0	26
Prescribing costs	0	17,813	17,813	0	103,651	103,651	0	207,328	207,328	0	156,184	156,184
Pharmaceutical services	0	3,680	3,680	0	22,083	22,083	0	44,014	44,014	0	0	0
GPMS/APMS and PCTMS	0	25,115	25,115	0	150,440	150,440	0	296,779	296,779	0	224,113	224,113
Other professional fees excl. audit	13	142	155	85	872	957	68	2,188	2,256	177	1,911	2,088
Legal Fees	18	14	33	82	129	211	234	258	492	124	76	199
Education and training	(14)	80	66	47	344	391	231	1,066	1,297	244	1,373	1,617
Other expenditure	13	7,890	7,903	13	46,483	46,496	35	98,289	98,324	22	23	45
Total other costs	**341**	**291,316**	**291,657**	**2,268**	**1,747,117**	**1,749,384**	**5,277**	**3,474,243**	**3,479,520**	**5,437**	**2,474,561**	**2,479,998**
Net Operating Expenditure	**2,203**	**293,946**	**296,149**	**13,990**	**1,765,127**	**1,779,117**	**28,121**	**3,509,511**	**3,537,632**	**26,652**	**2,499,936**	**2,526,588**
Net Expenditure	**2,203**	**291,914**	**294,116**	**13,990**	**1,742,025**	**1,756,014**	**28,121**	**3,462,056**	**3,490,177**	**25,530**	**2,477,061**	**2,502,591**
Revenue Resource Limit	**2,327**	**291,779**	**294,107**	**14,321**	**1,741,693**	**1,756,015**	**27,061**	**3,463,116**	**3,490,177**	**30,629**	**3,311,758**	**3,342,387**
Surplus / (Deficit) from Operations	**125**	**(134)**	**(10)**	**332**	**(331)**	**0**	**(1,060)**	**1,060**	**(0)**	**5,099**	**834,697**	**839,796**

North Central London
Integrated Care Board

Appendix 2 - Cash Flow Statement

	AP1 - APR 23	AP2 - MAY 23	AP3 - JUN 23	AP4 - JUL 23	AP5 - AUG 23	AP6 - SEP 23	AP7 - OCT 23	AP8 - NOV 23	AP9 - DEC 23	AP10 - JAN 24	AP11 - FEB 24	AP12 - MAR 24	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	**950**	**2,716**	**2,018**	**1,394**	**381**	**924**	**513**	**929**	**782**	**1,493**	**777**	**740**	**950**
RECEIPTS													
Main Cash Drawdown	260,000	261,500	264,000	266,000	280,000	277,000	277,000	261,000	253,000	259,000	260,000	256,000	3,174,500
Supplementary Drawdown	26,500	0	0	0	0	0	0	0	0	0	0	0	26,500
Other	4,779	4,244	3,376	1,478	3,692	885	184	0	0	0	0	0	18,638
VAT	676	453	160	449	878	331	300	300	300	300	300	300	4,748
Total Receipts	**291,955**	**266,198**	**267,536**	**267,927**	**284,570**	**278,216**	**277,484**	**261,300**	**253,300**	**259,300**	**260,300**	**256,300**	**3,224,386**
PAYMENTS													
NHS Payables	194,865	198,285	202,422	203,699	218,662	211,813	211,965	200,564	195,614	195,879	195,691	195,537	2,424,995
Non NHS Payables	90,874	64,162	60,043	59,513	60,664	62,189	60,358	56,138	52,230	59,392	59,901	55,908	741,372
Salaries & Wages (inc Tax, NI & Pension)	4,451	4,449	5,695	5,728	4,702	4,625	4,745	4,745	4,745	4,745	4,745	4,745	58,119
Total Payments	**290,189**	**266,896**	**268,160**	**268,940**	**284,027**	**278,627**	**277,068**	**261,447**	**252,589**	**260,016**	**260,337**	**256,191**	**3,224,486**
BALANCE CFWD	**2,716**	**2,018**	**1,394**	**381**	**924**	**513**	**929**	**782**	**1,493**	**777**	**740**	**850**	**850**

Appendix 3 – Block Contracts

North Central London
Integrated Care Board

NCL ICB Block Contract Summary as at 30th September 2023

Area	Trust	Budget £'000
Acute Services - NHS (BLOCK)	Barts Health NHS Trust	30,190
	Barking, Havering And Redbridge University Hospitals NHS Trust	1,219
	Chelsea And Westminster Hospital NHS Foundation Trust	4,247
	East And North Hertfordshire NHS Trust	1,588
	Great Ormond Street Hospital For Children NHS Foundation Trust	15,865
	Guy's And St Thomas' NHS Foundation Trust	18,412
	Homerton University Hospital NHS Foundation Trust	18,979
	Imperial College Healthcare NHS Trust	23,245
	King's College Hospital NHS Foundation Trust	3,422
	Lewisham And Greenwich NHS Trust	824
	London Ambulance Service NHS Trust	81,908
	London North West University Healthcare NHS Trust	18,111
	Mid and South Essex NHS Foundation Trust	666
	Moorfields Eye Hospital NHS Foundation Trust	30,726
	North Middlesex University Hospital NHS Trust	295,670
	The Princess Alexandra Hospital NHS Trust	1,518
	Royal Free London NHS Foundation Trust	544,423
	Royal National Orthopaedic Hospital NHS Trust	22,183
	St George's University Hospitals NHS Foundation Trust	1,754
	The Royal Marsden NHS Foundation Trust	1,203
	University College London Hospitals NHS Foundation Trust	361,444
	West Hertfordshire Hospitals NHS Trust	2,108
	Whittington Health NHS Trust	206,896
	LVA - NHST	3,180
	LVA - NHFT	7,529
Acute Services NHS Block Total		**1,697,311**

Appendix 3 (cont.) – Block Contracts

North Central London
Integrated Care Board

NCL ICB Block Contract Summary as at 30th September 2023 (cont.)

Area	Trust	Budget £'000
Mental Health Services Block	Barnet, Enfield And Haringey Mental Health NHS Trust	182,355
	Central And North West London NHS Foundation Trust	7,615
	Camden And Islington NHS Foundation Trust	136,551
	Central London Community Healthcare NHS Trust	2,526
	East London NHS Foundation Trust	1,117
	Royal Free London NHS Foundation Trust	2,170
	South London And Maudsley NHS Foundation Trust	1,798
	Tavistock And Portman NHS Foundation Trust	14,815
	Whittington Health NHS Trust	3,538
	North Middlesex University Hospital NHS Trust	821
Mental Health Services Total		**353,307**
Community Health Services Block	Barnet, Enfield And Haringey Mental Health NHS Trust	217
	Central And North West London NHS Foundation Trust	41,699
	Central London Community Healthcare NHS Trust	55,787
	Camden And Islington NHS Foundation Trust	227
	London North West University Healthcare NHS Trust	170
	North Middlesex University Hospital NHS Trust	44,380
	Royal Free London NHS Foundation Trust	20,401
	Tavistock And Portman NHS Foundation Trust	40
	University College London Hospitals NHS Foundation Trust	43
	Whittington Health NHS Trust	106,907
Community Health Services Block Total		**269,872**
	Secondary Dental Care – Intra Trust	29,828
	Secondary Dental Care – Inter Trust	9,292
	Secondary Dental Care – LVA Trust	176
Primary Care Dental, Opthalmic & Pharmacy Total		**39,297**
Total Commissioning Expenditure		**2,359,786**

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 November 2023

Report Title	Board Assurance Framework ('BAF') Report	**Date of report**	19 October 2023	**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. Since the last Board meeting significant work has been undertaken to further develop the ICB's approach to risk management, strengthening the organisation's strategic focus on risk and using risk to drive discussions, decision making and improvements. As part of this work this BAF Report is in a new style. The key risks for inclusion in the BAF are contained in the BAF Risks Overview Report in Appendix 1. This contains all of the strategic updates for each risk previously set out in this 'Report Summary' section of the coversheet. In addition, should Board members want to go into 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 containing this information is here. This report therefore focusses on the key interrelationships between the risks and on emerging areas of risks that the Executive Management Team would like to draw the Board's attention to. **Risk Categorisation** A further change is that all strategic risks have been categorised into three types to assist identification, thinking and discussions: • ICB Only risks; • ICB risks generated from risks or issues in other organisations; • System risks that need to be owned and managed by the system.				

Risk Overview

There are 12 risks on the BAF:

- Four are ICB only risks;
- Three are ICB risks generated from risks or issues in other organisations;
- Five are system risks.

There are three new risks- all of which are ICB only risks and relate to delivery of the financial plan, meeting of running cost allowing in future years and costs of Continuing Healthcare ('CHC')/Complex Individualised Commissioning ('CIC') packages of care. Further detail is set out below.

Four risks have decreased:

- Qual69- Failure to conduct timely Deprivation of Liberty Assessments ('DoLS') on our NCL ICB-funded clients (Threat): Decreased from 20 to 16;
- Comm26- Failure to develop, agree and implement the strategies and models of care to support the shift of resources/investment into prevention & proactive care (Threat): Decreased from 16 to 12;
- STR9- Failure to Deliver the 2023/24 ICB (Cost Improvement Plan including elements of Transformation Programmes) (Threat): Decreased from 16 to 12;
- Qual64- Failure to undertake timely Continuing Healthcare assessments and reviews within 28 days (Threat): Decreased from 16 to 12.

Two risks have closed:

- Fin3- Long Term Financial Sustainability (Threat): Closed
- Fin15- Failure to Deliver 2023/24 Statutory and Other Financial Requirements set by NHS England (Threat): Closed.

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:

Finance

Two new risks have been added to the BAF which focus on the ICB's delivery of its financial plan for 23-24 (Fin 16) and for the ICB to remain within its running cost allowance in 24-25 and 25-26 (Fin 29). These risks are both currently rated as 12, which is below the BAF threshold, but are included for oversight. They replace previous finance risks Fin 3 and Fin 15 which were closed following review.

These new risks correlate to STR9 *"Failure to Deliver the 2023/24 ICB CIP (Cost Improvement Plan including elements of Transformation Programmes) (Threat)"* which has seen a corresponding drop in the risk level from 16 to 12. This is because all of the CIP for the 2023/24 financial year has been identified and there are strong controls in place to mitigate the risk to delivery, including working closely with the Finance team as a key support in risk management.

An area of financial pressure that has emerged is a new risk "*Qual 72: Failure to manage the financial costs of CHC and CIC packages due to uncontrollable market factors (Threat)."* This risk arises from increased costs due to inflation, market demand and patient complexity. Consequently, it is difficult to control as it is driven by geopolitical events and patient demographics. The ICB has taken/is taking a number of actions to mitigate this risk including working with the Local Authorities and providers to reduce costs, streamline processes and continuing to ensure funding for care is appropriate. However, the risk is currently rated at 16 and further work is being undertaken to understand the extent of the financial pressure.

	Primary Care Patient Access There has been a significant increase in patient demand for GP services both during and since the Covid 19 pandemic. The ICB has developed a system capacity and access plan which is being presented to the Board at its meeting on 7th November 2023. In addition, it is proposed that the Primary Care Committee's remit is expanded to include decisions in relation to improving access to primary care, strengthening the ICB's oversight of this. This is also on the agenda for the Board meeting on 7th November 2023. The risk (Perf28) is currently assessed at 12 and whilst below the BAF threshold is included for oversight. However, the ICB has identified a further risk which is in the process of being assessed, mitigated and included onto the risk register. Due to reducing levels of patient satisfaction in view of their ability to access an appointment with a GP, primary care providers are diverting GP capacity to meet this demand for access. This is causing a reduction in the time available for proactive care and long-term condition optimisation. These have also been compounded by the systemic impact of industrial action and delays for patients accessing planned hospital care. Mitigations include: • Mobilisation of the Long Term Conditions Locally Commissioned Service providing remuneration to practices delivering systematic holistic person-centred care to optimise long term condition management; • GP Access Recovery Plan supporting delivery of a systematic and targeted support offer to practices to improve access and demand management, as well as work at the interface with secondary care to streamline processes and avoid duplication; • Regional collaboration in 'Deliberative Enquiry' to inform future state of regional offer for GPs; • Enhanced use of digital enablers such as NHS App, including focus on benefits realisation, to drive enhanced access for digitally literate patients and release capacity to support those who are not; • A systematic programme of communications to our residents, to promote the work being done, enable people to understand how to navigate services and demonstrate how access is improving. Further work on this risk is being undertaken. Ambulance Handover at North Middlesex University Hospital ('NMUH') The ambulance handover performance at NMUH remains pressured with higher rates of conveyance leading to increased demand on capacity, which can impact patient safety within the emergency department. A series of actions were agreed to support the hospital following discussion at System Flow Board on 29th September 2023 and the subsequent system Executive-led conversations. These include: • Ensuring alternative care pathways are fully utilised as well as the development of a protocol that is based on the Northwick Park/London North West University Healthcare approach but tailored to the emergency department specifics at NMUH; • London Ambulance Service support to cohort subject to space when NMUH reach a particular threshold; • System Flow Board agreed a series of high impact priority actions to improve discharge. The actions focus on long length of stay, patients not meeting the criteria to reside, and home before 12.00 and 17.00. Progress against actions will be reviewed at the weekly Chief Operating Officer ('COO') discharge group and fortnightly Flow Operational Group. This is being managed within risk Perf29.

	Delegation of Specialist Commissioning The Board requested at its meeting on 25th July 2023 that the risk on delegation of specialist commissioning remains on the BAF. This risk is Comm22 and is contained in the BAF Risks Overview Report in Appendix 1. It is currently rated at 12 which is below the BAF threshold but included for oversight. An up item on the delegation of specialist commissioning is on the agenda for the 7th November 2023 Board meeting for information. **Looking Forward** The ICB's approach to risk management continues to evolve with oversight by the Audit Committee. A comprehensive review of the ICB's risks was undertaken across the summer with the outputs of those reviews being presented to Board committees as appropriate. The overall outputs of the reviews were presented at the Executive Management Team meeting on 5th October 2023, are reflected in this BAF report, and an update will be presented to the Audit Committee on 14th November 2023. The Governance and Risk Team is in the process of developing a deep dive methodology to support risk deep dives.
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;
	  ○ Building relationships with key system colleagues including the Local Authorities;

	○ Strengthening the role of the NCL Governance Leads Network as a key mechanism for collaboration and information sharing on key health system risks.
Appendices	The following documents are included: • BAF Risks Overview Report; and, • Risk Scoring Key.

North Central London ICB BAF Risks - Oversight Report

Risk ID	Risk Title	Risk Owner	Risk description	Strategic update	2023 Current Risk Score FEB	MAY	JULY	OCT	Movement From Last Report	Target Risk Score
System Risks										
PERF7	Failure to manage patient flow during heightened periods of pressure, including winter, Easter, other Bank Holidays and Industrial Actions. (Threat).	Richard Dale - Executive Director of Performance and Transformation	**CAUSE:** If NCL ICS Providers fail to manage non-elective flows within planned hospital and community capacity to meet surges during periods of heightened pressure, **EFFECT:** there is a risk that patients may receive sub-optimal care and long waiting times. Patients may also remain in inpatient placements longer than anticipated. There may be an impact on capacity for elective pathways **IMPACT:** This may result in the local system being unable to deliver against the priority areas as set out in the UEC Recovery Plan and improvement trajectories not being met.	Work continues across NCL to improve operational resilience and put the ICS in a stronger position to manage system pressures. As part of this effort, a system pressures mitigation stocktake and review of winter 2022/23 was undertaken through the Flow Operations Group. This was done within the context that system pressures are no longer confined to the traditional winter period, with key issues continuing all year round. This is alongside the recognition that the ICS UEC focus for the remainder of 2023/24 includes: • Identifying the system level actions with named accountable persons that will support organisation specific actions to facilitate delivery of the A&E 76% 4-hour standard; • Realigning work the ICS is doing to propel towards the A&E 76% standard and reduction in response times for Category 2 incidents; • Understanding implications of the Mental Health 'Right Care/ Right Place' Letter and formulation of a sustainable and effective system response; • Development of an NCL system pressures plan for all year mitigation, building on learnings from schemes/actions implemented during winter 2022/23, learning from last winter and other periods of pressures including managing the strikes actions. Ensuring this is links in with the review of key urgent care services undertaken in May 2023. An early draft of the Winter Playbook has now been developed, though remains a dynamic document that reflects an approach of continuous refining of plans in response to an environment of changing pressures. Key elements of the 2023/24 Winter Playbook are: 1. Population Health Management, working together as an integrated system in local neighbourhoods and across borough partnerships to join up care and reduce health inequalities, focussing on our key communities and the five key health risks for NCL 2. Proactive steps to reduce pressures, by providing primary care clinicians dedicated time for proactive case finding and management of patients with long term conditions, as well as focussing attention on preventing infectious diseases via vaccinations 3. Dynamic use of capacity, including G&A beds, community and virtual ward capacity as well as flexible use of staffing 4. Continuous management of risk along the urgent care pathway and across primary care, community and mental health. This work is in recognition of the review of key urgent care services which took place in May 2023 and is expected to be finalised by the end of October 2023.	16	16	16	16	→	9
PERF8	Failure to Deliver Referral-To-Treatment ('RTT') Waiting Time Standard (Threat).	Richard Dale - Executive Director of Performance and Transformation	**CAUSE:** If there is a lack of adequate capacity and operational resilience to effectively manage waiting times. Year end pressure and industrial action impacts on capacity and adds further challenge and risk to operational delivery and elective waiting list management. Low volume, high complexity long waiting patients within specialised services requiring treatment remain on acute/tertiary waiting lists. **EFFECT:** There is a risk that the system will not meet the national ambitions around RTT or the system level plans agreed with NHSE, resulting in poor experience and outcomes for patients. **IMPACT:** This may result in the ICB missing the national expectations for long waits and adversely impact on SOF segmentation.	The British Medical Association industrial strike action has had a significant adverse impact on elective capacity and long waiting patient recovery. NCL is now forecasting a diversion from the Systems Long Waiting Patient Operating plan in November 2023 due to: • Industrial action held since March 2023 has resulted in large volumes of patients missing activity earlier in their pathways who are now having subsequent delays with every additional period of industrial action; • Industrial Action held in September, and future industrial action scheduled across October 2023; • Trusts continuing to prioritise rescheduling urgent and cancer pathways ahead of routine electives following each period of industrial action; • Significant growth to the total number of patients waiting 52 weeks increases the 65 week wait tip-in risk across all providers. NCL Providers continue to target: • Allocation of treatment / to come in ('TCI') dates to all patients currently waiting longer than 52 weeks who will breach 78 weeks in March 2024 if they remain unscheduled; • 78 week patient waits clearance; • Booking and rescheduling 65+ week waits to remain to 2023/24 operating plan trajectories; • A reduction in 52+ week waits where possible throughout 2023/24; • Constituted diagnostic backlog recovery across imaging and endoscopy in line with provider trajectories; • Audiology backlog recovery as part of the NHSE October Focus on Diagnostic Month National initiative ('FOD'). System Oversight Framework ('SOF') Segment 3 covers providers where significant delivery challenges have been identified, requiring coordinated actions across the system. RFL were in Segment 3 in respect of RTT performance and made significant progress in 2022/23 in reducing the number of long waiting patients (104+, 78+, and 52+ week waiters) in line with the agreed Exit Criteria. As a result, RFL are now not subject to any RTT related exit criteria for 2023/24.	12	16	16	16	→	12
PERF29	Failure to deliver timely urgent and emergency care for the residents of NCL (Threat).	Sarah Mansuralli - Chief Strategy and Population Health Officer	**CAUSE:** If NCL ICB fails to ensure provider delivery of commissioned capacity to meet emergency care demand within the system, **EFFECT:** there is a risk that the ICB will fail to achieve urgent and emergency care national performance standards. Pressures may result in patients being located in the wrong part of the system, which may have an adverse effect on their health outcome. **IMPACT:** This may result in the ICB missing the national standards expected for all patients, increasing patient waiting times in the Emergency Department ('ED') and potential risk of harm and negative patient experience.	A&E 4hour wait performance dipped in September 2023 following a period of sustained improvement from December 2022. NHS England have launched their national core offer (July 2023) to support delivery of the UEC recovery plan core standards including A&E 4hour waits (76%) by March 2024 and improving Category ('CAT') 2 response times. For systems grouped within Tier 3 (assessed as lowest risk) a series of learning events and improvement modules has been made available for nominated ICS service champions. The programme focusses on improvement methodologies, sharing best practice, peer review as well as a series of focussed core learning modules against 10 priority pathways. The programme will continue for a 2 year period. For NCL key learning modules focus on Frailty, Inpatient Flow, Intermediate Care, and Virtual Ward. North Middlesex University Hospital ('NMUH') ambulance handover performance remains particularly pressured with higher rates of conveyance leading to increased demand on capacity, which can impact patient safety within the emergency department. A series of site specific actions were agreed following discussion at System Flow Board on 29 September 2023 and subsequent system Executive-led conversations to support the hospital. This includes ensuring alternative care pathways are fully utilised as well as the development of a protocol that is based on the Northwick Park/London North West University Healthcare approach but tailored to the emergency department specifics at NMUH, including London Ambulance Service support to cohort subject to space when NMUH reach a particular threshold. System Flow Board, September 2023, agreed a series of high impact priority actions to improve discharge. Actions focus on long length of stay, patients not meeting the criteria to reside, and home before 12.00 and 17.00. Progress against actions will be reviewed at the weekly Chief Operating Officer ('COO') discharge group and fortnightly Flow Operational Group.			16	16	→	12
PC3	Strikes by NHS staff (Threat).	Sarah Morgan - Chief People Officer	**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 has emerged from national industrial action taken by unions and NHS staff regarding pay and working conditions disputes. Sector and pan-London Management, to keep minimal services running and protect the Urgent and Emergency Care pathway, is co-ordinated through the Flow Oversight Group, System Management Board and Clinical Advisory Group. There are plans for Junior Doctor strikes 3 days per month during the mandate. The Junior doctors 5 day strike from 13 - 18 July was very challenging in NCL. Derogations submitted to the NHS England regional and national team request approval from BMA were not granted. GOSH have had action on every strike since November 2022. The London derogation process was updated after the After Action Reviews undertaken by RFL and UCLH from the Junior Doctor's strike in July. This improved the process during the August strikes however no derogations were granted by the national BMA for NCL or nationally. Further consultant strikes have been announced for 19 and 20 September and 2, 3 and 4 October 2023.	15	20	20	20	→	15
QUAL69	Failure to conduct timely Deprivation of Liberty Assessments ('DoLS') on our NCL ICB-funded clients (Threat).	Chis Caldwell - Chief Nursing Officer	**CAUSE:** If the ICB fails to conduct our Depravation of Liberty ('DoLS') Assessments for NCL ICB-funded clients within the scheduled assessment period, **EFFECT:** There is a risk that individuals in receipt of ICB funding may unlawfully be deprived of their liberty, and that the ICB will fail to comply with its statutory responsibility under the Mental Capacity Act 2005. **IMPACT:** This may result in the ICB failing to ensure patients who are under high levels of care and supervision, but lack the mental capacity to consent to those arrangements for their care, are safeguarded. The ICB is also at risk of reputational damage and may incur financial penalties.	The proposed transition from Deprivation of Liberty Safeguards to Liberty Protection Safeguards ('LPS') will no longer be implemented in this parliament. The ICB has a statutory duty to ensure any patient who may be deprived of their liberty has the appropriate safeguards in place and has undertaken the correct assessment procedures including application to the courts. The ICB will now continue to progress Deprivation of Liberty ('DoLS') Reviews, for which we have a responsibility. The plan s to undertake assessments of high-risk/high-cost cases and reconcile against our existing DoLS information. Those with Learning Disability will be a priority. We have identified all of the individuals that require DoLS assessments across the five boroughs and processes are in place to undertake highest risk DoLS. The LPS Task & Finish Group is refocused on DoLS and Mental Capacity Act ('MCA') with training for Best Interest Assessors delivered. DoLS Reviews are now being undertaken as BAU for those with the highest risk, further to the identification of those individuals that require DoLS assessments across the five boroughs. Additional action includes • The Director of Safeguarding taking on the leadership for DoLS working in collaboration with the Director of Complex Care; • We have identified resources to train more of the staff as Best Interest assessors in this financial year to increase capability and an ICB MCA Leads training programme is to be developed. • The requirement for DoLS has been considered as part of the change programme for the CNO directorate to building leadership, capacity and capability into the team for assessment and oversight post implementation from April 2024; • All ICBs are facing the same issues and risks and there is currently a lobby for additional funding for ICBs in relation to DoLS; • Costs for the legal and court elements are still to be worked through. On this basis the risk has reduced from 20 to 16. Further reductions may be possible on the basis on progress against plan.			20	16	↓	8
System Risks dropping below BAF threshold and not included in BAF										

COMM26	Failure to develop, agree and implement the strategies and models of care to support the shift of resources / investment into prevention & proactive care (Threat).	Sarah Mansuralli - Chief Development and Population Health Officer	**CAUSE**: If the ICB / ICS does not develop, implement and embed the necessary strategies and models of care and address any existing cultural barriers or issues around ways of working, **EFFECT:** There is a risk that the progress in addressing population health will be slowed significantly, therefore meaning we are not able to support the shift of activity out of hospital and will continue to see rapid demand growth in unplanned care needs in our acute providers. **IMPACT:** This may result in reduced funding for the improvement in population health outcomes and reduction in health and care inequalities not being delivered as resources will not be deployed according to need and increasing acute care costs and activity further. This may also lead to increasing demand for acute services which could contribute to funding pressures.	The NCL Population Health and Integrated Care Strategy, in relation to public health and improvement ('PH&IC') outlines principles which will guide our new ways of working, including with our residents and communities, and where we prioritise our resources and efforts. We are working as a system to reconfigure so that we can deliver the NCL Population Health and Integrated Care Strategy in a sustainable way and have identified levers for change which will help the ICS create the right conditions for sustainable delivery and improved outcomes. Each of these levers consists of system-wide deliverables which will set our system up for long-term success. Work is now ongoing to oversee transition into delivery of the strategy in the form of the NCL delivery plan, which will take the deliverables of the strategy and ensure appropriate sequencing and milestones are in place for delivery. The Joint Forward Plan ('JFP') has been submitted to NHS England. Borough Partnership Chairs are leading discussions about the approach to refining the Borough Partnership elements of the Delivery Plan, utilising mapping that was based on local planning from Q1 2023/24. This is to be updated and opportunities to demonstrate alignment between BP plans, system transformation plans and the Outcomes Framework are being developed. We recognise the operational challenges, financial constraints and ongoing change both within and across organisations in the ICS (such as the ICB change programme) that makes delivery of our ambitions in the PH&I Strategy extremely challenging. Work is progressing on Childhood Immunisation which was the first of five priorities identified by the ICP for the whole system to test and learn about population health approach, working through borough partnerships to drive hyper-local delivery. Launch of the long term conditions locally commissioned service ('LTC LCS') is on track for October 2023. Work on the Renal Improvement Programme includes a focus on case-finding which is being aligned with the LTC LCS. All case-finding work will increase the size of the cohort for the LTC LCS and therefore the future cost of its delivery. The programme team is commencing modelling of that impact and likely trajectories over the lifetime of the contract. This can inform a wider system discussion around future investment in proactive care. This risk's rating was reduced as part of the directorates risk review.	16	16	16	12		↓	9
QUAL64	Failure to undertake timely Continuing Healthcare assessments and reviews within 28 days (Threat).	Chis Caldwell - Chief Nursing Officer	**CAUSE:** If the ICB fails to undertake patient assessment within the statutory target of 28 days, as well as patient package of care reviews **EFFECT:** There is a risk that patients will not be in receipt of the appropriate package of care in the most appropriate setting and patients/families will be left not knowing who will fund their care, and/or increase expectation for continuation of interim funding under Discharge to Assess ('D2A') due to delays **IMPACT:** This may result in a increase in negative patient experience (linked to increase in complaints and appeals). It has also negatively impacted patient choice for patients awaiting assessment whilst in interim funded placement. It may also result in significant increased cost to the ICB as well as reputational damage, and an increase in complaints and appeals. It may also impact the ICB's ability to meet future NHSE targets.	Significant collaborative work is underway with Local Authority ('LA') partners for the allocation of Social Workers, via Task and Finish Groups, Weekly Borough Local Authority Meetings, weekly escalation to the executive team and weekly reporting of the Social Workers Delays Tracker activity analysis. Focussed discussions are on-going with LAs on specific patients where delays persist. The ICB and LA are under a statutory duty to undertake patient assessments within 28 days of positive referral for Continuing Healthcare ('CHC') (referred via 'Discharge to Assess', Community, Local Health, GPs, and Fast Track patient with a material change in need who subsequently require an assessment for CHC). The formulation of Multi-Disciplinary Teams from the ICB and other stakeholders poses a significant workforce resourcing challenge in meeting this measure and the ICB continues to keep NHS England apprised of the situation through bi-monthly assurance meetings. For 2023/24 Quarter 2, the ICB delivered within the national target range of 30% - 39.9%. The agreed 2023/24 Targets are: Q1 30-39.9%, Q2 30-39.9%, Q3 30-39.9%, Q4 40-49.9%. The overall percentage of Social Worker referral delays remains high. Interim staff have been secured until December 2023. The risk rating has decreased from 16 to 12, although there continues to be challenges with the completion of CHC Referral Assessments, we are still delivering within expected 28-days 30%-39.9% target. Additionally, there has been an improvement with the Social Worker allocation across most boroughs especially in Camden, Haringey and Islington. Social Worker Delays fell from 60% in May 2023 to 48% in August 2023.	16	16	16	12		↓	12
ICB Risk arising from risks or issues in other organisations											
PERF18	Failure to effectively develop the primary care workforce (Threat).	Sarah McDonnell-Davies - Executive Director of Place	**CAUSE:** If the ICB is ineffective in developing the primary care workforce, **EFFECT:** There is a risk that it will not deliver the primary care strategy. **IMPACT:** This could mean that, for example, patients with long term conditions are not fully supported in primary care and require more frequent hospital care.	This risk highlights the importance of Primary Care workforce development, and the ongoing challenges with recruitment and retention. A range of national and local schemes are in place to mitigate the risk. These include the national Primary Care Network ('PCN') additional roles reimbursement scheme ('ARRS') which has enabled PCNs to access national funding to recruit into a range of 15 different roles. PCNs continue to recruit to these roles and are supported by Training Hubs with induction and professional development. There is an expectation that ICBs and systems will explore different ways of supporting PCNs to recruit.	16	16	16	16		→	9
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	**CAUSE:** If the ICB fails to address patient and stakeholder concerns around timely and appropriate access to general practice, **EFFECT:** There is a risk that patients 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 pressures elsewhere in the system. There may be a negative impact on the workforce and providers.	Access remains a key challenge and risk. Demand has increased significantly during and since the COVID-19 pandemic exacerbating access challenges. This is under discussion at the London Primary Care Board with NCL input. The ICB is required to publish a system capacity and access plan in November 2023 as part of responding to the Access Recovery Plan, which was received in May 2023. Further work will be required to address access as a core part of the primary care agenda locally, including: • patient experience; • ease of access (including digital inclusion / exclusion); and, • contributing factors including workforce and patient needs and expectations.	12	12	12	12		→	9
ICB Only Risk											
QUAL72 NEW RISK	Failure to manage the financial costs of CHC and CIC packages due to uncontrollable market factors (Threat).	Chis Caldwell - Chief Nursing Officer	**CAUSE:** If the ICB is unable to effectively manage and negotiate CHC and CIC packages due to uncontrollable external market forces, including, inflation, provider stock levels, clinical demand and complexity and commissioning pattern changes, through established brokerage arrangements and discharge processes, **EFFECT:** There is a risk that the ICB is exposed to higher than budgeted costs and service demands leading to commissioning care packages beyond the agreed financial envelope. **IMPACT:** This may result in a negative impact on patient care, financial sustainability, the ICB not meeting its statutory duties and increased complaints resulting in reputational damage.	This is a new risk. In 2022/23 NCL ICB Continuing Health Care ('CHC')/ Complex Individualised Commissioning ('CIC') had a £0.5m deficit however, achieved delivery against its £5.3m Cost Improvement Plan. The 2023/24 NCL ICB CHC/CIC at Month 4 has indicated a significant forecasted overspend, which needs further investigation, based on the cost and activity during this period. The challenges being experienced against the ICB financial plan are due to uncontrollable external market factors namely increased demand and complexity of clients, economic and inflationary pressures, change in commissioning patterns and dependence on local authority engagement, which has delayed assessments and resulted in the ICB incurring costs. This risk was identified during budget setting and remains active on the cost pressures list for 2023/24. To ensure that we fully understand, investigate and mitigate any areas of possible cost pressures, a CHC/CIC Finance Review Task & Finish Group with membership of the service Director, Assistant Directors and senior Finance Leads, meets on a weekly basis to scrutinise areas. A Financial Recovery Plan is in placed to focus on areas of concern and to ensure that our control processes remained strong to deliver within our 2023/24 financial envelope. In addition, other controls are included the established Standing Financial Instructions, CHC/CIC Brokerage Operating Framework, Adult Package of Care ('PoC') Authorisation Process and Templates for CIC are being piloted. The 2023/24 NCL ICB Uplift Policy & Process has been fully reviewed and embedded and the ICB/Local Authority ('LA') Joint Funding Decision-making Panels and Non-CHC Processes are being reviewed. The S117/Joint Funding Principles for agreement of uplifted rates and recharges approach has been shared and agreed to be adopted across all LAs (via the Joint Market Commissioning Board), however this needs to be embedded. Additionally, the NCL Joint Funding & S117 Reconciliation Governance & Reconciliation Working Groups are in the final stages of reviewing the closure of 2020/21 historical reconciliation queries, confirming the 2022/23 reconciliations and setting the 2023/24 baselines. Joint Funding Panels with CHC/CIC Assistant Directors/Senior Commissioners and Local Authority peers are fully established to scrutinise and agree PoC based on clinical/social needs and allocated funding. There has been a unproportional increase in some boroughs with Discharge to Assess Non-CHC referrals that do not have a health need and/or not reviewed within the required timelines. Given that this funding is a temporary measure, and in some cases there may be a risk of lack of clinical oversight (acute), an audit has been conducted on new and existing cases by dedicated clinicians along with learning captured and training. The Non-CHC Assessment Process was launched in July 2022 and is being re-engaged across the system. Invest to Save initiatives to be implemented to further reduce the risk of further financial impact and ensure quality of care to clients are as follows: • Patient Level Dataset Cleanse and Reclaims • CHC Personal Health Budget Cost & Improvements s75 CHC/CIC reviews/comments have been received and updates have been sent to Directors of Integration. The Better Care Fund is under review. Providers' invoice audit verification of commissioned care versus delivered care is being undertaken.				16		→	9

ICB Only Risks 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	**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.	Following the ICB submission of the Pre-Delegation Assurance Framework ('PDAF') to NHS England ('NHSE') we have received positive feedback on our system readiness for delegation. There remains five main risks that we have flagged to NHSE and discussed at our follow up meeting on 22 September 2023. The most material of these are the risks that are transferring to the ICB and the need for an agreed handling strategy. We have agreed a programme of work with NHSE and Providers that will see us finalising the work on this by the beginning of December and at that point we may need to revisit the risk rating based on the scale of risk (mainly financial but also potentially clinical and reputational) that is set to transfer. NHSE London Region have submitted our PDAF to the national team for assessment and we expect to hear the result in December 2023 although we do not expect the NHSE London assessment of 'Ready for Delegation with Conditions' to change. What is likely to change is the date for delegation as NHSE London Region have requested a delay in delegation to April 2025. We will not know whether this request has been accepted until December 2023. The rationale for the proposed delay is to enable all ICBs in London to complete the due diligence work being undertaken by NCL (referenced above) and to agree with NHSE a handling strategy for these risks. Again, the delay in delegation may also require us to revisit the risk rating. In addition to the two conditions referred to above around quantifying the risks being transferred and developing a handling strategy there are two further conditions with the first around resolving cross border decision making and the second being to understand what staffing is required to support delegation including the work to reshape the NHSE Staffing Hub.	16	16	12	12		→	9
PC5	Failure to successfully implement the ICB Change Programme (Threat).	Frances O'Callaghan - Chief Executive Officer	**CAUSE:** If the ICB fails to plan, design, and implement the Organisational Change programme to ensure that the ICB operates in a more effective and efficient manner within the ICS **EFFECT:** There is a risk that the ICB will no longer be able to commission appropriate health services to meet the entire needs of the population, the workforce may become demotivated or leave the organisation, and the ICB will not meet the efficiency savings required by NHS England. **IMPACT:** This may result in negative patient outcomes, a workforce that is unable to deliver on the ICB's objectives, negative reputation impacts, and the ICB being financially unsustainable without other efficiency savings.	Prior to the establishment of the ICB on 1 July 2022, the Executive Management Team was restructured in order to better deliver on the ICB's expected objectives. On 1 February 2023 a pan-NCL ICB Organisational Change Programme was launched. The goal is to design an organisational structure and ways of working that better enable us to work together with our system partners to meet the needs of our population and our people. The programme has 3 phases: 1. 'Reset and re-envisage', scheduled to be completed by April 2023; 2. 'Review and revision', to be completed by July 2023; and, 3. 'Relaunch and renew' from September 2023. The phases are to determine the ICB's future operating model, identifying the needs of the design and its implementation, and then operationalising the model. The programme is now moving into phase 3 and is on track, although the risk will continue to develop over the remainder of 2023. Formal consultation closed on 21 August 2023 and all of the feedback has been considered. The Voluntary Redundancy scheme pre-approval was received on 24 August 2023. An all staff briefing was held on the detail of the Voluntary Redundancy Scheme on 21 September 2023. The consultation outcome was published on 28 September 2023.		12	12	12		→	9
FIN16 NEW RISK	Failure to Deliver the ICB's 2023-24 Financial Plan (Threat).	Phill Wells - Chief Finance Officer	**CAUSE:** If the ICB failures to deliver the required level of recurrent and non-recurrent efficiency savings described in the 2023/24 financial plan for the Integrated Care Board, **EFFECT:** There is a risk of external imposition of additional financial controls onto the ICB in order to support in year efforts to maintain its financial position. **IMPACT:** This may result in a limiting of the ICB's ability to deliver its population health ambitions, improve patient outcomes and invest in services, alongside a loss of credibility with regulatory bodies.	This is a new risk. As at Month 5, August 2023, the ICB is reporting a balanced financial plan to deliver a £10.6m surplus for this financial year. To achieve a balanced position the 2023/24 plan assumes c.£24m of efficiencies and c£15m non-recurrent actions will be achieved in full. In addition, there is an estimated c.£54.3m of risk which, if it emerges, is assumed will be fully mitigated in year. As at month 5 c. £27.2m of mitigations have been identified leaving a potential c.£24.5m to be identified if all risks emerge. Cost Improvement Plans ('CIP') have been fully identified, risks are regularly reviewed and strong expenditure controls are in place. The delivery timetable for organisational redesign could present some challenges to the planned budget position later in the year.				12		→	9
FIN29 NEW RISK	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	**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.	This is a new risk. As the 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.				12		→	6
ICB Only Risk dropping below BAF threshold and not included on BAF											
STR9	Failure to Deliver the 2023/24 ICB CIP (Cost Improvement Plan including elements of Transformation Programmes) (Threat).	Richard Dale - Executive Director of Transition	**CAUSE:** If the Integrated Care Board (ICB) fails to deliver the 2023/24 Cost Improvement Plan, **EFFECT:** There is a risk that the ICB will not achieve a balanced budget and control total, and will be unable to release sufficient funds to invest in services and deliver the quality improvements to patient care. **IMPACT:** This may result in a negative impact on patient care and financial sustainability.	The ICB Cost Improvement Plan ('CIP') process for the 2023/24 financial year has identified 100% of the required efficiency savings. Work continues to identify additional opportunities with schemes leads on a rolling basis with input from all Directorates to continuously support the financial recovery plan as well as system transformational programmes. Monitoring and reporting has begun and meetings are held jointly by Finance and System Efficiency Plans ('SEP') teams via the CIP Assurance Meetings and Finance budget holder meetings on a monthly basis to ensure CIP is on track for delivery. As it stands, the portfolio does include the efficiencies across all directorates with key efficiencies across Continuing Health Care ('CHC')/ Complex Individualised Commissioning ('CIC'), Primary Care Prescribing and the Development and Population Health Directorate. If schemes are materially slipping, the Efficiency and Productivity Group ('EPG') will be reinstated which is chaired by Executive Director of Performance and Transformation and the Chief Finance Officer. This oversight group will examine the risks and mitigations and discuss an action plan to mitigate the slippage. A overall progress update will be shared with the Finance Committee on a bi-monthly basis. In addition, where any underperformance is being forecasted, we are asking scheme leads to mitigate this slippage in year. The risk rating has reduced from 16 to 12 as we have now identified all the CIP for the 2023/24 financial year and have strong controls in place to mitigate the risk to delivery, including working closely with the Finance team as a key support in risk management.		16	16	12		↓	12
ICB Only Closed Risks											
FIN3	Long Term Financial Sustainability (Threat).	Phill Wells - Chief Finance Officer	**CAUSE:** If there are unavoidable cost pressures for commissioners and providers, under-delivery of QIPP activity and population growth exceeding funding levels, staffing shortages and recruitment difficulties, **EFFECT:** There is a risk of failure to maintain long term financial sustainability. **IMPACT:** This may result in reputational damage, inability to invest as desired to improve patient care and a threat to existing services.	In August 2023 the Finance Team undertook a comprehensive risk review and this risk was closed.	20	20	20			→	16
FIN15	Failure to Deliver 2023/24 Statutory and Other Financial Requirements set by NHS England (Threat).	Phill Wells - Chief Finance Officer	**CAUSE:** If the Integrated Care Board ('ICB') fails to meet the 2023/24 financial plan due to the impact of material 2023/24 cost pressures and the deficit underlying financial position, **EFFECT:** There is a risk of significant overspend, that NHS England may take action against the ICB and there may be a lack of funds to invest in strategic priorities. **IMPACT:** This may result in the ICB being placed in legal directions and under a requirement to reduce or cease some services, negatively impacting on patient care.	In August 2023 the Finance Team undertook a comprehensive risk review and this risk was closed.		20	20			→	12

Risk Scoring Key

This document sets out the key scoring methodology for risks and risk management.

1. Overall Strength of Controls in Place

There are four levels of effectiveness:

Level	Criteria
Zero	The controls have no effect on controlling the risk.
Weak	The controls have a 1- 60% chance of successfully controlling the risk.
Average	The controls have a 61 – 79% chance of successfully controlling the risk
Strong	The controls have a 80%+ chance or higher of successfully controlling the risk

2. 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

3. 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**

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 November 2023

Report Title	Update to Governance Arrangements	**Date of report**	19 October 2023	**Agenda Item**	4.1
Lead Director / Manager	Ian Porter, Executive Director of Corporate Affairs	**Email / Tel**		Ian.porter3@nhs.net	
Board Member Sponsor	Usman Khan, Non-Executive Member (Chair of Primary Care Committee) Phill Wells, Chief Finance Officer (Chair of the Procurement Oversight Group) Liz Sayce, Non-Executive Member (Chair of Quality and Safety 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	As part of further strengthening our strategic approach to corporate governance, following the review work undertaken during the summer, and to ensure that we have suitable arrangements in place to assist the Board to effectively discharge its duties, there are some proposed amendments to the ICB's governance arrangements and key governance documentation which require the approval of the Board of Members ('ICB Board'). These are as follows: <u>Primary Care Committee</u> Clinical Commissioning Groups first took on fully delegated primary care commissioning in 2017. At this point delegated commissioning and funding was managed in relative isolation from local commissioning and funding. Over time, and with national contract changes like the introduction of Primary Care Networks (PCNs), there is less distinction between delegated and non-delegated primary care commissioning. The recent governance review agreed the Committee should continue to perform its key business (which is complex and can be open to formal challenge) but operate with a wider scope to take account of the changes in the primary care landscape, our major strategic priorities requiring action, and to better reflect Committee key risks.				

	The Terms of Reference have been reviewed. Recommendations include expansion of the list of low risk, non-contentious, contractual decisions that can be made outside of committee meetings by the Chair, Executive Director of Place and the Chief Medical Officer. The list would be as follows: • Requests to add or remove a partner; • Requests for individuals to be added or removed from PMS contracts; • Retirement of a partner and adding of a new partner; • Partnership changes- 24 hour retirement; • Requests for contract novation where there is no change of provider; • Requests to increase a catchment area; • Increases in practice boundaries; • Requests for GP practices to change which Primary Care Network they are part of; • List closures for a period of up to 6 months; • Caretaking contract extensions where the extension is permitted under the contract and so is not a new procurement or award of contract; • Requests for GP practice reimbursement of Stamp Duty Land Tax ('SDLP') and/or legal fees where the request has been submitted after a decision on the premises has already been taken); • Increases in rent following district valuer rent reviews; • Increased in rent to the value of £50k per annum. This will speed up decision making, reduce bureaucracy and enable the Primary Care Committee discussions, and time, be spent on wider priorities and risks. This also supports further recommendations that the remit of the Committee be expanded to include: • Decision making in relation to Local Enhanced Services; • Decisions in relation to access to primary care including enhanced access; • Overseeing and approving primary care workforce plans; • Approval of non-delegated new strategic investments/business cases for up to £5m per annum; The proposed changes have the following benefits: • The Primary Care Committee can take a formal view on these key primary care priorities and the risks and opportunities within and across them without compromising its relationship to Strategy & Development Committee; • Focussing on both delegated and non-delegated primary care enables the Primary Care Committee to have a more holistic view and join up across primary care as we seek to sustain and transform general practice and optimise its role in population health improvement. • The proposed financial limit of £5m enables the Primary Care Committee to take decisions (for example in relation to the commissioning of Local Enhanced Services) across and within the 5 boroughs, whilst retaining the requirement for any more significant strategic and/or financial decisions to go to Strategy and Development Committee. Further to the above, we propose some changes to the membership: • Following review by the Chief Medical Officer ('CMO') and the Chief Nursing Officer ('CNO') earlier in the year, the role of the independent non-conflicted primary care clinician was reviewed and it was concluded that this role could be undertaken by the CMO, CNO or their deputies as they are non-conflicted. Both the CMO and the CNO are already members of the Primary Care Committee and therefore it is recommended that the independent non-conflicted primary care clinician be removed from the Terms of Reference. • The Chief Development and Population Health Officer be removed as a member;

- The Chief People Officer, who is currently a Standing Participant, becomes a voting member to align the Primary Care Committee's role on workforce.

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

Procurement Oversight Group Terms of Reference

The draft statutory guidance on the new NHS Provider Selection Regime ('PSR') was published on 19th October 2023. The new regime is expected to come into force on 1st January 2024. The PSR will fundamentally change the way in which all NHS organisations in England procure services and will significantly impact the commissioning cycle and current ways of working. From an organisational perspective ensuring the ICB, its governance arrangements and its relevant staff are ready for the new regime, which is a major change.

The proposed amendments to the Procurement Oversight Group's Terms of Reference will support the ICB to have robust governance arrangements in place to oversee the implementation of PSR and, as there is a transition and cross-over period, ensure procurements are compliant with the appropriate procurement regime. The amendments have been made in accordance with the draft statutory guidance and so will help ensure the Procurement Oversight Group is ready and prepared to effectively operate in the PSR environment.

In addition, the Procurement Oversight Group has identified areas in which its Terms of Reference can be amended to strengthen oversight and support it in its role. These include:

- Ensuring procured contracts are being managed effectively once awarded and that lessons learned reviews are implemented;
- Providing authority to proceed to procurement in line with approved business cases rather than having to remit the decision to other committees. This gives effect to Procurement Oversight Group's role to review and scrutinise procurements before they are launched and ensures our governance processes are efficient and robust. For the avoidance of doubt this does not give Procurement Oversight Group the ability to approve business cases;
- Revising the membership to reflect the current composition and to expand the membership to include the Chief Strategy and Population Health Officer.

The Board of Members is asked to **APPROVE** the Terms of Reference for the Procurement Oversight Group.

Quality and Safety Committee Terms of Reference

As part of the governance review the Quality and Safety Committee reviewed its Terms of Reference on 18th July 2023 and recommended the following changes to its Terms of Reference:

- The expansion of its membership to better reflect the Committee's role to include the Chief People Officer, Director of Quality, Director of Safeguarding and a place-based safety representative;
- To include in its role an additional responsibility to scrutinise research proposals to ensure that there are robust processes in place for the effective management of quality and safety;
- The removal of the role to review reports about services that are managed by Local Authorities and funded (whole or in part) by the ICB as it is the role of each Local Authority to do this;
- A general update to streamline the Terms of Reference and update language where this has changed nationally.

The Board of Members is asked to **APPROVE** the Terms of Reference for the Quality and Safety Committee.

Integrated Medicines Optimisation Committee ('IMOC') Terms of Reference

In the 2023-24 financial year the ICB became responsible for the delegated commissioning of community pharmacy from NHS England. Consequently, on 26th September 2023 IMOC reviewed its Terms of Reference and recommended the following amendments to its role to support the Board's strategic oversight of this:

- Ensure the development/transformation of community pharmacy is embedded in local Pharmacy and Medicines Optimisation Strategy;
- 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;
- Support implementation and delivery of all responsibilities retained by each individual ICB for Community Pharmacy described in the Memorandum of Understanding ('MOU) with North East London ICB ('NEL ICB') following delegation to ICBs of pharmacy, optometry and dental commissioning under the NHS England Delegation Agreement;
- 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;
- Escalate as appropriate to the Strategy & Development Committee 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.

The Board of Members is asked to **APPROVE** the Terms of Reference for the Integrated Medicines Optimisation Committee.

Standing Financial Instructions ('SFIs')

To facilitate the roles of the Primary Care Committee and the Procurement Oversight Group set out in their draft Terms of Reference the following amendments to annex 1 of the SFIs are requested:

Line	**Column(s)**	**New Wording**
1.3 New Strategic Investments/Business Cases	Primary Care Committee	Add the words: £5m for non-delegated budgets.
2.1 Approval to proceed to procurement	Primary Care Committee	Add the words: £5m for non-delegated budgets.
2.1 Approval to proceed to procurement	NCL ICB Committees Primary Care Committee	Add the words: Procurement Oversight Group £ As per approved business cases

In addition, an inconsistency in the SFIs has been identified whereby that the Chief Executive Officer and the Chief Finance Officer acting together can approve new strategic investments/business cases up to £5m but can only give approval to proceed to procurement up to a value of £1m. Therefore, the Board is asked to approve an amendment to the SFIs so that the Chief Executive Officer and the Chief Finance Officer acting together can give approval to proceed to procurement up to a value of £5m as follows:

	<table><tr><th>Line</th><th>Column(s)</th><th>New Wording</th></tr><tr><td>2.1 Approval to proceed to procurement</td><td>Chief Executive Officer Chief Finance Officer</td><td>Amend £1m to £5m.</td></tr></table> The Board of Members is asked to **APPROVE** the amendments to the Standing Financial Instructions. <u>Functions and Decisions Map and other governance documentation</u> Any approved amendments to committee Terms of Reference and the SFIs will need to be reflected, as appropriate, in the ICB's Functions and Decisions Map and in other relevant governance documentation. 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 Primary Care Committee Terms of Reference; • **APPROVE** the Procurement Oversight Group Terms of Reference; • **APPROVE** the Quality and Safety Committee Terms of Reference; • **APPROVE** the Integrated Medicines Optimisation Committee Terms of Reference; • **APPROVE** the amendments to the Standing Financial Instructions; • **APPROVE** the amendments to the Functions and Decisions Map and to other governance documentation.
Identified Risks and Risk Management Actions	<u>Changes to the Primary Care Commissioning & Provider Landscape</u> The role of the ICB around Primary Care has evolved. PCNs as key vehicles for delivery of general practice services and improvements in population health mean there is less differentiation between national delegated and local non-delegated funding, commissioning and contracting. The Primary Care Committee has identified key risks in primary care (such as primary care access and workforce) and the proposed amendments to the Terms of Reference supports the Primary Care Committee to mitigate those risks. <u>Introduction of the NHS Provider Selection Regime</u> The new NHS Provider Selections Regime is being introduced in January 2024. It will fundamentally change how the NHS commissions and procures services. The amendments to the Procurement Oversight Group's Terms of Reference ensures that the ICB has the appropriate governance arrangements in place to be ready for PSR, oversee the introduction and transition period and support strong organisational compliance. <u>Quality and Safety Committee</u> The revisions to the Terms of Reference support the Board to discharge its Quality and Safety functions by strengthening the Committee's membership and its remit. <u>Integrated Medicines Optimisation Committee</u> The revisions to the Terms of References support the Board to effectively oversee the delegated arrangements for community pharmacy.
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 Primary Care Committee Terms of Reference (and the SFIs) will support the ICB to improve population health and make better use of its resources by enabling the Primary Care Committee to make decisions on key areas such as Local Enhanced Services and primary care access.

	The proposed amendments to the Procurement Oversight Group Terms of Reference will support the ICB to make better use of its resources by ensuring that PSR is properly implemented. This will also reduce the risks associated with the introduction of a major transformation and legal challenge.
Engagement	The draft Terms of Reference were shared with the respective committee members. They were both recommended for approval by the Board.
Equality Impact Analysis	This paper has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	A Governance Review paper was last presented to the Board on 25th July 2023.
Next Steps	If the ICB Board approve the recommendations the next step is to implement them.
Appendices	• Draft Primary Care Committee Terms of Reference; • Draft Procurement Oversight Group Terms of Reference; • Draft Quality and Safety Committee Terms of Reference; • Draft Integrated Medicines Optimisation Committee Terms of Reference.

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

1. Introduction

1.1 The Primary Care 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 Strategy and Development 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, scrutiny and decision making for primary medical services;
b) Make decisions in relation to the commissioning and management of primary medical services contracts;
c) Have oversight of quality and performance in primary medical services; and,
d) Provide oversight and assurance of the primary care budget delegated from NHS England.

3. Role

3.1 The Committee will:

a) Make decisions for the commissioning and management of Primary Medical Services Contracts, including but not limited to the following activities:
- Decisions in relation to GP core contracts and directed enhanced services;
- Decisions in relation to Local Enhanced Services;
- Decisions in relation to the establishment of GP practices (including branch surgeries) and closure of GP practices;
- Decisions in relation to access to primary care including enhanced access;
- Decisions about 'discretionary' payments permissible under Guidelines;
- Management of delegated primary care funds;
- Decisions about commissioning for out of area registered patients;
- Approval of practice mergers;
- Planning primary medical care services in the area, including carrying out needs assessments and monitoring of list size changes;
- Ensuring the ICB and providers of primary medical services uphold the duty to engage Undertaking reviews of primary medical care services;
- Ensure there is appropriate oversight of primary care procurements;
- Decisions in relation to the management of poor performance, which –without limitation – include, use of remedial and breach notices and application of wider contract terms and , decisions and liaison with NHSE and the CQC where the CQC has reported non-compliance with standards (excluding any decisions in relation to the performers list which remains with NHSE);
- Application of the Premises Cost Directions in the planning, approval and funding of primary care estate;
- Approve the elements of ICB estates schemes that pertain to primary care rent, rates or patient access;

- Coordinating a consistent approach to the commissioning of primary care services aligned to the primary care strategy and ICB Population Health and Inequalities Improvement Strategy; and
- Such other ancillary activities that are necessary in order to exercise the Delegated Functions.

b) Give due regard to the Primary Medical Care Policy and Guidance Manual, Delegation Agreements with NHS England and ICB commissioning policies and frameworks;
c) Shape and set ICB commissioning policies and frameworks for primary care contracts;
e) Oversee and approve primary care workforce plans including those that pertain to national primary care contracts including but not limited to minimum staffing numbers and the Additional Roles Reimbursement Scheme ('ARRS'); and,
f) Oversee and approve Digital plans that pertain or have implications for primary care access service models. This may include but is not limited to online consultation models.
g) Receive information on and give due regard to Primary Care strategy and policy set at a national and local level.

4. Membership

4.1 The Committee shall comprise of the following voting members:
a) Two Non-Executive Members;
b) Chief People Officer;
c) Chief Medical Officer;
d) Chief Nursing Officer;
e) Executive Director of Place;
f) 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) Director of Primary Care Transformation and Programmes;
b) Assistant Director of Primary Care Contracts;
c) Clinical Director for Primary Care;
d) A representative from the Quality Directorate;
e) A Director of Public Health;
f) Healthwatch Representative;
g) LMC Representative;
h) Community Participants;;
i) VCSE Alliance 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 a 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 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 the 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 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 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. Meetings Held in Public

14.1 Meetings of the Committee shall be held in public unless the Committee resolves to exclude the public from a meeting. In which case the meeting, in whole or in part, may be held in private. The Committee may also exclude non-voting attendees and observers. Meetings or parts of meetings held in public will be referred to as 'Meeting Part 1'. Meetings or parts of meetings held in private will be referred to as 'Meeting Part 2.'

14.2 Attendees, observers and the public may be excluded from all or part of a meeting at the Committee's absolute discretion whenever publicity would be prejudicial to the public interest by reason of:

a) The confidential nature of the business to be transacted;
b) The matter is commercially sensitive or confidential;
c) The matter being discussed is part of an on-going investigation;
d) The matter to be discussed contains information about individual practitioners, patients or other Individuals which includes sensitive personal data;
e) Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings is to be discussed;
f) Other special reason stated in the resolution and arising from the nature of that business or of the proceedings;
g) Any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time; or
h) Allowing the meeting to proceed without interruption, disruption and/or general disturbance.

15. Questions from the Public and Deputations

15.1 The Committee may receive questions from the public at its absolute discretion in line with the ICB's protocol for public questions which is available on the ICB's website.

15.2 The Committee may receive, at its absolute discretion, Deputations from members of the public or interested parties to make the Committee aware of a particular concern or concerns they have.

15.3 Any Deputations should be sent to the Committee secretariat who will pass it to the Chair for consideration.

15.4 Any Deputations must be received by the Committee secretariat at least three working days before a Committee meeting is due to take place to be eligible to be heard at that Committee meeting. However, where it is not possible to comply with this deadline due to the papers of the meeting being published later or due to a public holiday the Deputations must be submitted within a reasonable time.

15.5 Any Deputations not received within this time will not be eligible to be heard at that Committee meeting. However, on a strictly case by case basis there may be times where it would be highly beneficial to the Committee's business to waive this requirement due to the relevance or content of the Deputations. In these circumstances the Chair may do so on a case by case basis and without setting any precedents of future or further waivers.

15.6 Any Deputations must take the form of a written request together with a statement setting out what the Deputation is about. If any Deputation fails to set out this information it will be rejected.

15.7 Any Deputations which are not relevant to the Committee's business will be rejected

15.8 The Chair may accept or reject any relevant and properly completed Deputations on a strictly case by case basis at his/her absolute discretion and without setting any precedents for future or further decisions.

15.9 If a request is agreed the interested party and/or parties will be invited to a Committee meeting where the Committee will consider the Deputation.

15.10 The Chair may decide how much time to allocate to any Deputations at his/her absolute discretion on a case by case basis and without setting any precedents for future or further decisions on time allocated for Deputations.

15.11 Nothing in this section 15 shall limit, prohibit or otherwise restrict the Committee's powers contained in sections 4, 5, 14 or 16 of these Terms of Reference.

16. Confidentiality

16.1 Members of the Committee shall respect the confidentiality requirements set out in these Terms of Reference unless separate confidentiality requirements are set out for the Committee in which event these shall be observed.

16.2 Committee meetings may in whole or in part be held in private as per section 14 above. Any papers relating to these agenda items will be excluded from the public domain. For any meeting or any part of a meeting held in private all members and/or attendees must treat the contents of the meeting and any relevant papers as strictly private and confidential.

16.3 Decisions of the Committee will be published by Committee members except where matters under consideration or when decisions have been made in private and so excluded from the public domain in accordance with section 14 above.

17. Authority

17.1 The Committee is accountable to the ICB Strategy and Development 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.

17.2 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.

18. Reporting Responsibilities

18.1 The Committee will report to ICB Strategy and Development Committee on all matters within its duties and responsibilities.

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

19. Delegated Authority

19.1 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.

20. Virtual Meetings and Decision Making

20.1 Committee meetings may be held in person or virtually.

20.2 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.

20.3 In addition to the general authority set out in clause 20.2 above, due to the nature of primary care commissioning 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 20.4 – 20.5 and 20.8 below.

20.4 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 non-conflicted clinician;
c) Executive Director of Place.

20.5 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 non-conflicted clinician;
c) Executive Director of Place.

20.6 Due to the nature of primary care commissioning the Committee recognises that the following non-contentious, low risk, decisions may be made outside of Committee meetings by those listed in clause 20.7 below:

- Requests to add or remove a partner;
- Requests for individuals to be added or removed from PMS contracts;
- Retirement of a partner and adding of a new partner;
- Partnership changes- 24 hour retirement;
- Requests for contract novation where there is no change of provider;
- Requests to increase a catchment area;
- Increases in practice boundaries;
- Requests for GP practices to change which Primary Care Network they are part of;
- List closures for a period of up to 6 months;
- Caretaking contract extensions where the extension is permitted under the contract and so is not a new procurement or award of contract;
- Requests for GP practice reimbursement of Stamp Duty Land Tax ('SDLP') and/or legal fees where the request has been submitted after a decision on the premises has already been taken);
- Increases in rent following district valuer rent reviews;
- Increased in rent to the value of £50k per annum;

20.7 The following people or their nominated deputies may collectively make the non-contentious, low risk decisions set out in clause 20.6 above:

a) The Committee Chair;
b) A non-conflicted clinician;
c) Executive Director of Place.

20.8 Decisions made outside of Committee meetings will be reported to the Committee at the next Committee meeting. This may be in a public or private part of the meeting depending on the nature of the business and the decision(s) made.

21. Sub-Committees

21.1 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 or working group.

22. Conflicts of Interest

22.1 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.

22.2 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

23. Gifts and Hospitality

23.1 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.

23.2 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

24. Standards of Business Conduct

24.1 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.

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

25. Review of Terms of Reference

25.1 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.

25.2 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 Committee are:

Position	Name
Non-Executive Member	
Non-Executive Member	
Chief People Officer	
Chief Medical Officer	
Chief Nursing Officer	
Executive Director of Place	
Director of finance	

Committee Chair:

Position	Name
Non-Executive Member	

The standing participants are:

Position	Name
Director of Primary Care Transformation and Programmes	
Assistant Director of Primary Care Contracts	
Clinical Director for Primary Care	
A representative from the Quality Directorate	
A Director of Public Health	
Healthwatch Representative	
LMC Representative	
Community Participants	
VCSE Alliance Representative	

NHS North Central London
Integrated Care Board
Procurement Oversight Group
Terms of Reference

1. Introduction

1.1 The Procurement Oversight Group ('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:

a) Be a non-conflicted forum which provides oversight and scrutiny of key procurements undertaken by the ICB and ensure that the correct procurement regime is complied with, properly evidenced, is transparent, and that conflicts of interest are appropriately managed;
b) Oversee the organisational transition to the NHS Provider Selection Regime and its implementation;
c) Provide assurance to the Board of Members and other committees and sub-committees as appropriate that conflicts of interest are properly managed throughout the development of the business case, the approval process and that the procurement routes for services are appropriate;
d) Ensure that procurement processes are proportionate to the cost and complexity of the services to be procured;
e) Provide approval to proceed to procurement for approved business cases;
f) Approve service models where these have been remitted to the Procurement Oversight Group by the Board of Members or one of its committees or sub-committees;
g) Have oversight of any procurement where the contract value is £500,000 (five hundred thousand pounds) or greater across the life of the contract and/or any other procurement where the Board of Members and/or any of its commissioning committees request oversight by the Procurement Oversight Group;
h) Ensure procured contracts are being managed effectively once awarded and that lessons learned are implemented.

3. Role

3.1 The Committee shall:

a) Ensure the ICB is operating under the correct procurement regime that is legally in force in England at the time;
b) Until the NHS Provider Selection regime is in place the ICB is required to act in accordance with the National Health Service (Procurement, Patient Choice and Competition) (No.2 Regulations 2013) and the Public Contracts Regulations 2015. This includes but is not limited to:
    - Ensuring that services are commissioned free of bias and that procurement decisions are defendable from scrutiny and challenge;
    - Ensuring that robust tender documentation, clear evaluation criteria, and an appropriate evaluation panel with non-conflicted subject matter experts is in place;

- Ensuring robust scrutiny of the process, documented evidence and final award documentation to ensure that the decision made aligns to both the process included in the tender documentation and to the original business case;
- Review ICB business case proposals to ensure procurement implications have been tested prior to the business case decision and to agree the most appropriate procurement route to market;
- Ensuring conflicts of interest are managed appropriately throughout the commissioning cycle;

c) Oversee the organisational transition to the NHS Provider Selection Regime and its implementation;
d) Ensure that when the NHS Provider Selection Regime comes into force that procurement decisions are taken appropriately, there is a sound rationale for which process is followed and decisions and rationale are properly evidenced in line with the law and NHS England guidance;
e) Ensure that procurements are transparent, fair and proportionate;
f) Ensure that conflicts of interest are managed appropriately throughout the commissioning cycle, the development of business cases and when making decisions under the NHS Provider Selection Regime;
g) Ensure that there is a clear procurement process in place that follows best practice and is proportionate to the complexity and cost;
h) Provide oversight where procurements under the NHS Provider Selection Regime are abandoned or where a procurement is returning to an earlier stage;
i) Consider lessons learned reviews and ensure that there are suitable systems, processes and action plans in place to address issues arising from the reviews. This includes during the procurement and contracting process and where procurements have been stopped or failed;
j) Provide approval to proceed to procurement for approved business cases;
k) Approve service models where these have been remitted to the Committee by the Board of Members or one of its committees or sub-committees;
l) Provide oversight of compliance with the ICB's Procurement Policy;
m) Approve the ICB's procurement policy and procedures;
n) Receive Procurement Representation Panel outcomes, advice, recommendations and lessons learned;
o) Approve the Terms of Reference for the Procurement Representation Panel;
p) Scrutinise awarded contracts where there are concerns about the operational, financial or performance aspects and establish the appropriate procurement and/or contract approach the ICB should implement to deal with these issues;
q) Oversee the ICB's approach to delivering the Procurement Target Operating Model (or its successor) including as part of a wider Integrated Care System;
r) Ensure the ICB has a robust procurement savings plan and oversee its delivery;
s) Provide oversight and scrutiny of procurement risks;
t) Provide advice, guidance and recommendations on any area within its remit to the Board of Members and/or any of its committees or sub-committees as appropriate;
u) Oversee the Register of Procurement Decisions and ensure that Single Tender Waivers are included.

4. Membership

4.1 The Committee shall comprise of the following voting members:
a) Chief Finance Officer;
b) Chief Strategy and Population Health Officer;
c) Executive Director of Corporate Affairs;
d) Director of Quality.

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) A procurement specialist;
b) Assistant Director of Governance, Risk and Legal Services.

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 Chief Finance 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 (or their deputies) are present:
   a) The Chair;
   b) A Clinician; and,
   c) An Executive Director other than the Chair.

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 the Corporate Affairs Directorate.

10. Frequency of Committee Meetings

10.1 Committee meetings will be held 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 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 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 Corporate Affairs Directorate 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 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 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.

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
Chief Finance Officer	
Executive Director of Corporate Affairs	
Chief Strategy and Population Health Officer	
Director of Quality	

Committee Chair:

Position	Name
Chief Finance Officer	

The standing participants are:

Position	Name
Procurement specialist	
Assistant Director of Governance, Risk and Legal Services	

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) Chief People Officer.
g) Director of Quality.
h) Director of Safeguarding.
i) 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 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 Last Review:
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	
Chief People Officer	
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	

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) 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') and the NCL Medicines Optimisation Board ('MOB');
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 Non-Executive Member;
b) A clinical member of the Board of Members other than the Chief Medical Officer or Chief Nursing Officer;
c) Chief Medical Officer;

d) Chief Pharmaceutical Officer;
e) Chief Nursing Officer;
f) Executive Director of Place;
g) 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 Directors/Heads of Medicines Management;
c) 2 Community Participants;
d) 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 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 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 Non-Executive Member	
A clinical member of the Board of Members other than the Chief Medical Officer or Chief Nursing Officer	
Chief Medical Officer	
Chief Pharmaceutical Officer	
Chief Nursing Officer	
Executive Director of Place	
A director of finance	

Committee Chair:

Position	Name
A Non-Executive Member	

The standing participants are:

Position	Name
Clinical and Care Director (prescriber)	
Assistant Director / Heads of Medicines Management	
2 Community Participants	
5 Sector members who bring sector experience and perspective to Committee's deliberations	

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 November 2023

Report Title	Update on the Delegation of Commissioning of Specialised Services	**Date of report**	17 October 2023	**Agenda Item**	5.1
Lead Director / Manager	Sarah Mansuralli Chief Strategy & Population Health Officer	**Email / Tel**		Sarah.mansuralli@nhs.net	
Board Member Sponsor	Not applicable.				
Report Author	Mark Eaton, Director of Strategic Commissioning & Procurement	**Email / Tel**		Mark.eaton1@nhs.net	
Name of Authorising Finance Lead	Anthony Browne, Deputy Chief Finance Officer	**Summary of Financial Implications** Specialised Services income represents £1.2bn for NCL of which less than 1/3 arises from our own patients. The proposal is that from April 2024 approximately 62% of this total will be delegated to the ICB for direct commissioning of services with a further 28% scheduled for delegation from April 2025. At this time there is a possibility that delegation will be delayed until April 2025. There are a number of risks associated with delegation in regards to existing issues with services that are still being assessed and quantified. These will need the development of a handling strategy that will need to be agreed with NHS England (NHSE).			
Report Summary	The North Central London ICB (NCL ICB) is the second largest sector for income arising from Specialist Commissioned Services in London and one of the largest sectors overall in the country. Our total income from specialist services is £1.2bn across our 7 providers with only 1/3 of this arising from our own patients. This makes the NCL Integrated Care System (NCL ICS) one of the largest importers of patients needing specialised care in the country. The proposal is currently that 59 services, representing 62% of the total value of specialised services will be delegated to the NCL ICB. In September, following submission of a Pre-Delegation Assurance Framework (PDAF), the NCL ICB was rated as, “Ready for Delegation with Conditions”. This was the case for all London ICBs with the exception of North West London who were rated as needing intensive support. In September 2023, NHSE London submitted recommendations to the national team that the following four conditions be applied to the delegation of services in				

	London along with a request by NHSE London to defer delegation by 1 year until April 2025 to allow time for these actions to be resolved: 1. the production of a strategic risk-based clinical framework for specialised services, 2. an articulation of the risks being transferred to ICBs, both financial and quality (i.e. a legacy risk log) 3. finalisation of a future operating model working with a single 'hub' of NHSE staff who are part of the resource to support ICBs on delegation, and 4. to set out a model of joint decision making where some specialised services need to be planned on a population footprint bigger than a single ICB The first two actions arise from work initiated within the NCL ICS to understand the risks that are transferring along with the services. This work has been undertaken in collaboration between providers, the ICB and NHSE London and is approaching completion. This is identifying material clinical, operational and financial risks associated with services that will require investment both in terms of revenue and capital. This work is now being emulated across London by all ICBs and we will need to work with NHSE London to develop a handling strategy for these risks (in terms of how we account for investments that will be needed). This work is also key to finalising our clinical priorities for Spec Comm with these already including work on Renal (particularly to address dialysis capacity), Sickle Cell and Liver Disease. Following the submission by NHSE London, a moderation meeting was held by the NHSE National team in October 2023 with the following outcomes: • London's request to defer delegation in 25/26 is agreed with 24/25 being a year of operation in shadow form and joint working. • There is an aspiration for the pathfinder programme (currently running only in South London) to be extended to cover the entirety of London. • As it is likely that there will be a mixed economy nationally (with some regions gaining delegation from April 2024 and others from April 2025), London Region will need to work quickly with the East of England and South East Region to assess risks and put in place mitigations. • To avoid destabilisation of services in London, there is a desire to create a longer term strategy for specialised services that ensures sustainability but the priority in the short term is a safe landing for delegated services. • The protection of specialised budgets at a time of financial challenge was noted as being key to successful implementation of delegation. During the transition period we will continue working with the NHSE London team and London ICB colleagues noting the need for NHSE London to strengthen its programme management support for the overall delegation programme and the need to improve coordination of actions related to delegation such as concurrently finalising the clarification of all risks that will transfer to ICBs, determining the longer term strategy for mandated clinical networks and reshaping and landing the future of the NHSE Staffing Hub, with the latter including some 90 people working for NHSE London to support the entirety of specialised services (including those to be retained). During this period of joint working with the London region in 24/25, there will also be a focus on developing and agreeing operating procedures designed to manage how decisions are made across multiple ICS footprints including change management processes and cashflow and contracting processes. This work is of great importance to NCL due to the large % of our income that arises from patients from other ICBs. The most important ICBs to NCL are the East of England and South East Region, with the income from the East of England being almost as much as the income received from all other London ICBs (East of England £219m – all other London ICBs £268m).

	The delegation of Specialist Commissioning services to ICBs presents a significant opportunity for improving outcomes for the many patients who use our services. We have already taken steps to improve outcomes for patients with diabetes and Chronic Kidney Disease (CKD) to reduce the number who will ultimately need Renal Dialysis as well as the progress made in improving Sickle Cell pathways and establishing an improvement plan for Liver Disease. The joining up of pathways and the ability of systems to make end to end pathway decisions designed to improve outcomes and at the same time ensure the sustainability of complex specialised services is a significant step forward in delivering integrated care. Prior to delegation in April 2025 there remains a significant number of tasks to undertake including: • Ensuring we have fully understood the clinical, operational, financial and performance risks and issues associated with all services that are being delegated. • Agreeing a handling strategy with NHSE for the identified risks and issues. • Refreshing our clinical priorities based on the identified risks and issues whilst progressing our existing clinical priorities around Renal, Liver and Sickle Cell. • Working with NHSE London and our London ICB partners to shape the future functions and structure of the NHSE Staffing Hub. • Considering the resourcing we will need to put in place as a system to respond to the challenges around delegation. • Understanding how decisions that affect populations across ICS boundaries will be made. • Ensuring we have robust standard operating procedures around change management, cashflow and contracting. Beyond the initial wave of delegated services, rated 'Green' to indicate they are ready for delegation, there are a further 28 services rated 'Amber' indicating that they will be suitable for delegation at a point in the future. The timeline for delegation of 'Amber' rated services is not yet clear but is potentially now April 2025, along with the Green services. The 89 services that will remain commissioned by NHSE (Red Rated) primarily affect the services that are classified as 'Highly Specialised' which will not be delegated to ICBs. It is expected that we will work closely with NHSE and be involved in joint decision making around retained services. NHSE have also made the decision to retain responsibility for all drugs and devices related to specialised services, again requiring us to work closely with NHSE on these matters. This paper highlights the key areas of work still to be undertaken as well as progress to date to achieve a successful transfer of services from NHSE commissioning to NCL ICB in April 2025.
Recommendation	The Board of Members is asked to: • **NOTE** the progress of the delegation of NHSE specialised services to the ICB and the work still to be undertaken to prepare for delegation in April 2025. • **NOTE** that a delegation agreement will be presented to the Board for approval to sign in November 2024 to allow delegation to proceed from April 2025.
Identified Risks and Risk Management Actions	The main risks associated with delegation are summarised below: • There are material risks associated with existing services that will be delegated and we are undertaking a detailed programme of due diligence to

	assess, quantify and rate each of these. This work is being done in collaboration with Providers and NHSE. • There is a need for clarity around how decisions are to be taken with respect to cross-ICB/ICS pathways, something of material interest to NCL due to the sector being a significant importer of care from elsewhere in the UK. This work is linked to the development of a number of national standard operating procedures associated with delegation and also impacted by changes to the funding formula (although the impact of this last point will not be material on NCL). • NHSE London need to strengthen the programme management and oversight to ensure that all four tasks that were flagged as being required prior to delegation are completed across all London ICBs by October 2024. • We need clarity around the roles, functions and hosting arrangements for the NHSE Staffing hub and are working with London ICBs and NHSE to agree this. A full list of risks and mitigations is outlined within the body of the report.
Conflicts of Interest	None identified.
Resource Implications	See Financial Implications section above. Additional commissioning resources may be required to support delegation and this is yet to be determined as to whether it will come from the NHSE centralised team or need to be provided locally.
Engagement	We have undertaken a wide range of engagement activities with providers across the sector. We are also planning an initial NCL ICS Stakeholder Engagement session on 4th December 2023 to raise awareness of delegation and the challenges we face as well as outlining the opportunities and workplan.
Equality Impact Analysis	Not applicable.
Report History and Key Decisions	This report builds on information provided to Board previously. Updates have also been discussed at EMT and Strategy and Development Committee at points over the last 2 years.
Next Steps	Depending on the discussions at Board and any feedback from NHSE (regional or national) the following are the next steps we anticipate occurring: • Progress the actions outlined earlier within this document to prepare for delegation and deal with the tasks/conditions set by NHSE in advance of delegation in April 2025. • Engage Providers to finalise the due diligence as planned and together with NHSE London and the NCL Clinical Reference Group review, quantify the risks and develop mitigating actions. • Continue with developing transformation work via working groups/networks and engagement with other ICBs. This will include important stakeholder areas like East Of England ICBs. • Work with NHSE and NCL Providers to prepare Finance and Contracting parameters for the 2024/25 contract agreement noting that the contracting and contract management will be undertaken on a joint basis during 2024/25 in advance of delegation from 2025/26. • Host an initial NCL ICS Stakeholder Engagement session on 4 December 2023 to raise awareness of delegation and the challenges we face as well as outlining the opportunities and workplan.
Appendices	For brevity we have not included Appendices with this document but the following are available on request:

	• Supporting tables outlining income for NCL, sources of that income and how this breaks down across providers and services. • The NCL Pre-Delegation Assessment Framework Assessment and NCL ICB cover letter • NCL PDAF Response Letter from NHSE London Region • The London Joint Working Agreement • Details of our Clinical Priorities • Details of the outstanding risks and issues identified by providers associated with existing services that are part of our due diligence process.

North Central London
Integrated Care Board

Delegation of Specialised Commissioning Services from NHS England to the North Central London ICB

November 2023

1. Executive Summary

The North Central London ICB (NCL ICB) is the second largest sector for income arising from Specialist Commissioned Services in London and one of the largest sectors overall in the country. Our total income from specialist services is £1.2bn across our 7 providers with only 1/3 of this arising from our own patients. This makes the NCL Integrated Care System (NCL ICS) one of the largest importers of patients needing specialised care in the country.

The proposal is currently that 59 services, representing 62% of the total value of specialised services will be delegated to the NCL ICB. In September, following submission of a Pre-Delegation Assurance Framework (PDAF), the NCL ICB was rated as, “Ready for Delegation with Conditions”. This was the case for all London ICBs with the exception of North West London who were rated as needing intensive support.

In September 2023, NHSE London submitted recommendations to the national team that the following four conditions be applied to the delegation of services in London along with a request by NHSE London to defer delegation by 1 year until April 2025 to allow time for these actions to be resolved:

1. the production of a strategic risk-based clinical framework for specialised services,
2. an articulation of the risks being transferred to ICBs, both financial and quality (i.e. a legacy risk log)
3. finalisation of a future operating model working with a single ‘hub’ of NHSE staff who are part of the resource to support ICBs on delegation, and
4. to set out a model of joint decision making where some specialised services need to be planned on a population footprint bigger than a single ICB

The first two actions arise from work initiated within the NCL ICS to understand the risks that are transferring along with the services. This work has been undertaken in collaboration between providers, the ICB and NHSE London and is approaching completion. This is identifying material clinical, operational and financial risks associated with services that will require investment both in terms of revenue and capital. This work is now being emulated across London by all ICBs and we will need to work with NHSE London to develop a handling strategy for these risks (in terms of how we account for investments that will be needed). This work is also key to finalising our clinical priorities for Spec Comm with these already including work on Renal (particularly to address dialysis capacity), Sickle Cell and Liver Disease.

Following the submission by NHSE London, a moderation meeting was held by the NHSE National team in October 2023 with the following outcomes:

- London’s request to defer delegation in 25/26 is agreed with 24/25 being a year of operation in shadow form and joint working.
- There is an aspiration for the pathfinder programme (currently running only in South London) to be extended to cover the entirety of London.

- As it is likely that there will be a mixed economy nationally (with some regions gaining delegation from April 2024 and others from April 2025), London Region will need to work quickly with the East of England and South East Region to assess risks and put in place mitigations.
- To avoid destabilisation of services in London, there is a desire to create a longer term strategy for specialised services that ensures sustainability but the priority in the short term is a safe landing for delegated services.
- The protection of specialised budgets at a time of financial challenge was noted as being key to successful implementation of delegation.

During the transition period we will continue working with the NHSE London team and London ICB colleagues noting the need for NHSE London to strengthen its programme management support for the overall delegation programme and the need to improve coordination of actions related to delegation such as concurrently finalising the clarification of all risks that will transfer to ICBs, determining the longer term strategy for mandated clinical networks and reshaping and landing the future of the NHSE Staffing Hub, with the latter including some 90 people working for NHSE London to support the entirety of specialised services (including those to be retained).

During this period of joint working with the London region in 24/25, there will also be a focus on developing and agreeing operating procedures designed to manage how decisions are made across multiple ICS footprints including change management processes and cashflow and contracting processes. This work is of great importance to NCL due to the large % of our income that arises from patients from other ICBs. The most important ICBs to NCL are the East of England and South East Region, with the income from the East of England being almost as much as the income received from all other London ICBs (East of England £219m – all other London ICBs £268m).

The delegation of Specialist Commissioning services to ICBs presents a significant opportunity for improving outcomes for the many patients who use our services. We have already taken steps to improve outcomes for patients with diabetes and Chronic Kidney Disease (CKD) to reduce the number who will ultimately need Renal Dialysis as well as the progress made in improving Sickle Cell pathways and establishing an improvement plan for Liver Disease. The joining up of pathways and the ability of systems to make end to end pathway decisions designed to improve outcomes and at the same time ensure the sustainability of complex specialised services is a significant step forward in delivering integrated care.

Prior to delegation in April 2025 there remains a significant number of tasks to undertake including:

- Ensuring we have fully understood the clinical, operational, financial and performance risks and issues associated with all services that are being delegated.
- Agreeing a handling strategy with NHSE for the identified risks and issues.
- Refreshing our clinical priorities based on the identified risks and issues whilst progressing our existing clinical priorities around Renal, Liver and Sickle Cell.
- Working with NHSE London and our London ICB partners to shape the future functions and structure of the NHSE Staffing Hub.
- Considering the resourcing we will need to put in place as a system to respond to the challenges around delegation.

- Understanding how decisions that affect populations across ICS boundaries will be made.
- Ensuring we have robust standard operating procedures around change management, cashflow and contracting.

Beyond the initial wave of delegated services, rated ‘Green’ to indicate they are ready for delegation, there are a further 28 services rated ‘Amber’ indicating that they will be suitable for delegation at a point in the future. The timeline for delegation of ‘Amber’ rated services is not yet clear but is potentially now April 2025, along with the Green services.

The 89 services that will remain commissioned by NHSE (Red Rated) primarily affect the services that are classified as ‘Highly Specialised’ which will not be delegated to ICBs. It is expected that we will work closely with NHSE and be involved in joint decision making around retained services. NHSE have also made the decision to retain responsibility for all drugs and devices related to specialised services, again requiring us to work closely with NHSE on these matters.

This paper highlights the key areas of work still to be undertaken as well as progress to date to achieve a successful transfer of services from NHSE commissioning to NCL ICB in April 2025.

2. Strategic Overview of Delegation

Specialised services support people with a range of rare and complex conditions. These services often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions.

The new Health and Care Act 2022 gives the NHS the opportunity to reconnect the commissioning of whole pathways of care (from Primary, Community, Secondary and Specialised) and as part of this, NHSE announced that 59 specialised services would be planned for delegation to ICBs (Green - Ready for Delegation). A further 28 specialised services were deemed suitable but not yet ready to be delegated (Amber – Ready at a later stage), while 89 specialised services are not suitable to be transferred to ICBs and so will continue to be commissioned by NHSE (Red - Retained services).

Initially, delegation of the Green services were due to happen from April 2023 but due to the level of risk raised by ICBs in 2022/23 it was agreed that ICBs would enter into a Joint Working Agreement with NHSE during 2023/24 in preparation for delegation from April 2024. This provided an opportunity to collaboratively work through the associated risks flagged in the 2022/23 Pre-Delegation Assessment Framework (PDAF). However, delays in certain key actions, such as completing the due diligence on the risks that will be transferring and the difference in pace of preparation for delegation across London (most notably between NWL and the rest of London) led to NHSE London requesting a further delay to delegation until April 2025.

To avoid the need for any further delays NHSE London will have to strengthen the programme support provided for delegation to ensure all ICBs have completed the tasks required to ensure safe delegation from April 2025 and that the national actions required around Standard Operating Procedures for such things as Cashflow, Contracting and Change Management are in place.

For the NCL ICB, throughout Q3 and Q4 of 2022/23 and for Q1 and Q2 of 2023/24 we have worked closely with NHSE London, London ICB partners and NCL system partners as well as with colleagues from neighbouring ICBs and regions, including those from the East of England and South East regions. This has enabled us to establish robust governance arrangements including a Delegated Services Board involving all of our partners in joint discussions, joint work with providers and NHSE to quantify and address risks, establishment of North London governance arrangements around data, finance and contracting as well as the beginnings of a clinical strategy. Whilst there remains work to do we have made significant progress throughout the last 12 months and are in a strong position to accept delegation of services.

In South London ICBs, the Joint Working Arrangements has included running a national ‘pathfinder’ programme to trial aspects of delegation such as managing finances and accessing data. The learning from this supported the learning already gained by the NCL team in our work on Data, Finances and Clinical Prioritisation providing us with additional assurance that fed into our PDAF.

In August 2023/24 ICBs were required once again to complete a PDAF to support system readiness for delegation. ICBs were assessed regionally with three possible outcomes being suggested:

1. Category 1: Ready for Delegation
2. Category 2: Ready for Delegation with Conditions
3. Category 3: Ready for Delegation with Intense Support

The regional assessment was that four out of five London ICBs were Category 2 whilst North West London was assessed as Category 3 (Ready for Delegation with Intense Support). The conditions applied to all London ICBs related to the following four tasks that need to be completed to ensure a safe landing of delegated services:

1. the production of a strategic risk-based clinical framework for specialised services,
2. an articulation of the risks being transferred to ICBs, both financial and quality (i.e. a legacy risk log)
3. finalisation of a future operating model working with a single 'hub' of NHSE staff who are part of the resource to support ICBs on delegation, and
4. to set out a model of joint decision making where some specialised services need to be planned on a population footprint bigger than a single ICB

Following the NHSE Moderation Meeting in October 2023 it was agreed that NHSE London's request to extend the date for delegation to April 2025 had been accepted and it was further proposed to extend the South London pathfinder to the whole of London.

Prior to delegation occurring, the NCL ICB (along with all other ICBs) will be required to sign a 'Delegation Agreement', this being the legal document transferring commissioning responsibility from NHSE to the NCL ICB. This will be reviewed by external legal advisors and the resulting advice and the document itself will be presented to the Board in November 2024 for approval.

Other key matters related to delegation that the Board should be aware of include:

1. Budgets will move from the current activity base to a revised population needs based. The impact of this over time for NCL is a reduction in our allocation by ~£5m (<0.5% of our budget) but is not expected to be a material matter given that neighbouring regions (such as the East of England) will see an increased allocation.

2. Along with services that are rated as Amber (ready for delegation from April 2025) and Red (services not suitable for delegation), NHSE will also retain responsibility for all Drugs & Devices even for Green services. This is due to the specialist nature of these items.

3. The workplan required to address the four conditions/tasks set by NHSE is underway and is outlined within the Executive Summary. To support ICBs, NHSE are appointing a new Director of Delegation to create and manage a roadmap to delegation. This will build on the significant progress we have already made in areas such as identifying and improving key clinical priorities (such as Sickle Cell, Renal and Liver), due diligence on the outstanding risks that will transfer at the point of delegation and engagement with our providers.

3. Risks and Mitigation

Accompanying the PDAF that was submitted the NCL ICB sent a covering letter outlining five priority risks that needed to be addressed. These risks are included in the table below along with the appropriate mitigations. All of these are required to be addressed prior to or as part of delegation. It is clear that the risks identified by NCL have strongly influenced the tasks/conditions identified by NHSE for action prior to delegation.

Risk Name	Risk Description	Mitigations	Rating
Existing Service Issues & Risks	A material number of services have existing issues that need to be resolved. Some of these are long-standing and will take some time to resolve and we need to consider how the risk that is transferring is managed collaboratively between the ICB, Providers and NHSE post delegation.	We have been working with NHSE to categorise and assess these risks. We now need to work with providers to finalise this work. We need to agree with NHSE how the risk will be handled post delegation particularly where this negatively impacts on the ICS financial position.	High
Cross Border Decision Making	With budgets devolving to individual ICBs there is a risk that decisions will be made that could impact on other sectors. Whilst interim arrangements are in place to ensure there is cross border communication, particularly with ICBs outside of London, this needs to be formalised before delegation. This risk could also be affected by differential arrangements between ICBs where the statuses (fully delegated, intense support etc) are different.	We have received a draft Standard Operating Procedure for Change Management and have run a Simulation Event. We now need to see the final version of the SOP. We need to agree a robust Collaborative Commissioning Agreement across London and with surrounding regions setting out how we will work together.	High
Contracting Arrangements	Currently providers for specialised services have a single arrangement coordinated with NHSE London for all Specialised Activity. Whilst we have moved in some case to integrated contracts between NHSE and the ICB the process of delegation will mean providers having to negotiate with ICBs instead of NHSE. For many providers this just means increased financial risk on existing associate relationships whilst for others it could mean needing to form new relationships with ICBs across the country.	We have received a draft Standard Operating Procedure for Contracting Management and have run a Simulation Event. We now need to see the final version of the SOP. The change of the LVA threshold from £500k to £1m will help but this may need further review and revision.	Medium
Resourcing Capacity	It is clear that the workload associated with delegation is significant and ICBs/ICSs are at varying levels of readiness in terms of resourcing. This resourcing will be affected by the future operating model for the NHSE Staffing Hub that is still to be agreed as well as any impact on the limited staffing hub resource required to support ICBs deemed to require 'intensive support'.	We are working with NHSE and London ICB colleagues to shape the future model and the hosting arrangements post delegation (recognising that the transition arrangements for 24/25) but these obviously need to be finalised. We are seeking to establish a jointly funded team and would wish to ensure that any additional staffing recruited to support delegation sit outside of the running cost allowance reductions for the ICB.	Medium
Funding Formula Changes	The impact of the funding formula changes including the speed of convergence to the new arrangements will have a negative impact on NCL and it is unclear how much of this loss of income will be recouped through income from other regions in England.	We have been involved in discussions with NHSE on this matter but there are clearly further concerns given the negative impact on NCL that need to be resolved prior to delegation including being clear about how the impacts on system financial totals will be considered in future assurance arrangements.	Medium

4. Recommendations

The NCL Board of Members is asked to:

- **NOTE** the progress of the delegation of NHSE specialised services to the ICB and the work still to be undertaken to prepare for delegation in April 2025.

- **NOTE** that a delegation agreement will be presented to the Board for approval to sign in November 2024 to allow delegation to proceed from April 2025.

5. Next Steps

Depending on the discussions at Board and any feedback from NHSE (regional or national) the following are the next steps we anticipate occurring:

- Progress the actions outlined earlier within this document to prepare for delegation and deal with the tasks/conditions set by NHSE in advance of delegation in April 2025.

- Engage Providers to finalise the due diligence as planned and together with NHSE London and the NCL Clinical Reference Group review, quantify the risks and develop mitigating actions.

- Continue with developing transformation work via working groups/networks and engagement with other ICBs. This will include important stakeholder areas like East Of England ICBs.

- Work with NHSE and NCL Providers to prepare Finance and Contracting parameters for the 2024/25 contract agreement noting that the contracting and contract management will be undertaken on a joint basis during 24/25 in advance of delegation from 25/26.

- Host an initial NCL ICS Stakeholder Engagement session on 4th December 2023 to raise awareness of delegation and the challenges we face as well as outlining the opportunities and workplan.