NHS
North Central London
Integrated Care Board

NHS North Central London ICB
Board of Members Meeting

Tuesday, 27 September 2022
2pm – 4pm
Claremont Room
Laycock Professional Development Centre
Laycock Street
N1 1TH

AGENDA
Part 1

Item	Title	Lead	Action	Page	Time
1.	**INTRODUCTION**				
1.1	Welcome and Apologies	Chair	Note	Oral	2pm
1.2	Declarations of Interest (not otherwise stated)	Chair	Note	3	
1.3	Minutes of the NCL ICB Board of Members Meeting on 4 July 2022	Chair	Approve	8	
1.4	Minutes of the NCL CCG Governing Body Meeting on 30 June 2022	Chair	Note	13	
.21.5	Matters Arising	Chair	Note	Oral	
1.6	**Questions from the public relating to items on the agenda received prior to the meeting** Members of the public have the opportunity to ask questions. These must relate to items that are on the agenda for this meeting and should take no longer than three minutes per person.				2.10pm
1.7	Update from the Chair	Chair	Note	Oral	2.25pm
1.8	Report from the Chief Executive Officer	Frances O'Callaghan	Note	22	2.30pm
2.	**STRATEGY AND BUSINESS**				
2.1	Community and Mental Health Services Strategic Reviews	Sarah Mansuralli	Approve	29	2.40pm
2.2	NCL Quality Vision	Deidre Malone	Approve	71	2.55pm

2.3	Start Well Update	Sarah Mansuralli	Endorse	79	3.05pm
2.4	Working With Our People and Communities Strategy and Working With Our VCSE Sector Strategy	Ian Porter	Approve	110	3.20pm
3.	**OVERVIEW REPORTS**				
3.1	Integrated Performance and Quality Escalation Report	Richard Dale and Deidre Malone	Note	139	3.30pm
3.2	Finance Report	Phill Wells	Note	160	3.40pm
3.3	Board Assurance Framework	Ian Porter	Approve	177	3.50pm
4.	**GOVERNANCE**				
4.1	Committee Terms of Reference, Standing Financial Instructions and Chair's Action Report	Ian Porter	Approve	192	3.55pm
5.	**ANY OTHER BUSINESS**				
5.1	Any Other Business				
6.	**DATE OF NEXT MEETING**				
6.1	29 November 2022 (2pm – 4pm)				

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
27 September 2022

Report Title	Declaration of Interests Register – NCL ICB Board of Members	**Date of report**	12 September 2022	**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**			
Report Author	Steve Beeho Board Secretary			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 - September 2022

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			
			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					
	Chair of ICB Board Member of ICB Finance Committee Chair of ICB Strategy and Development Committee	BEAT, the national Eating Disorders Charity	No	no	yes	direct	Chair of Trustees	19/11/2019	current	18/11/2019	08/07/2022
Ms Frances **O'Callaghan**	Chief Executive of North London Integrated Care System		no	no	no	no	nil return			24/02/2020	16/08/2022
	Member of ICB Finance Committee										
	Member of ICB Strategy and Development Committee										
	Member of ICB Executive Management Team										
Mr Phill **Wells**	Chief Finance Officer								current	23/06/2022	21/07/2022
	NCL ICB Board Member and Chief Finance officer Member of ICB Finance Committee Attendee of ICB Audit Committee Member of ICB Executive Management Team	Audit and Risk Committee, Department for Digital, Culture, Media and Sport	yes	yes	no	direct	Independent Member	2016	current	23/06/2022	21/07/2022
		Essex County Council	no	no	no	indirect	Partner is an IT Director	01/09/2019	current	21/07/2022	
		The Air Ambulance Service	yes	yes	no	direct	Trustee and Chair of Audit and Risk Committee	01/03/2022	current	23/06/2022	21/07/2022
Dr Jo **Sauvage**	Chief Medical Officer, Member of ICB Board, Member of ICB Executive Management Team		yes	yes	yes	direct		01/07/2022	current	10/07/2022	
	Also participate in multiple work streams NHS England & Improvement and Health Education England, London Region		yes	yes	yes	direct			current	10/07/2022	
		NCL Clinical representative London Clinical Executive Group	yes	yes	yes	direct	NCL Clinical Representative		current	10/07/2022	
		London People Board	yes	yes	yes	direct	CMO Representative		current	10/07/2022	
		London Primary Care School	yes	yes	yes	direct	ICS Representative		current	10/07/2022	
		London Anchors Board	yes	yes	yes	direct	GP Representative		current	10/07/2022	
		NHS London Sustainability Network/Co-Chair of the Board	yes	yes	yes	direct	Clinical Director		current	10/07/2022	
		London Region Air Quality Delivery Group	yes	yes	yes	direct	Co - Chair		current	10/07/2022	
		Membership Expert Advisory Group for Evidence based interventions. Hosted by Academy of Royal Colleges	yes	yes	yes	direct	Member		current	10/07/2022	
		Working for Islington GP Federation	yes	yes	yes	direct	Salaried GP	01/07/2022	current	10/07/2022	
		City Road Medical Centre	yes	yes	yes	direct	GP Partner	11/07/2019	current	10/07/2022	
		South Islington PCN	yes	yes	yes	direct	GP Pracitce is a member		current	01/07/2022	
Ms Kay **Boycott**	Non Executive Member, Member of the ICB Board,		yes	yes	yes	Direct		01/07/2022	current	11/07/2022	
	Member of ICB Strategy and Development Committee	Eakin Healthcare Group	yes	yes	yes	Direct	Director	01/09/2021	current	11/07/2022	
	Member of ICB Quality and Safety Committee	Imperial College Healthcare NHS Trust	yes	yes	yes	Direct	Director, Non Executive	01/09/2019	31/08/2022	11/07/2022	
	Chair of ICB Audit Committee	Kings Fund	yes	yes	yes	Direct	Member of the General Advisory Council	01/01/2017	31/12/2022	11/07/2022	
	Member of ICB Finance Committee	London Fire Brigade	yes	yes	yes	Direct	Independent Audit Committee Member	01/11/2020	current	11/07/2022	
	Member of ICB Remuneration Committee	Durham University	yes	yes	yes	Direct	Lay member of Council and Audit and Risk Committee Chair	27/11/2018	current	11/07/2022	
		English Heritage Trust	yes	yes	yes	Direct	Director	01/01/2022	current	11/07/2022	
		Various	yes	yes	yes	Direct	Various		current	11/07/2022	
		IBM	no	no	no	Indirect				11/07/2022	
Ms Liz **Sayce OBE**	Non Executive Member, Member of the ICB Board										

NCL ICB Board of Members Declaration of Interest Register - September 2022

	Chair of ICB Remuneration Committee	Commission for Equality at Centre for Mental Health	yes	yes		direct	chair	2018	2021	26/08/2022	
	Chair of ICB Quality and Safety Committee	Action on Disability and Development International	yes	yes		direct	vice chair	26/01/2021	current	26/08/2022	
	Member of ICB Audit Committee	London School of Economics	yes	yes		direct	Visiting Senior Fellow		current	26/08/2022	
	Vice-Chair of ICB Integrated Medicines Optimisation Committee	Social Security Advisory Committee	yes	yes		direct	Member and Vice-Chair	2016	current	26/08/2022	
	Member of ICB Primary Care Contracting Committee	Fabian Society Commission on Poverty and Regional Inequality	yes	yes		direct	Commissioner	2021	current	26/08/2022	
		Royal Society of Arts	no	no	no	direct	Fellow		current	26/08/2022	
		Institute for Employment Studies Commission on the Future of Employment Support	yes	yes	no	direct	Commissioner	2022	2024	26/08/2022	
		Recovery Focus (a national voluntary organisation)	no	no	no	indirect	Partner is a Trustee		current	26/08/2022	
		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	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, Member of ICB Board	none	N/A	N/A	N/A	N/A	N/A			04/07/2022	
Ms Caroline **Clarke**	Board Member ICB		no	yes	no	Direct	Member			02/07/2022	
	Member of ICB Finance Committee	Royal Free Hospitals	yes	yes	no	Direct	Group Chief Executive	2019	current	02/07/2022	
		North Middlesex University Hospital	yes	yes	no	Direct	Accountable Officer	01/04/2021	current	02/07/2022	
		Royal Free Charity	no	yes	no	Direct	Director / Trustee	24/06/2020	current	02/07/2022	
		UCL Partners Ltd	yes	yes	no	Direct	Director	29/04/2019	current	02/07/2022	
		RFC Developments	yes	yes	no	Direct	Director	21/03/2019	current	02/07/2022	
		Overcoming MS	no	yes	yes	Direct	Trustee	04/05/2017	current	02/07/2022	
		Healthcare Financial Management Association (HFMA)	no	yes	no	Direct	Trustee	09/12//2016	current	02/07/2022	
Mr Dominic **Dodd**	Board Member ICB		no	yes	no	Direct	Member	01/07/2022	current	04/07/2022	
		UCLH Alliance	yes	yes	yes	Direct	Chair	30/10/2019	current	04/07/2022	
		Royal National Orthopaedic Hospital	yes	yes	yes	Direct	Chair	01/11/2019	current	04/07/2022	
		KEHF Ltd	yes	yes	yes	Direct	director	31/03/2021	current	04/07/2022	
		Wildwood Square Ltd	yes	yes	yes	Direct	director	07/07/2020	current	04/07/2022	
		Disinformation Index Ltd	yes	yes	yes	Direct	director	01/02/2022	current	04/07/2022	
		Skin Analytics Lrd	yes	yes	yes	Direct	director	11/09/2019	current	04/07/2022	
		Kings Fund	no	yes	No	Direct	Trustee	06/12/2016	current	04/07/2022	
		NHSE/I	no	yes		Direct	Advisor on National and Regional Operating Model	01/10/2021	current	04/07/2022	
		UK Biobank	no	yes	No	Direct	Trustee	01/12/2021	current	04/07/2022	
Dr Usman **Khan**	Board Member ICB		no	yes	no	Direct	Member		current	07/09/2022	
	Chair of ICB Primary Care Contracting Committee	ModusEurope	yes	yes	yes	Direct	director	29/11/2012	current	07/09/2022	
	Chair of ICB Finance Committee	Motor Neurone Disease (Sales) Ltd	yes	yes	yes	Direct	director	27/06/2022	current	07/09/2022	
	Member of ICB Audit Committee	London Metropolitan University	yes	yes	yes	Direct	director	01/08/2022	current	07/09/2022	
	Member of ICB Remuneration Committee	Motor Neurone Disease Association	yes	yes	yes	Direct	Chair of Trustees / director	01/07/2021	current	07/09/2022	
		Good Governance Institute	no	yes	No	Direct	Managing Director	01/02/2022	current	07/09/2022	
Baroness Julia **Neuberger DBE**	Board Member ICB			yes	yes	direct	Member	01/07/20222	current	07/07/2022	
		UCLH	yes	yes	yes	direct	Chair	25/02/2019	current	07/07/2022	
		Whittington Health Trust	yes	yes	yes	direct	Chair	01/04/2020	current	07/07/2022	
		Walter and Liesel Schwab Charitable Trust	no	yes	no	direct	Trustee	06/12/2001	current	07/07/2022	
		Rayne Foundation	no	yes	no	direct	Trustee	09/09/2018	current	07/07/2022	
		Independent Age	no	yes	no	direct	Trustee	09/10/2019	current	07/07/2022	
		The Lyons Learning Trust	no	yes	no	direct	Trustee	13/04/2016	current	07/07/2022	
		Leo Baeck Institute	no	yes	no	direct	Trustee	15/07/2020	current	07/07/2022	
		Yad Hanadiv Charitable Foundation	no	yes	no	direct	Trustee	2021	current	07/07/2022	
		UK Commission on Bereavement	no	yes	no	direct	Member / Bereavement Commissioner	2021	current	07/07/2022	
		UCL Health Alliance	no	yes	no	direct	Vice Chair	2021	current	07/07/2022	
		House of Lords	yes	yes	no	direct	Independent Cross Bench Peer	15/06/2004	current	07/07/2022	
		West London Synagogue	no	yes	no	direct	Rabbi Emirata	01/03/2020	current	07/07/2022	
Ms Harjinder **Kandola MBE**	Board Member ICB							01/07/2022	current	21/07/2022	
		Barnet Enfield Haringey Mental Health Trust	yes	yes	yes	direct	Chief Executive	16/07/2018	current	21/07/2022	
		Camden and Islington Foundation Trust	yes	yes	yes	direct	Chief Executive	01/10/2021	current	21/07/2022	
Mr Ian **Porter**	Board Attendee ICB	none	n/a	n/a	n/a	n/a	n/a	01/07/2022	current	01/07/2022	
	Audit Committee, attendee										
	Procurement Oversight Group, voting member										

NCL ICB Board of Members Declaration of Interest Register - September 2022

	Remuneration Committee, attendee Member of ICB's Executive Management Team System Management Board, attendee										
Mr John **Hooton**	Board Attendee ICB		no	yes	no	direct		01/07/2022	current	06/07/2022	
		Barnet Borough Coiuncil	yes	no	yes	direct	Chief Executive	01/02/2017	current	06/07/2022	
		Live Unlimited Charity (no 1176418)	no	yes	no	direct	Chair of Trustee	01/03/2018	current	06/07/2022	
Dr Jonathan **Levy**	Board Attendee ICB		yes	yes	no	Direct		01/07/2022	current	04/07/2022	08/09/2022
	Clinical Lead – Living Well Camden Borough Mental Health	Jonathan Wigg Practice	Yes	Yes	No	Direct	GP Partner	15/11/2015	current	10/09/2019	08/09/2022
	Member of ICB Quality and Safety Committee 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 Attendeed ICB		yes	yes	no	Direct		01/07/2022	current	04/07/2022	
	Clinical Director Welbourne PCN	Fernlea Surgery	Y	Y	Y	Direct	Partner	1990	current	26/01/2021	04/07/2022
	Member of ICB Audit Committee	NCL GP Providers Alliance	Y	Y	Y	Direct	Board Member	01/05/2022	current	04/07/2022	
	Member of ICB Strategy and Development Committee	Jewish Care (National charity)	Y	Y	Y	Direct	Member of Clinical Governance Committee		current	26/01/2021	04/07/2022
		Federated4Health	Y	Y	Y	Direct	Practice is a member	2016	current	26/01/2021	04/07/2022
		Welbourne PCN	Y	Y	Y	Direct	Practice is a member	01/06/2020	current	26/01/2021	04/07/2022
		NHSE & I (London region) Medical Directorate	Y	Y	Y	Direct	Senior Clinical Advisor NHSE & I	01/04/2020	current	26/01/2021	04/07/2022
		Freelance Covid vaccinator	no	no	no	indirect	spouse is vaccinator	01/05/2021	current	04/07/2022	
Richard **Dale**	Executive Director of Transtion and Performance Member of Executive Management Team Attend ICB Board of Members Attend Finance Committee Attend Strategy and Development Committee	No interests declared	No	No	No	No	Nil Return	03/07/2018	current	04/09/2019	06/07/2022
Sarah **Mansuralli**	Chief Development and Population Health Officer Member of Executive Management Team Attend ICB Board of Members Exec Lead for Strategy and Development Committee Attend Finance Committee Attend Procurement Oversight Group	No interests declared	No	No	No	No	Nil Return	07/11/2018	current	07/11/2019	04/07/2022
Sarah **McDonnell-Davies**	Executive Director of Place member of Executive Management Team Attend ICB Board of Members Attend NCL Committee Meetings as required e.g. Strategy and DEvelopment Committee Primary Care Contracting Committee Borough Commissioning Committee	None	no	no	no	Direct	n/a			20/06/2018	09/09/2021
Sarah **Morgan**	Chief People Officer Member of the Executive Member Team										

North Central London
Integrated Care Board

Draft Minutes
Meeting of NHS North Central London ICB Board of Members

4 July 2022 between10am and 10.45am
Virtual Meeting

Present:	
Mike Cooke	Chair, NCL Integrated Care Board
Frances O'Callaghan	Chief Executive Officer
Kay Boycott	Non-Executive Member
Dr Chris Caldwell	Chief Nursing Officer
Dr Simon Caplan	GP - Provider of Primary Medical Services
Caroline Clarke*	Group Chief Executive, Royal Free Hospitals and Accountable Officer, NMUH
Richard Dale*	Executive Director of Performance and Transformation
Dominic Dodd	Chair, UCL Health Alliance
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
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Sarah Mansuralli*	Chief Development and Population Health Officer
Sarah McDonnell-Davies*	Executive Director of Places
Sarah Morgan*	Chief People Officer
Dr Alpesh Patel*	Acting Chair, GP Provider Alliance
Ian Porter*	Executive Director of Corporate Affairs
Liz Sayce	Non-Executive Member
Phill Wells	Chief Finance Officer
In Attendance:	
Andrew Spicer	Head of Governance and Risk
Apologies:	
Cllr Kaya Comer-Schwartz	Leader, Islington Council
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
Dr Jo Sauvage	Chief Medical Officer
Minutes:	
Steve Beeho	Board Secretary

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	The Chair welcomed attendees to the inaugural NCL ICB Board of Members ('Board') Meeting. He noted that the Appointments Committee, which met prior to this meeting, had formally ratified the membership of the Board. The Chair further noted that the focus of the Board meeting would be on approving the governance arrangements required to finish constituting the ICB. As the agenda was process-orientated it had been decided that it would be more appropriate to elaborate on the ICB's ambitions in greater detail at the next meeting in September. This was also the reason for the first meeting taking place via MS Teams, rather than face to face.

* Standing Participant

1.1.2	Apologies had been received from Baroness Julia Neuberger, Cllr Kaya Comer-Schwartz and Dr Jo Sauvage.
1.2	**Declarations of Interest relating to the items on the Agenda**
1.2.1	The Chair noted that a register of the Board of Members' interests was in the process of being completed and would be presented at the next meeting. In the meantime, members were invited to declare any interests relating to items on the agenda. There were no additional declarations.
1.3	**Declarations of Gifts and Hospitality**
1.3.1	The Chair invited Board members to declare any gifts and hospitality received. No gifts or hospitality were declared.
1.4	**Update from the Chief Executive Officer**
1.4.1	Frances O'Callaghan began by paying tribute to everybody involved in the 'safe landing' from NCL CCG as it transitioned into NCL ICB. She also thanked everybody who contributed to the final meeting of the NCL CCG Governing Body on 30 June 2022, the final day of the CCG's existence. The CCG had come into being just as Covid was striking and consequently the last Governing Body meeting was the only one held in person.
1.4.2	She then welcomed the new ICB executive team, particularly Phill Wells, Chief Finance Officer and Sarah Morgan, Chief People Officer.
1.4.3	It was acknowledged that NCL faces significant challenges, including financial challenges and ongoing activity pressures, but there are also major opportunities to improve the wellbeing of local residents and patients and the system is committed to working together in a collegiate way to achieve this. In addition, a cultural change is underway, as the NHS organisations come together and the ICB continues to strengthen its relationships with local authority colleagues and the voluntary sector.
1.4.4	She highlighted that the ICB Board has a crucial role to play in terms of finding a common purpose and expressed her optimism for the future.
1.4.5	The Chair echoed the welcome that Frances offered to new colleagues and her thanks to CCG staff for ensuring that the transition passed so smoothly.
1.5	**Questions From the Public**
1.5.1	The Chair noted that no questions had been submitted in advance by members of the public. He observed that the ICB had followed the historic approach taken by the CCG but the Board would consider in due course how it wishes to receive representations from the public in regards to Board agenda items as there are various models it might wish to adopt going forward.
2.	**FINANCE / COMMISSIONING**
2.1	**Budget 2022/23**
2.1.1	Phill Wells provided a high-level overview of the 2022/23 budget, as well as the challenges and risks: • The NCL system has submitted a balanced plan for 2022/23, albeit one with significant financial risks • The core efficiency expectations within the ICB and the providers are in many places larger than the historical values delivered previously • In aggregate, the NCL provider sector is in deficit, due primarily to the figures for the Royal Free and GOSH, partly due to challenges in establishing funding baselines for both organisations. This is balanced by the ICB which is planning to deliver a relatively large surplus • At the time of submitting the plan to NHS England, the ICB submission contained £21m which effectively represents growth money for the system as a whole. This will

	be allocated over the year to providers and primary care with a net-neutral impact on the system bottom line • The report shows that the ICB has an underlying £19.3m deficit, which is addressed by the release of £23.7m non-recurrent support throughout the year that will be directed towards a specific programme of investments, resulting in a £4.4m surplus. With the retention of the system growth funds at the point of submission, this represents an overall surplus of £25.6m • The ICB has a £22m efficiency target, some of which is yet to be identified • £20m of high-medium level risk has been identified. If any of this comes to pass, it may require further non-recurrent support while the ICB establishes ways of bringing the overall position into balance • In conclusion, the challenge facing NCL is high but there are also great opportunities.
2.1.2	The Chair commended the huge amount of work that had taken place across the system to develop the financial plan. He acknowledged that members would have questions about some of the detail and gave assurance that they would have the opportunity to discuss these with Phill Wells before the next meeting.
2.1.3	The Board of Members **NOTED** the report.
2.2	**Standing Financial Instructions (SFIs)**
2.2.1	Phill Wells introduced the SFIs which contained a number of changes from the previous CCG version, particularly regarding approval limits. He noted that the SFIs followed a national template and would be reviewed again in due course after they have been implemented to ensure that they are operating effectively.
2.2.2	The Board of Members **APPROVED** the NCL ICB's SFIs.
3.	**GOVERNANCE**
3.1	**Clinical and Care Leadership Model**
3.1.1	Chris Caldwell provided an overview of the work taking place to develop a Clinical and Care Leadership Model for the ICB encompassing clinical and care leaders from across health and social care. This builds on the substantial amount of work which has taken place in recent years in this area across the system, as well as the establishment of the Clinical Advisory Group during the pandemic.
3.1.2	The ICB proposes to put in place interim arrangements to help it to proceed with the co-production process to create a model that people feel fully engaged with. A draft model has been created which is being socialised across the system and a range of interim appointments have been made until the end of September to facilitate the transition process. Recruitment is underway for the post of Deputy Medical Director and the ICB will also maintain the short-term continuation of the CCG's clinical leadership at borough level, including the Individual Funding Request (IFR) roles, as an interim model.
3.1.3	The Board then discussed the paper, making the following comments: • In response to a query about the future size of the clinical leadership, it was clarified that going forward the ICB would potentially be able to draw upon the clinical leadership from across the system. However, there is also a firm intention to bring on new clinical leaders to strengthen future sustainability • In response to a question about the practicalities of different clinical leaders working together, it was noted that the model envisages a matrix approach, whereby junior leaders who might need some system development will work in teams with people who have more experience of system leadership. People will also be recruited to do specific pieces of work who will also represent their professional body. It is important that that ICB is able to demonstrate that the clinical leadership model aims to be multi-professional and is able to attract a wide range of people by the way in which the roles are set up and through the arrangements for remuneration that are put in place

	• It was noted that the model is still in developmental stage and therefore remains a work in progress. The new model will incur a lower cost than the previous CCG model.
3.1.4	The Board of Members: • **ENDORSED** the strategic shape of the emerging clinical leadership model. • **APPROVED** the next steps in developing the Clinical and Care Leadership Model and to delegate responsibility to the Chief Medical Officer and Chief Nursing Officer to further develop the model and commence implementation • **ENDORSED** the short-term continuation of the CCG's clinical leadership/IFR model in the interim period and the supporting remuneration rates.
3.2	**Supporting Documents to the Constitution**
3.2.1	Ian Porter introduced the Scheme of Reservation and Delegation (SORD) which sets out the power and authority of the Board of Members, the Chair, the Board Committees and senior officers. The SORD should be read in conjunction with the SFIs as part of the ICB's decision-making processes. He also explained that any cosmetic changes to the CCG policies which are transferring over to the ICB will be made automatically, rather than being brought to a Board meeting for approval. In the event of any significant changes to any policies, these will be taken through the relevant approval process.
3.2.2	The Board of Members: • **APPROVED** the Scheme of Reservation and Delegation.
3.3	**Committee Terms of Reference**
3.3.1	Ian Porter introduced the Committee Terms of Reference which he took as read. He noted that as the new Committees settle into the rhythm of the ICB, any changes to their Standing Participants will be made without needing to bring revised Terms of Reference back to the Board for approval.
3.3.2	He then provided an overview of the ICB Functions and Decisions Map. The Map provides a high level overview of the ICB's governance structure, including its key functions and how these are exercised in accordance with the SORD. The Map also sets out the system forums, including the System Management Board, the Population Health Forum and the Clinical Advisory Group. It further references the North Central London Specialist Commissioning Steering Group to support the transition of the services that are scheduled to be delegated to ICBs by NHS England from 1 April 2023.
3.3.3	In response to a suggestion that it would be helpful to also articulate role of Integrated Care Partnership (ICP) in more detail, assurance was given that after emergent discussions have taken place over the summer and the ICP has agreed its Terms of Reference and its work programme, a formal item on the ICP will be brought to a future Board meeting.

3.3.4	The Board of Members:
	• **APPROVED** the Terms of Reference of:
	  ○ Audit Committee
	  ○ Remuneration Committee
	  ○ Strategy and Development Committee
	  ○ Primary Care Contracting Committee
	  ○ Individual Funding Requests Panel
	  ○ Individual Funding Requests Appeals Panel
	  ○ Procurement Oversight Group
	  ○ Finance Committee
	  ○ Quality and Safety Committee
	  ○ Integrated Medicines Optimisation Committee
	• **APPROVED** the Functions and Decisions Map.

3.4	**ICB Forward Plan**
3.4.1	Richard Dale introduced the latest version of the ICB Forward Plan, which incorporates Board meetings in public and seminars. He noted that members would already be very familiar with much of the content, which builds on work undertaken by the ICS Steering Committee and Transition Board. The plan will be kept under regular review and updated accordingly, while ensuring that the workload of the Board remains manageable.
3.4.2	Ian Porter highlighted that this marked the start of the formal management of the committees and the Board Secretariat will shortly be circulating key meeting dates for the remainder of the year. He thanked the Governance team for the significant amount of work over recent months which is reflected in the meeting papers.
3.4.3	The Chair invited Board members to contact Ian Porter outside the meeting if they have any suggestions for items that ought to be added to the Forward Plan.
3.4.4	The Board of Members **NOTED** the ICB Forward Plan.
4.	**ANY OTHER BUSINESS**
4.1	There was no other business.
5.	**DATE OF NEXT MEETING**
5.1	27 September 2022 between 2pm and 4pm.

North Central London
Clinical Commissioning Group

Minutes
Meeting of North Central London CCG Governing Body
30 June 2022 between 2.30pm and 4pm
Claremont Room, Laycock Professional Development Centre,
Laycock Street, N1 1TH

Members Present:	
Dr Charlotte Benjamin	**Chair** and Clinical Representative – Barnet
Karen Trew	Deputy Chair and Lay Member
Frances O'Callaghan	Accountable Officer
Simon Goodwin	Chief Finance Officer
Claire Johnston	Registered Nurse
Ian Bretman	Lay Member
Arnold Palmer	Lay Member
Dr Peter Christian	Clinical Representative – Haringey
Dr Clare Stephens	Clinical Representative – Barnet
Dr Neel Gupta	Clinical Representative – Camden
Dr John McGrath	Clinical Representative – Islington
Dr Kevan Ritchie	Clinical Representative – Camden
Dr Chitra Sankaran	Clinical Representative – Enfield
Dr Nitika Silhi	Clinical Representative – Enfield
In Attendance:	
Richard Dale	Executive Director of Transition
Sarah McDonnell-Davies	Executive Director of Borough Partnerships
Ian Porter	Executive Director of Corporate Services
Dr Jo Sauvage	Chief Medical Officer – Designate, NCL ICB
Phill Wells	Chief Finance Officer – Designate NCL ICB
Deidre Malone	Director for Quality
Cllr Anna Wright	Camden Council
Cllr Nurullah Turan	Islington Council
Dudu Sher-Arami	Director of Public Health, Enfield Council
Sharon Grant	Chair, Healthwatch Haringey
Anna Stewart	Director – Major Reconfigurations
Emma Whicher	Medical Director, NMUH
Chloe Morales Oyarce	Head of Communications and Engagement
Apologies:	
Subir Mukherjee	Secondary Care Specialist
Dr John Rohan	Clinical Representative – Haringey
Dr Chris Caldwell	Chief Nursing Officer - Designate, NCL ICB
Sarah Mansuralli	Executive Director of Strategic Commissioning
Minutes:	
Steve Beeho	Board Secretary

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	The Chair welcomed Governing Body members, executive officers and attendees to the meeting. She noted that due to the impact of the pandemic this was the first time that a Governing Body meeting was being held face to face in public.
1.1.2	Apologies had been received from Subir Mukherjee, John Rohan, Sarah Mansuralli and Chris Caldwell.
1.1.3	Cllr Anna Wright and Cllr Nurullah Turan were attending on behalf of the NCL Councils, Sharon Grant was representing the borough Healthwatches, Dudu Sher-Arami was attending on behalf of the borough Directors of Public Health, Jo Sauvage was attending in her capacity as Chief Medical Officer – Designate and Phill Wells was attending in his capacity as Chief Finance Officer – Designate.
1.2	**Declarations of Interest Register**
1.2.1	The Chair presented the Governing Body Declarations of Interest Register.
1.2.2	The Governing Body **NOTED** the Declarations of Interest Register.
1.3	**Declarations of Interest relating to the items on the Agenda**
1.3.1	The Chair invited members of the Governing Body to declare any interests relating to items on the agenda. There were no additional declarations.
1.4	**Declarations of Gifts and Hospitality**
1.4.1	The Chair invited members of the Governing Body to declare any gifts and hospitality received. No gifts or hospitality were declared.
1.5	**Draft minutes of the previous meetings**
1.5.1	The Governing Body **APPROVED** the minutes of the meeting on 24 March 2022 and 19 May 2022 as accurate records.
1.6	**Action Log and Matters Arising**
1.6.1	The Chair welcomed the fact that all of the previous actions had been closed and therefore there were no outstanding actions to pass on to the Integrated Care Board (ICB).
1.6.2	The Governing Body **APPROVED** the action log.
1.7	**Report from the Chair**
1.7.1	The Chair noted that this marked the end of an era for this iteration of the NHS. She acknowledged the significant contribution that Governing Body members had made to the work of the CCG, as well as the clinical leads and CCG staff. She noted the recent sad death of Dr Muhammed Akunjee, who had been a member of the Haringey CCG Governing Body and mental health lead. Dr Akunjee had been an outstanding GP and the Governing Body's thoughts were with his family and colleagues.
1.7.2	The Chair observed that there had been significant achievements over the lifetime of the CCG. She highlighted a range of services which did not exist nine years ago, including Improving Access to Psychological Therapy (IAPT), which now treats 3000 patients per month and Mental Health Liaison Services, which make 1200 hospital referrals per month. In addition, 2500 individuals across NCL are supported with Personal Health Budgets, 13,000 people per month are seen by the Urgent Treatment Centres, the Integrated Discharge Teams look at 350 discharges per week and NHS111 handles 10,000 calls per week across NCL.

1.7.3	NCL is the sixth-most cost-effective CCG in England for its use of medicines and the lowest prescriber of antibiotics. The CCG opened a Community Diagnostic Hub at Finchley Memorial in August 2021 and a further hub is due to be opened in Wood Green in August 2022.
1.7.4	The CCG has created a single NCL-wide Fertility Policy over the past year, following widespread consultation, and this will be implemented in July. This will significantly improve access to fertility treatments for the majority of patients. The CCG is also proud of the establishment of its Inequalities Fund, which will provide £8.75m funding over two years for more than 50 initiatives.
1.7.5	The establishment of Primary Care Networks and hubs provides 100% coverage across NCL. The rapid roll-out of video consultations enabled patients to continue to be seen in the early stages of the pandemic, along with remote monitoring at care homes and community acute Covid services run by the GP Federations. 3.1 million Covid vaccinations have been delivered to date in a variety of settings across NCL.
1.7.6	The Chair lastly paid tribute to the outstanding leadership of Frances O'Callaghan and the previous Chair, Jo Sauvage over the incredibly challenging period of the pandemic.
1.8	**Report From the Accountable Officer**
1.8.1	Frances O'Callaghan echoed the Chair's thanks to all of the Governing Body members, Jo Sauvage and her executive team for their fantastic support and ensuring that the CCG is doing the very best it can for its residents and patients. The CCG's commitment to partnership working and addressing health inequalities provides a strong foundation for its transition into the ICB. She noted that the appendix to the Report highlights the wide range of projects that are being supported by the aforementioned Inequalities Fund and the CCG is keen for this approach to be taken forward in the future. The report also highlighted the breadth of work taking place at borough level.
1.8.2	The Governing Body discussed the report, making the following comments: • The qualitative and quantitative analysis of the schemes supported by the Inequalities Fund, and the embedding of monitoring and learning, were welcomed. The importance of maintaining clarity and transparency going forward was noted • It was acknowledged that it will be challenging to sustain this approach within a more constrained financial environment but assurance was given that the ICB will remain committed to the principles of the fund as part of its common purpose. It was also noted that that there are recurrent national monies available to support the Fund and it is hoped that its status as a leading-edge programme will continue to attract funding into NCL • It was confirmed that Governing Body committees have maintained two-tier action logs to ensure that key issues are picked up by the successor committees. In addition, the PMO (Project Management Office) has managed a tight due diligence process, including managing all transition-related risks, and the CCG has received full assurance from NHS England on all of its preparations for the transition. A forward plan has been developed and this will be presented to the ICB Board at its inaugural meeting on 4 July 2022. A firm commitment has also been given to staff that good practice, including the staff networks, will be carried over into the new organisation. • The challenge that the impact of the cost of living crisis poses to the ambitions of the ICS was acknowledged. It is recognised that access to meaningful work is an important determinant of health and the NHS offers the ability to be a fair and good employer, particularly through its commitment to anchor institutions. As the ICB resets its priorities it will need to consider how they link to the risks on the Board Assurance Framework, and the impact of the cost of living will be included in this work.
1.8.3	The Governing Body **NOTED** the Accountable Officer's Report.
1.9	**Questions From the Public**
1.9.1	No questions had been submitted in advance. The following responses were given in reply to questions posed at the meeting: • Assurance was given that the responses to the questions that were submitted in the run-up to the March Governing Body meeting which did not relate to agenda items

	would be published on the CCG website, in line with the commitment given at the meeting. (This was subsequently discharged after the meeting.) • It was confirmed that prior to the implementation of the legal requirement for care home staff to be vaccinated against Covid, the CCG worked closely with local authority colleagues, led organised extensive webinars to address staff questions and also made GPs available to answer questions. It is estimated that the ensuing disruption affected 8-10% of care home staff but it should also be noted that this workforce tends to have a high level of turnover • It was clarified that the relatively small number of cases considered by the IFR Panel reflects the fact that the requests, which are made by a clinician on behalf of a patient, are exceptional in nature and fall outside the usual commissioning remit • It was agreed that although increased digitisation offers a range of opportunities for patients, it can also pose challenges as not all residents are able to take advantage of them. Healthwatch Haringey have led on a piece of work on tackling digital exclusion and assurance was given that the ICB is committed to supporting people to better access digital services.
2.	**OVERVIEW REPORTS & BUSINESS**
2.1	**Update on NCL ICS Transition**
2.1.1	Richard Dale provided an overview of the paper which focused on providing assurance on the key things that needed to be in place for the safe transfer to the ICB on 1 July 2022. He highlighted the following points: • As previously mentioned, the CCG has received full assurance from NHS England on all of its preparations for the transition which is a tremendous testament to the hard work of everybody involved • The developmental work of the Integrated Care Board (ICB) and work around the formation of the Integrated Care Partnership will be ongoing after 1 July • Although the majority of the transition-related risks have been downgraded following the recent assurance from NHS England, the devolution of Specialist Commissioning services remains a live issue and this risk will be transferred to the ICB Risk Register.
2.1.2	The Governing Body discussed the report, making the following comments: • It was clarified that the direct commissioning of Dentistry, Optometry and Pharmacy, as well as Specialist Commissioning, had been due to transfer to ICBs on 1 July 2022 but this has now been delayed. Although things are advancing for Dentistry, Optometry and Pharmacy, there has been a lot of dialogue between the ICB, specialist Trusts and NHS England to understand the associated risks around Specialist Commissioning. Under a recently published consultation paper, a large amount of money would potentially leave NCL as it has a high number of specialist Trusts but it is unclear at this stage whether this risk will materialise or what the precise figures might be • It was clarified that not all of the national £20 billion Specialist Commissioning budget will be delegated to ICBs – a small number of services will continue to be nationally commissioned on account of their size. Any service changes will need to approved by NHS England, to protect critical mass and clinical expertise • It was confirmed that no concerns were raised by staff during the statutory consultation about transferring into a new organisation, which is a tribute to the vast amount of engagement work that has taken place. Assurance was given that the ICB is committed to transparency and consulting staff about any future changes that might take place and will ensure that new staff joining the organisation are fully integrated.
2.1.3	The Governing Body **NOTED** the progress of the ICS Transition Programme
2.2	**Keys Areas of Focus for the Quality Team**

2.2.1	Deidre Malone introduced the paper, highlighting the following points: • The Quality Report, which was attached as an appendix, had previously been presented to the Quality and Safety Committee on 9 June 2022. This paper also contained the fruits of the Committee's reflections on its work and what needed to be taken forward into the ICB • The main paper set out the key areas of focus for the Quality Team as it moves into the ICB: o Understanding the impact of delays in transferring patients from LAS directly into Emergency Departments from a clinical safety and patient experience perspective. o Working with the NCL Sickle Cell network, acute providers, Primary Care and communities to improve understanding and management of Sickle Cell Disease across NCL's diverse population o Working closely with the four maternity providers to support the implementation of the immediate and essential actions set out in the Ockenden Report o Working collaboratively with the NCL Mental Health Liaison teams and acute providers, to reduce the incidence of the use of restraint and seclusion across Mental Health and acute providers of care.
2.2.2	The Governing Body discussed the report, making the following comments: • Assurance was given about the culture of safety in maternity services, in light of two recent maternal deaths. Work is proceeding at pace on reducing inequalities experienced by pregnant women in NCL, and as part of this, the Local Maternity Neo-Natal System (LMNS) is reviewing maternal deaths since 2018 to consider their demographics, common issues and the implementation of any learning. Although the initial investigation into the two recent tragic cases did not identify any service delivery issues, there may have been wider determinants of health that were contributory factors, which will be uncovered as part of the investigation into these deaths. • It was noted that the Patient Safety Incident Response Framework (PSIRF) will replace the existing Serious Incident Framework (SIF). The PSIRF will have a stronger focus on quality improvement, as opposed to the more rigid approach of the SIF. Although there is a concern that commissioners might be less sighted on specific incidents at Trusts under the new arrangements, ICB Patient Safety Specialists (PSS), working in collaboration with the Trust PSSs, will continue to have regular discussions about incidents that have been reported by providers, emerging themes or trends and any actions being taken in response to ensure that there is system-wide learning • Concern was expressed about the relative lack of research into Sickle Cell and the apparent loss of the learning and expertise that had been developed in the course of the re-design of clinical protocols. Assurance was given that improving Sickle Cell treatment is being viewed as a priority and consideration is being given as to how best to do this as part of a continuous piece of work • It was highlighted that the successor committee to the Quality and Safety Committee needs to continue to engage with provider collaboratives in order that consistency of approach ensures that shared learning is taken forward across organisations to improve patient care • There is now a great opportunity for the Quality directorate to re-frame what it does, with an increased focus on quality improvement over the next year.
2.2.3	The Governing Body **NOTED** the Report.
2.3	**Performance Report**
2.3.1	Richard Dale introduced the Performance Report, highlighting the following points: • The system remains under intense pressure. Primary care activity is currently at 130% of pre-pandemic levels and bed occupancy at all providers stands above 95% • Covid admissions are increasing and currently represent 13% of overall admissions • Excellent progress has been made on reducing the number of long-waiters • Although progress continues to be made on the cancer targets, it is recognised that more still needs to be done in this area

	• NCL is responding to the challenge around ambulance handovers by treating this as an urgent care pathway. As part of this response, Silver-line has reduced the conveyance rate from Enfield and Haringey care homes by two-thirds and sites across NCL have strengthened proactive senior clinical handover to help meet the 30-minute standard • Extensive work is taking place to address mental health 12-hour trolley breaches • 56% of primary care appointments now take place face to face. Alongside this, work is ongoing to address digital exclusion • There continues to be strong staffing and wellbeing challenges across providers. Maintaining wellbeing will be essential as part of the recovery process.
2.3.2	The Governing Body discussed the report, making the following comments: • Concern was expressed about the current length of IAPT waiting times and the ability of the system to understand 'real time' mental health data to ensure people receive adequate support. In response, it was noted that it is hoped that the Mental Health Services Review will provide longer term answers to the known challenges by providing insights into the differences across the patch. It is clear that there also needs to be a focus on short term solutions to reduce IAPT waiting times. Work has been taking place to improve the quality of mental health data so that clinicians have greater access to 'real time' data, which will help to reduce some of the current bottlenecks • Assurance was given that there is an aspiration to break down the data of future Performance Reports so that the link to inequalities work and outcomes is made clearer and further thought will be given to how this might be presented • At present there is no requirement from NHS England for additional contingency planning in respect of Covid admissions across the patch but the ICB will continue to monitor the situation closely • Assurance was given that ongoing work is taking place on how more detailed primary care data can be incorporated into future Performance Reports. The system already has good information sources but the challenge is to present the key fundamental indicators in a meaningful way to understand how best to address the demand for primary care.
2.3.3	The Governing Body **NOTED** the Performance Report. .
2.4	**Start Well Programme (Children's Young Persons Maternity and NeoNatal review)**
2.4.1	Jo Sauvage, Anna Stewart, Emma Whicher and Chloe Morales Oyarce introduced the paper which sets out the progress to date and proposed next steps. They highlighted the following points: • Partner organisations have been working together since November 2021 on the initial phase of Start Well, a long term programme looking at maternity, neonatal and children and young people services across NCL. • The programme builds on the reconfiguration work that took place in response to the pandemic to ensure continuity of care in a collaborative way • The review has engaged local authorities as well as partner organisations, as well as a significant co-production element • The review explicitly covers the interface with specialist services, particularly GOSH, and the connections with other major pieces of work taking place within the system, such as the Community and Mental Health Services reviews • The key drivers of the programme include the calls to action in the NHS Long Term Plan, the Ockenden Report and the learning from the temporary changes made during the pandemic; the need to address inequalities highlighted during the pandemic as well as building on the increased integrated working that took place and the need to ensure that the system learns from and responds to national guidance and best practice • There has been considerable clinical engagement, including three clinical workstreams • The report identifies various opportunities for improvement, including o addressing variations in the rate of still-births across NCL, variations in maternity services' capacity and workforce challenges o Matching neonatal care capacity and demand; considering the sustainability of the Royal Free Hospital Special Care Unit and addressing variations in provision in the community

	○ Increasing demand for emergency care for children and young people, improving long-term conditions management; reducing long waits for elective care and improving transition to adult services Workforce challenges are additionally a common theme in all three areas. • A 10 week engagement period on the case for change is planned, running from 4 July – 9 September 2022. Accessible material has been produced which summarises the main document. As part of the engagement process, the CCG is working with local authorities, providers and VCS organisations to invite the public to comment on the case for change findings, in addition to working with local HealthWatches, an online resident panel and obtaining feedback via a series of youth summits • A summary report will be published at the end of the engagement period. This feedback will inform a final version of the case for change. The NCL ICB Board of Members will then decide in autumn 2022 on the next steps for the programme.
2.4.2	The Governing Body discussed the report, making the following comments: • Assurance was given that the programme is running alongside work taking place on the wider determinants of health • It was confirmed that the questionnaires will have 'free' sections to allow members of the public to comment on specific areas of interest and expertise, along with a variety of mechanisms for providing feedback • Assurance was given that the workforce will be a key area of development, including looking innovatively at creating new roles, such as midwifery-led care.
2.4.3	The Governing Body: • **APPROVED** the full version of the Start Well case for change • **APPROVED** a period of engagement on the opportunities identified in the case for change.
3.	**FINANCE**
3.1	**Finance Report – Month 2**
3.1.1	Simon Goodwin presented the paper, which reflected the fact that at the time of writing the 2022/23 plan was still being finalised and the CCG was holding money on behalf of the system. He highlighted the following points: • At month 2 the CCG is in line with the position that the ICB is reporting for the whole year and it is anticipated that this will also be the case for month 3 • The ICB Board of Members will discuss the plan and the financial risks in more detail at its meeting on 4 July 2022.
3.1.2	The Governing Body thanked Simon Goodwin for his contribution as Chief Finance Officer to the work of the CCG and for handing over a strong finance team to the ICB
3.1.3	The Governing Body **NOTED** the Finance Report.
4.	**GOVERNANCE**
4.1	**Board Assurance Framework (BAF)**
4.1.1	Ian Porter provided an overview of the paper, which was taken as read. He highlighted the following points: • There are 13 risks on the BAF, 12 of which meet the BAF threshold, as well as the risk relating to the transition to an ICB • Two new risks had been added to the BAF, relating to Specialist Commissioning and the need to shift resources into prevention and proactive care • Although the risks relating to LSS and CSU staff transfers and the transition to the ICB can effectively be closed with effect from 1 July 2022, consideration will need to be given to the ongoing risk around transition and ensuring that the system does not lose the opportunities that the ICB and ICS present • All of the current risk registers will be moved into the new organisation.

4.1.2	The Governing Body welcomed the organisational ownership of risk which had been consistently demonstrated over the lifetime of the CCG. It was suggested that there should be an ambition for high-level ICS risks to be shared across organisations which would sit alongside their own 'local' risks.
4.1.3	The following assurances were given in response to comments about how the workforce challenges that underpin various risks will be addressed: • The system is now in a much stronger position to be able to understand the baseline • The appointment of Chris Caldwell as Chief Nursing Officer and Sarah Morgan as Chief People Officer and the experience they bring with them will strengthen the ICB's strategic response to workforce development and planning • The pandemic has provided an opportunity to think through the system challenges and how things can be done differently, including greater collaboration via the sharing of staff and creating roles which can move across organisations • The Fuller Report highlights the importance of primary care networks and the augmentation of delivery of services through teams which also derive from secondary care and this is something which will need to be developed, potentially through increased rotation and training hubs • The GP Alliance will also have a crucial role in responding to the workforce challenges.
4.1.4	The Governing Body **NOTED** the BAF highlight report.
5.	**ITEMS FOR INFORMATION AND ASSURANCE**
5.1	**Minutes of the Audit Committee on 17 March 2022**
5.1.1	Karen Trew provided a verbal update on the Audit Committee meeting on 8 June 2022. The Committee had overseen the Annual Report and Accounts and the final audit to the end of March 2022 under delegated authority from the Governing Body, and at the June meeting the CCG received a 'clean' audit of the accounts and a 'good' report on value for money. One unadjusted error was reported by the auditors but this was not material. The auditors noted that the internal auditors had provided an 'unqualified' opinion and that the internal audit programme produced three 'substantial' assurances during the financial year, relating to finance and governance. The auditors also commented on the good progress that had been made in respect of the transformational work in continuing healthcare.
5.1.2	Karen Trew then noted that the Audit Committee has put together a secondary action log which contains actions for the successor Committee to discharge at its first meeting. These relate to an audit for the first three months of 2022/23, the appointment of auditors for 2022/23 through a competitive process and consideration of how internal audit can be undertaken in future at a system level, rather than an organisational one.
5.1.3	The Governing Body **NOTED** the minutes.
5.2	**Minutes of the Finance Committee on 24 February, 24 March, 26 April and 28 April 2022**
5.2.1	The Governing Body **NOTED** the minutes.
5.3	**Minutes of the Patient and Public Engagement and Equalities Committee on 10 February and 21 April 2022**
5.3.1	The Governing Body **NOTED** the minutes.
5.4	**Minutes of the Primary Care Commissioning Committee on 17 February and 21 April 2022**
5.4.1	The Governing Body **NOTED** the minutes.

5.5	**Minutes of the Quality and Safety Committee on 10 February and 14 April 2022**
5.5.1	The Governing Body **NOTED** the minutes.
5.6	**Minutes of the Strategy and Commissioning Committee on 10 March 2022**
5.6.1	The Governing Body **NOTED** the minutes.
6.	**ANY OTHER BUSINESS**
6.1	There was no other business.
7.	**CLOSING REMARKS**
7.1	Governing Body members took the opportunity to reflect on the work and achievements of the CCG. Members welcomed the changes that had occurred over the lifetime of the CCG, often during difficult periods, including the productive collaborative working between CCG management and clinicians and the increasing use of data to identify and address health inequalities. Members also looked forward to the legacy of Governing Body discussions being taken forward into the work of the ICB.

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
27 September 2022

Report Title	Chief Executive's Report	**Date of report**	13 September 2022	**Agenda Item**	1.8
Lead Director / Manager	Not applicable.	**Email / Tel**		Not applicable.	
Board Member Sponsor	Not applicable.				
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 is my first report since we became NHS North Central London Integrated Care Board (NCL ICB) on 1 July 2022. Whilst we did meet early in July, it was largely to agree formalities. I wanted to share my excitement about moving forward together as an ICB and also as an Integrated Care System. I am very proud to have been selected to lead the ICB and am determined to build on the work we have done in recent years, and also tackle the challenges we face, in particular around population health outcomes, inequalities and inequity.

2. Her Majesty, Queen Elizabeth II

2.1 Following the sad passing of Her Majesty, Queen Elizabeth II, I would like to offer a personal reflection. The Queen's presence throughout my life has offered stability, despite so much having changed around the world throughout her reign. For 70 years, The Queen has dedicated her life to public service and has been at the core of our nation. Throughout the pandemic her reassuring presence and messages of support to NHS staff provided both comfort and pride, as we worked together to protect local people from COVID-19. I hope her family and those closest to her find peace and comfort as the country mourns our loss.

3. NHS North Central London Integrated Care Board transition

3.1 On 1 July 2022, NHS North Central London Integrated Care Board (NCL ICB) formed. With the abolition of clinical commissioning groups (CCGs), our commissioning functions transferred to the new organisation from NCL CCG.

3.2 The Health and Care Act (2022) gives NHS organisations and Councils across Barnet, Camden, Enfield, Haringey and Islington a statutory footing to work collaboratively towards improving the health and wellbeing of our population and make faster, greater progress on eliminating inequalities, which is a shared ambition of the partners that make up the Integrated Care System (NCL ICS).

3.3 We have been working closely together, alongside residents and voluntary and community sector colleagues, to develop our NCL ICS plans. New ideas and ways of thinking, and new approaches and ways of delivering care have already emerged. This new organisation, and new way of working will allow us to work with and support each other to understand, and respond to, the needs of our local communities with the ultimate aim of improving outcomes for our residents.

4. NCL Population Health Improvement Strategy and Outcomes Framework

4.1 The development of the NCL Population Health Improvement Strategy and Outcomes Framework has been overseen by the NCL Population Health and Inequalities Committee (PHI Committee) and steering group and this includes partners from across the ICS system. Both the strategy and outcomes framework have been, and are being, socialised across both system and borough groups/partnerships.

4.2 In summary, the draft Population Health Improvement Strategy describes the rationale, the strategic context and ambitions and what success will look like. It has been a coproduction exercise across system partners that speaks to and brings together the work of system, place and neighbourhood to improving population health outcomes.

4.3 The Outcomes Framework will help us understand opportunities for improvement and reducing variation in outcomes at system and place. It is structured around the life course with outcomes for Start Well, Live Well, Age Well and includes the Core20PLUS5 priorities, designed to address inequalities across 5 clinical indicators and the 20% most deprived populations within the ICS.

4.4 There is a substantial amount of work remaining with regard to finalising the Population Health Improvement Strategy, outcomes indicators and setting improvement trajectories. In addition, there is a need to consider the implementation/delivery approach that underpins this strategy. Further work is required to develop metrics underpinning Work Well as part of the outcomes framework and this is being led by the ICB Chief People Officer. Additionally, indicators, alongside qualitative data and community insights that will be delivered through our Working With Our People and Communities Strategy and Working With Our VCSE Sector Strategies, will enable us to identify areas which require greater focus and where investment or a different approach to resource deployment may be required.

5. Delegation of Commissioning Responsibilities – Specialised, Dental, Optometry and Pharmacy Services

5.1 In April 2023, it is proposed that ICBs will take on responsibility for approximately 50% of the specialised services that were previously commissioned nationally via NHS England (NHSE) along with Dental, Community Ophthalmology and Community Pharmacy (DOP) services. These delegation proposals are significant due to the number of services for which the ICB will take commissioning responsibility, as well as the financial values associated with these.

5.2 The devolution of commissioning responsibilities back to ICBs is to enable systems to integrate services, address health inequalities and improve outcomes. This is in alignment with the NCL Population Health Improvement Strategy (see above), and our anticipated programmes of work to support the devolution of specialised services will seek to embed and utilise the principles of our population health improvement approach. In particular, the focus on prevention, early diagnosis, supporting good self-care and supporting other interventions at the earlier stages of pathways will not only see improved outcomes and experiences for residents, but will also support a re-balancing of activity and expenditure in the system.

5.3 Historically the demand for Specialised Services (which are typically some of the most costly services) has grown faster than the rate of other services and in many cases the underlying cause of this growth is caused by issues earlier in the pathway. For example, an under-investment in preventing the development of diabetes can lead to downstream renal (kidney) problems and an increased need for dialysis. We are therefore developing clinical priorities that would benefit from this population health approach to improving outcomes while enabling sustainable healthcare in the future. As part of this we are reviewing current dental services to understand current provision, challenges and opportunities for improvement and integration.

5.4 While there are opportunities to better integrate services that are nationally commissioned with ICB commissioned services to facilitate a greater shift towards prevention and early intervention, there are material risks associated with the transfer of these responsibilities to ICBs, which has required the ICB to put in place due diligence arrangements underpinning both delegation proposals.

5.5 NCL providers deliver a substantial amount of specialised services through our hospitals (RNOH, GOSH, MEH, UCLH and RFL) to both NCL residents and out of NCL residents. NCL has the largest specialised income amongst the five London ICBs, which is approximately 75% of the total NCL income for Specialised Services. The Dental, Optometry and Pharmacy services represent approximately £150m of income for NCL.

5.6 To mitigate risks, as well as identify opportunities for improvement, we have been working collaboratively with London ICBs, bordering ICBs and regional colleagues to develop mitigations to key risks, develop decision making processes and agreeing areas where further collaboration would be valuable. The aim of the extensive due diligence process we have put in place for both specialised and DOP delegation is to ensure that services are safely transferred, without service

interruptions and that existing risks are understood and managed.

6. Maternity services

6.1 In line with the ICB commitment to eliminating inequalities and improving population health outcomes so that all NCL residents have the best start in life, we are specifically focussed on understanding disparities for specific groups and addressing gaps in outcomes and experiences such as levels of mortality and morbidities in women and their babies.

6.2 We continue to progress our improvement work collaboratively with clinical and service leaders and lived experience groups through the NCL Local Maternity and Neonatal System (LMNS), with oversight of quality of our maternity services reported through the ICB Quality & Safety Committee.

6.3 Maternity care remains a key focus for the NHS at a regional and national level. Initial feedback from regional NHS England visits to each of our maternity units as part of their assurance process following the publication of the (Ockenden) independent report on maternity services in Shrewsbury & Telford, have been positive. This is likely to be followed by further scrutiny when two further independent inquiries in maternity services (in Kent and Nottingham) report later this year.

7. Preparing for Winter

7.1 The UEC pathway is complex and comprises a number of competing national, regional and local priorities. Whilst significant progress has been made in-year to improve aspects of the urgent care pathway, the ICB is now undertaking a review of system priorities, associated high impact actions and escalation processes to further mitigate winter pressures with specific reference to in-hospital, out-of-hospital and front door services.

7.2 The NCL Flow Group and Board has overseen the delivery of a number of improvement priorities across the urgent care pathway in relation to ambulance conveyance and handover, admissions avoidance, improving flow and increasing discharge. For example, a Silver Triage model of pre-hospital emergency to reduce unnecessary conveyances to hospital for older people living with frailty, especially those who live in residential care or nursing homes. Consultant Geriatricians provide practical guidance to paramedics to help determine whether emergency hospital conveyance is the most appropriate course of action or whether an alternative route to assessment and treatment (e.g. home visit or next-day ambulatory care review) can be identified. Following a pilot period the service went live 05 September 2022, operating 7 days a week 9:00 – 17:00 as a CNWL hosted service for all NCL. In the first week of operation, more than 15 conveyances were avoided.

7.3 Additionally, significant progress has been made by NCL Rapid Response Community providers to increase 2hr response, which has resulted in a reduction in unplanned hospital episodes (attendance & admission), reductions in LAS episodes (incidence and conveyance) and an increase in patients receiving their care closer to home.

8. NCL Mental health system winter planning

8.1 There has been specific focus on the mental health urgent care pathway within the ICS, particularly as there is anticipated to be greater demand for mental health services this winter due to the current cost of living crisis, that is likely to have a disproportionate impact on our most vulnerable communities and patients. Mental health partners are focussing four key priorities that are likely to have the greatest impact:

- Reduce the number of mental health 12 hour breaches from an A&E
- Reduce the use of s.136, and in particular a reliance on the use of an A&E as a place of safety for people who are detained under s.136

- Reduce inpatient lengths of stay to ensure flow and capacity for mental health admissions which don't require an out of area placement
- Reduce the number of patients residing in a setting for more than 60 and 90 days

8.2 Winter initiatives that are being implemented are based on an evaluation of what worked during the previous winter surge and include Mental health Integrated Discharge Teams (IDTs) and Breach avoidance beds. In addition, NCL have maintained all crisis support lines, enhanced liaison and Children and Young People (CYP) crisis hubs, which were all established as part of our Pandemic response as a means to supporting the system through winter.

9. Cancer

9.1 Throughout the pandemic we continued to deliver cancer services, although in this time performance fell below the high standards we want to deliver for our residents. In addition, there was a reduction in the number of cancer referrals which has since recovered through population awareness campaigns and primary care vigilance. Recovering the performance of these services and working to detect cancer earlier across our communities is a priority for the ICB.

9.2 We are implementing best practice pathways to reduce waiting times from referral to confirmation of diagnosis, particularly, in colorectal, dermatology and urology services which account for two-thirds of patients waiting longer than 62 days on a suspected cancer pathway. Initiatives being implemented include straight to endoscopic examination in colorectal services, roll out of Teledermatology, and ring-fencing of diagnostic capacity for suspected prostate cancer investigations.

9.3 New innovative approaches, such as working with the voluntary sector on screening and home testing, allowing residents to access diagnostics directly and transformation of high volume cancer pathways such as breast cancer will allow us to save more lives and improve resident's outcomes. Our work will take a population health approach focussing on early diagnosis, using data in line with CORE20PLUS5 to target and tailor our work for greatest impact. Further development of partnership working across the ICS with colleagues in NHS Trusts, public health and boroughs will accelerate the impact we can have for our communities impacted by cancer.

10. Sickle Cell Disease

10.1 Sickle cell disease is the name for a group of inherited health conditions that affect the red blood cells. The disease is particularly common in people with an African or Caribbean family background.

10.2 Although, sickle cell disease is a serious and lifelong health condition, treatment can help manage many of the symptoms. It is therefore important to ensure that patients are screened early and that appropriate advice, support and treatment plans are put in place.

10.3 There are two centres in NCL; a hub at University College London Hospital, the Whittington Hospital and the North Middlesex University Hospital. The Red Cell Network (TRCN), commissioned by NHS England and led by UCLH, is responsible as the Haemoglobinopathy Coordinating Centre (HCC) to support the provision of specialist and non-specialist haemoglobinopathy services to adults and children with Sickle Cell Disease (SCD), thalassaemia (TA) and rare inherited anaemia (RIA).

10.4 We are working with system partners and the regional team to ensure that quality improvements are made to our pathways across NCL for sickle cell patients focussing on the following deliverables:

- Provision of analgesia within 30 minutes in EDs.
- Provision of equitable access to apheresis treatment across equitably NCL.
- Provision of training and education on SCD for all staff working in acute care.

10.5 We anticipate that this will bring significant improvements in equity of access and improved pain relief, which would result in reduced lengths of stay and better management of this long term condition.

Frances O'Callaghan
Chief Executive

20 September 2022

NHS
North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
27 September 2022

Report Title	Community and Mental Health Service Reviews - Approach to implementing the "core offer"	**Date of report**	12 September 2022	**Agenda Item**	2.1
Lead Director / Manager	Sarah Mansuralli, Chief Development and Population Health Officer	**Email / Tel**		sarah.mansuralli@nhs.net	
Board Member Sponsor	Not applicable.				
Report Author	Alex Smith, Director of Transformation Dan Morgan, Director of Aligned Commissioning Anthony Browne, Director of Finance	**Email / Tel**		alexander.smith1@nhs.net daniel.morgan4@nhs.net anthony.browne@nhs.net	
Name of Authorising Finance Lead	Phill Wells, Chief Finance Officer	**Summary of Financial Implications** The report sets out the financial implications to support the delivery of an equitable service offer across NCL's Community and Mental Health Services. The approach to investment follows the principles of targeting areas in NCL with the greatest level of need, existing gaps in the core offer and, where relevant, the ability to support reduction in acute activity. Additional investment from other SDF schemes such as Ageing Well & Virtual Ward is expected to support core offer delivery as appropriate. The total investment required over three years for mental health service review is £25.1m. For community services the total investment across the 5 year programme is £57.7m. These values reflect the service review baseline findings that there is a correlation between mental health spend and need but this is not the case for community services. The investment will need to be met from a combination of national funding (SDF, MHIS, Virtual Ward), ICB funding, system savings and productivity/efficiency requirements for providers.		

		In Year 1 (2022/23) the funding is entirely support by system reserves - £3.8m pro-rata. This funding requirement has been included within NCL 2022/23 operating plan with full year effect (£7m) confirmed in 2023/24. Future year investment is predicated on Trusts delivering efficiencies and productivity savings in future years to support investment targets.
Report Summary	As a new ICS, we must quickly take action to improve population health, individual patient outcomes and access and experience of care. We must also ensure our services are productive and offer value for money. There is a pressing need to enhance our local care offer and develop teams able to provide proactive and reactive care to all communities in NCL. NCL ICB commenced a collaborative review of NHS community and mental health services 18 months ago. The aims of the review are to ensure there is an equitable service available across NCL which promotes out of hospital care and prevention, improving outcomes for residents and reducing the pressure on acute services. The stages of the review have included a Case for Change (Baseline Review) followed by the articulation of a co-produced "core offer" – i.e. the level of service every resident in NCL should expect. This work has engaged partners from all five boroughs. Both reviews have considered how we work most effectively at system, place and neighbourhood to improve outcomes. The "core offer" will support equitable access for all patients across NCL and support NCL to deliver its vision for integrated care and respond to major National reviews such as the Fuller Review. Investment is required in order to implement the "core offer". Our baseline review identified three key findings. Firstly, that there is significant variation in access, outcomes as well as experience per borough within mental health and community services and that higher spend did not always equate to improved outcomes. Secondly, that community service investment by borough is not correlated with need by borough, due to historic inequities in funding. Lastly, that in mental health there is variation in need and spend and that whilst mental health investment is correlated with need, investment is required to improve the provision of mental health services across NCL. Without this investment, community and mental health services will not have sufficient base-capacity in some boroughs to play a full role in population health improvement. While Mental Health has access to the national Mental Health Investment Standard and Service Development Fund (MHIS), it is insufficient to fully implement the "core offer"; Community Services have no equivalent access to ring-fenced funding and therefore need access to system investment. Three to five year investment plans for mental health and community health respectively are supported by the relevant ICS committees and programme boards. Year 1 of the plan is already approved via the relevant governance and implementation is being mobilised. The total investment required over three years for mental health is **£25.1m; for community services it is £57.7m**. This investment requirement will be met through a combination of national funding (SDF, MHIS, Virtual Ward), ICB funding, system savings and productivity/efficiency requirements for providers. This report provides a summary of the reviews, outlines the approach to funding the "core offer" and summarises priorities for year 1 within the respective programmes alongside programme benefits and next steps.	

Recommendation	The Board of Members is asked to **APPROVE** the proposed 3 – 5 year investment approach for both community and mental health services, noting affordability for mental health is subject to using the MHIS and SDF funding, which reflects the strong alignment between delivery of the MH core offer programme and MH Long Term Plan deliverables.
Identified Risks and Risk Management Actions	**Risk:** There is a risk that without investing in the "core offers", the capacity associated with creating a sustainable health economy that focuses on keeping people well at home and population health improvement will simply not be realisable in some boroughs due to historic variation and underfunding. **Management Action:** The proposal presented to the ICB within the accompanying paper provides a suggested method for delivering the "core offer". **Risk:** There is a risk that because of skills shortages in key roles within community and mental health services, that despite investment providers struggle to secure sufficient additional capacity. **Management Actions:** (i) Providers to work in increasingly close collaboration around recruitment and workforce planning activities (ii) The design of new roles including rotations and training posts, including through collaboration with other providers in the system e.g. acutes. **Risk:** There is a risk that intended system savings and productivity benefits do not transpire leading to a sustainability challenge in providing sufficient ICS investment to implement the core offer **Management Actions:** (i) A benefits realisation methodology including project level KPI reporting and regular programme level financial/activity analysis has been outlined on slides 29/30 to ensure appropriate mitigating action can be taken early should progress not be on track (ii) Provider led implementation and co-creation of plans and the establishment of a CFO level finance sub-group to enable joint ownership of the sustainability challenge across the system (iii) Year 1 investment in community is focused on areas that contribute to reducing pressure on acute hospitals. **Risk:** Insufficient capacity for delivering transformation work alongside delivering services within community and provider organisations. **Management Actions:** (i) Providers have been encouraged to use a portion of their investment funding to secure sufficient dedicated project management to enable the change (ii) The establishment of a cross system PMO that reports to both the ICS and place level governance re. delivery.
Conflicts of Interest	Not applicable.
Resource Implications	The programme will have a PMO in place to manage successful delivery at both place and ICS level throughout the lifespan of the programme. Dedicated system finance resource is available to the programme and providers are contributing significant transformation resource to lead delivery.
Engagement	The proposed investment plan for implementing the "core offer" has been co-developed with ICS system fora including the System Chief Finance Officers Meeting, NCL System Management Board as well as both Community and Mental Health Review Programme Boards. Wider system partners including Local Authority colleagues have been engaged in the implementation planning through a series of borough-level workshops. Board members should also note that partners from across the system were engaged in the development of the "core offer". This includes Primary Care, Community providers, Local Authority, Acute providers, Commissioner Borough & Strategic, Voluntary Sector and Residents/Users/Carers.

Equality Impact Analysis	An Equalities Impact Assessment was carried out when the Core Offer was produced and signed off in Summer 2021. Implementation of the core offer is expected to have significant positive benefits for population health improvement and tackling inequalities given the foundation that it will create at place and neighbourhood for integrated, proactive and personalised care as well as ensure sufficient capacity within neighbourhoods for population health improvement. Each collaborative project that providers are working together has completed an EQIA as part of its development.
Report History and Key Decisions	This proposal was supported at the following forums: • Community and Mental Health Review Programme Boards – June 2022 • NCL System Management Board – July 2022 • NCL System Chief Finance Officers Meeting – July 2022 • Community and Mental Health Finance sub groups – July and September 2022 • NCL ICB Executive Management Team – June and September 2022 In addition, a discussion took place about the critical interdependencies between implementing the reviews and the NCL population health improvement strategy at the ICB Members Board Seminar in August 2022.
Next Steps	See page 34 of the accompanying report.
Appendices	Not applicable.

NHS
North Central London
Integrated Care Board

Community and Mental Health Service Reviews - Approach to implementing the “core offer”

15 September 2022

Contents

NHS
North Central London
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Introduction and overview of the programme

Executive summary for ICB Members Board

Context

- As a new ICS, we must quickly take action to improve population health, individual patient outcomes and access and experience of care. We must also ensure our services are productive and offer value for money. There is a pressing need to enhance our local care offer and develop teams able to provide proactive and reactive care to all communities in NCL.
- NCL ICB commenced a collaborative review of NHS community and mental health services 18 months ago. The aims of the review are to ensure there is an equitable service available across NCL which promotes out of hospital care and prevention, improving outcomes for residents and reducing the pressure on acute services. The stages of the review have included a Case for Change ( ) followed by the articulation of a co-produced “core offer” – i.e. the level of service every resident in NCL should expect.
- This work has engaged partners from all five boroughs. Both reviews have considered how we work most effectively at system, place and neighbourhood to improve outcomes. The “core offer” will support equitable access for all patients across NCL and support NCL to deliver its vision for integrated care and respond to major National reviews such as the Fuller Review.
- Investment is required in order to implement the “core offer”. Our baseline review identified three key findings. Firstly, that there is significant variation in access, outcomes as well as experience per borough within mental health and community services and that higher spend did not always equate to improved outcomes. Secondly, that community service investment by borough is not correlated with need by borough, due to historic inequities in funding. Lastly, that in mental health there is variation in need and spend and that whilst mental health investment is correlated with need, investment is required to improve the provision of mental health services across NCL. Without this investment, community and mental health services will not have sufficient base-capacity in some boroughs to play a full role in population health improvement.
- While Mental Health has access to the national Mental Health Investment Standard and Service Development Fund (MHIS), it is insufficient to fully implement the “core offer”; Community Services have no equivalent access to ring-fenced funding and therefore need access to system investment. Three to five year investment plans for mental health and community health respectively are supported by the relevant ICS committees and programme boards. Year 1 of the plan is already approved via the relevant governance and implementation is being mobilised.
- The total investment required over three years for mental health is **£25.1m; for community services it is £57.7m**. These values reflect the service review baseline findings that there is a correlation between mental health spend and need but this is not the case for community services.This investment requirement will be met through a combination of national funding (SDF, MHIS, Virtual Ward), ICB funding, system savings and productivity/efficiency requirements for providers.
- This report provides a summary of the reviews, outlines the approach to funding the “core offer” and summarises priorities for year 1 within the respective programmes alongside programme benefits and next steps.

Executive summary for ICB Members Board

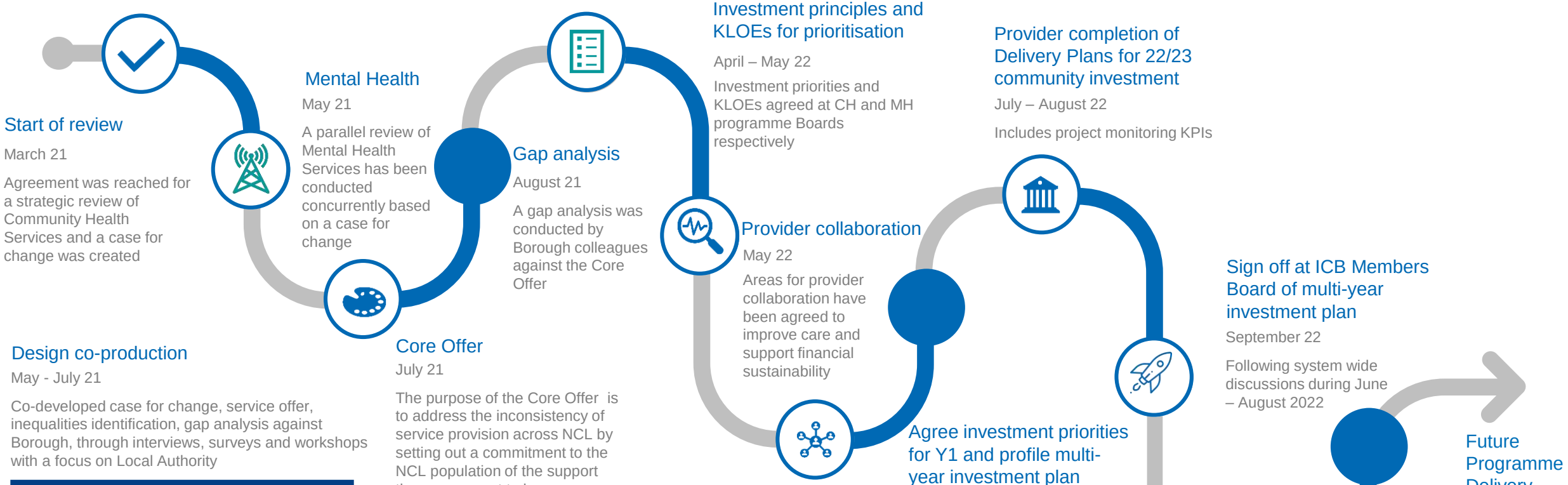
Objectives of this ICB Members Board paper

1. Provide an overview and update on the progress of the Community and Mental Health reviews including areas of focus during Y1;
2. Outline the benefits that implementing the core offers will bring, including for population health improvement; and
3. Obtain ICB MB support for the proposed 3 – 5 year investment approach for both community and mental health services, noting affordability for mental health is subject to using the MHIS and SDF funding, which reflects the strong alignment between delivery of the MH core offer programme and MH Long Term Plan deliverables.

Subject to Board approval, the work will be implemented across all five boroughs. This is a significant opportunity for Borough Partnerships to come together to support detailed local design and delivery and leaders in each borough have already met to consider the next steps and interdependencies locally.

There is a significant amount of collaboration and partnership working ongoing across health, local government and key partners. The community and mental health reviews are aligned to and support other key programmes including the development of a population health model for Long Term Conditions led by primary care and the Start Well programme focused on outcomes for children and young people in NCL.

The journey so far for community and mental health service reviews



Start of review

March 21

Agreement was reached for a strategic review of Community Health Services and a case for change was created

Mental Health

May 21

A parallel review of Mental Health Services has been conducted concurrently based on a case for change

Design co-production

May - July 21

Co-developed case for change, service offer, inequalities identification, gap analysis against Borough, through interviews, surveys and workshops with a focus on Local Authority

Partners Involved In Design Workshops
Primary Care
Community providers
Local Authority
Acute providers
Commissioner Borough& Strategic
Voluntary Sector
Residents/Users/Carers

Gap analysis

August 21

A gap analysis was conducted by Borough colleagues against the Core Offer

Core Offer

July 21

The purpose of the Core Offer 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 regardless of their borough of residence

Investment principles and KLOEs for prioritisation

April – May 22

Investment priorities and KLOEs agreed at CH and MH programme Boards respectively

Provider collaboration

May 22

Areas for provider collaboration have been agreed to improve care and support financial sustainability

Provider completion of PIDs for collaborative projects

July – August 22

Benefits realisation and financial impact to be articulated for each project

Provider completion of Delivery Plans for 22/23 community investment

July – August 22

Includes project monitoring KPIs

Agree investment priorities for Y1 and profile multi-year investment plan

June 22

Programme Board agreed investment priorities based on gap analysis and correlation with investment and programme principles. NCL System Management Board (CEO level) endorsed approach

Sign off at ICB Members Board of multi-year investment plan

September 22

Following system wide discussions during June – August 2022

Borough Implementation workshops

July – September 22

Borough Implementation workshops with place based partners in each borough

Future Programme Delivery

There is a powerful case for changing community health and mental health services

Inequalities

There are stark inequalities in health needs and outcomes across NCL

Provision

There is significant variation and gaps in service provision depending on where you live and this is not aligned to need

Access

The way you access services and how long you wait is also dependent on where you live

Spend

Different amounts are spent per head in different boroughs and this does not correlate with need

Service user/resident feedback

Services are difficult to navigate, and require servicer users to repeat their stories

Enfield has over twice the prevalence of diabetes as Camden; but half the diabetes resource

18% of people on the NCL mental health services caseload are Black/Black British, however, Black/Black British people accounted for 27% of NCL mental health inpatient admissions in 2019/20.

20% of children referred to mental health services in Islington wait over 18 weeks from referral to their first contact with services, compared to 1.2% of children in Barnet and 1.6% of children in Camden

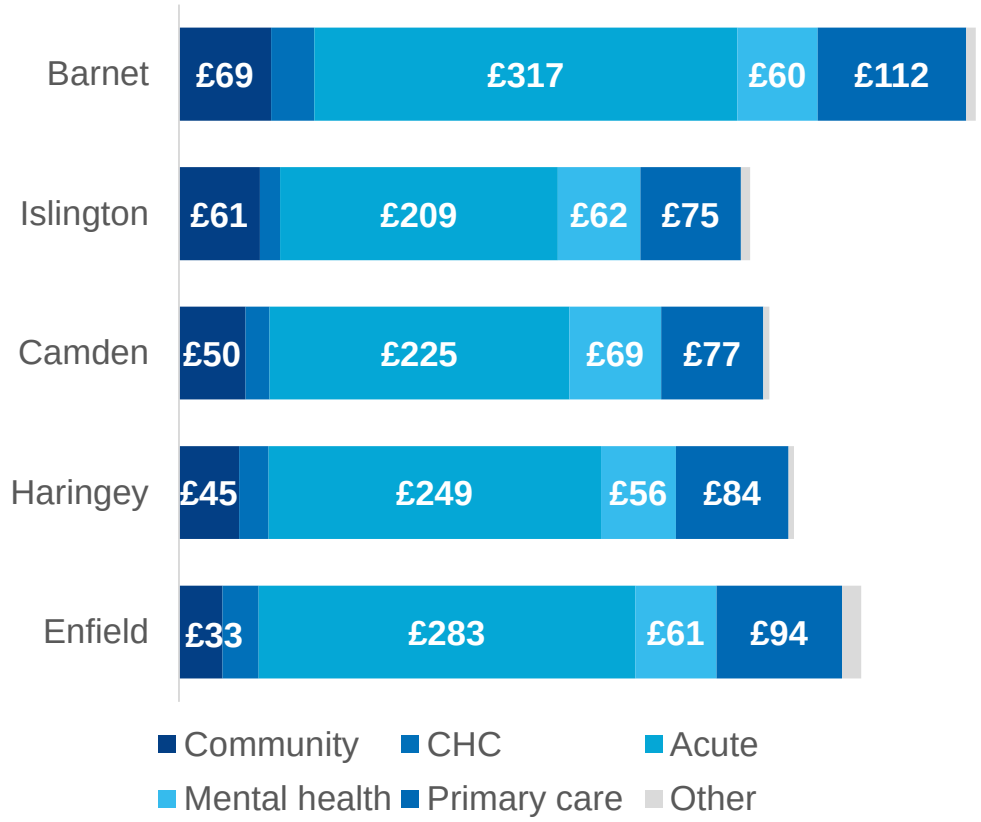
Much of our mental health services are geared to a crisis response. In 2020/21, North Central London STP had the highest rate of detentions under the Mental Health Act per weighted population of STPs in England.

In Haringey £98 per head is spent on community health services vs. £192 per head in Islington. This results in less capacity in core services, meaning community health services would struggle to be full participants in population health improvement work.

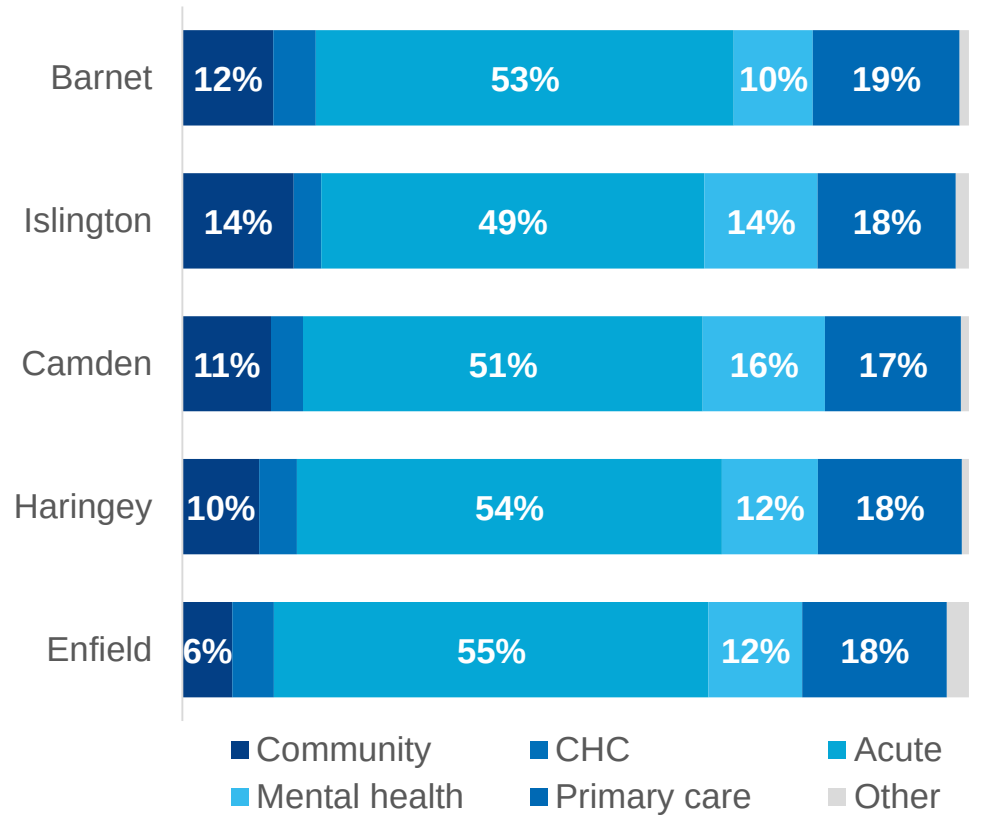
Feedback from residents via our Reference Group notes the distress caused by constant repetition of histories and stressed need for shared records

Boroughs with a lower proportion of spend on community health services tend to have a higher proportion of spend on acute services

CCG spend by service type, total spend, £M, 2019/20



CCG spend by service type, % of total spend, 2019/20

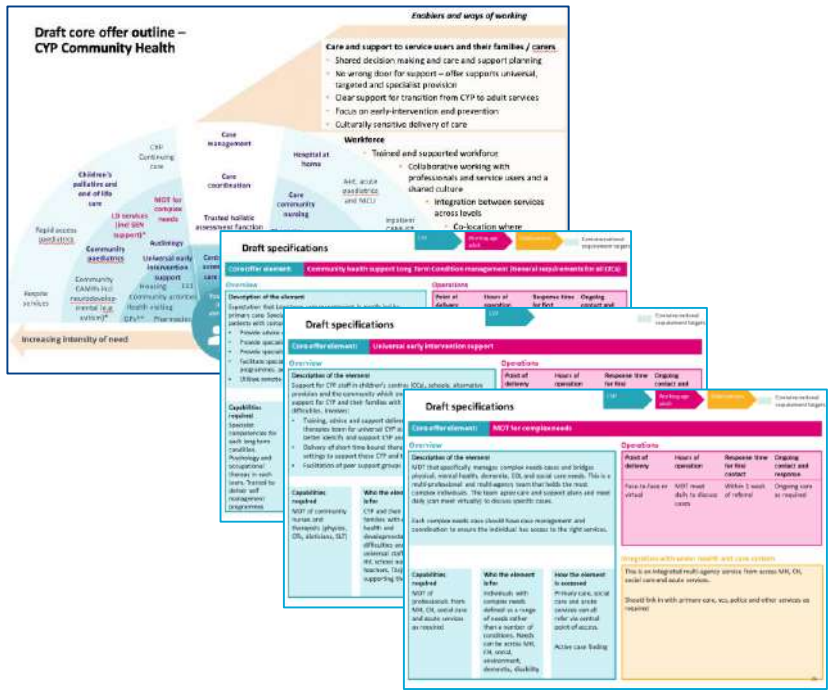


Note: Primary care includes primary care, primary care co-commissioning and primary care prescribing. Other denotes other programme services, excluding running costs.

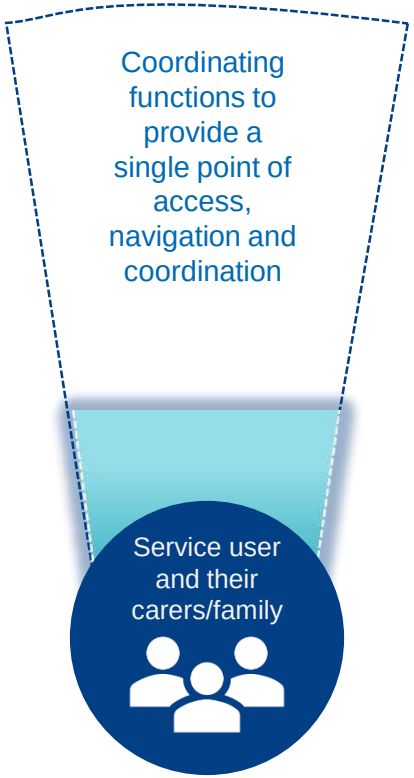
Source: NHSE CCG general and acute, community health services and mental health services weighted populations 2019/20, NCL CCG finance data, CF analysis

To respond to the case for change a core offer has been agreed which specifies what services should be available to everyone in NCL

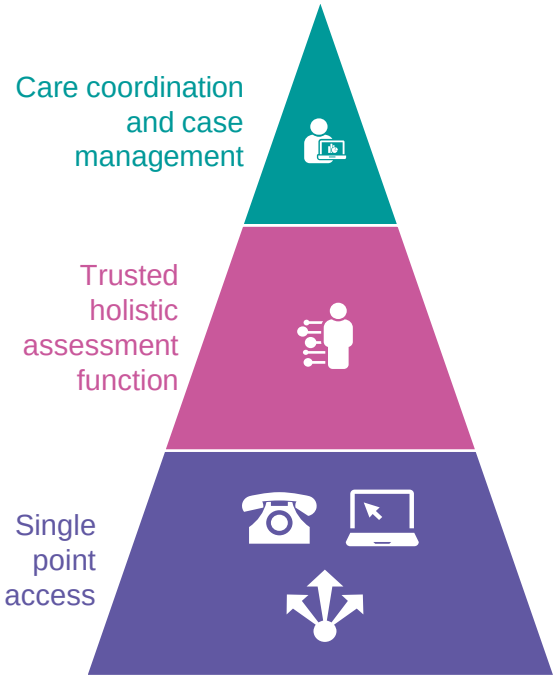
Each core offer outline provides a description of the care function for the services and lays out access criteria, hours of operation, capabilities required, where the care function should be delivered, waiting times and how the care function should link in with the wider health and care system.



Each outline also contains a set of coordinating functions encompassing a single point of access, care coordination and case management.



Care coordination links service providers, ensuring effective communication,, preventing duplication of services, identifying gaps in care, and assuring better health outcomes. Case management helps to integrate services around the needs of individuals with long-term conditions and complex needs



A borough gap analysis has been completed against the core offer for community and mental health services

Key takeaways from gap analysis vs core offer

Boroughs which had been historically under-funded had larger gaps relative to the core offer, but in **all boroughs** there is already work underway to address some of these gaps

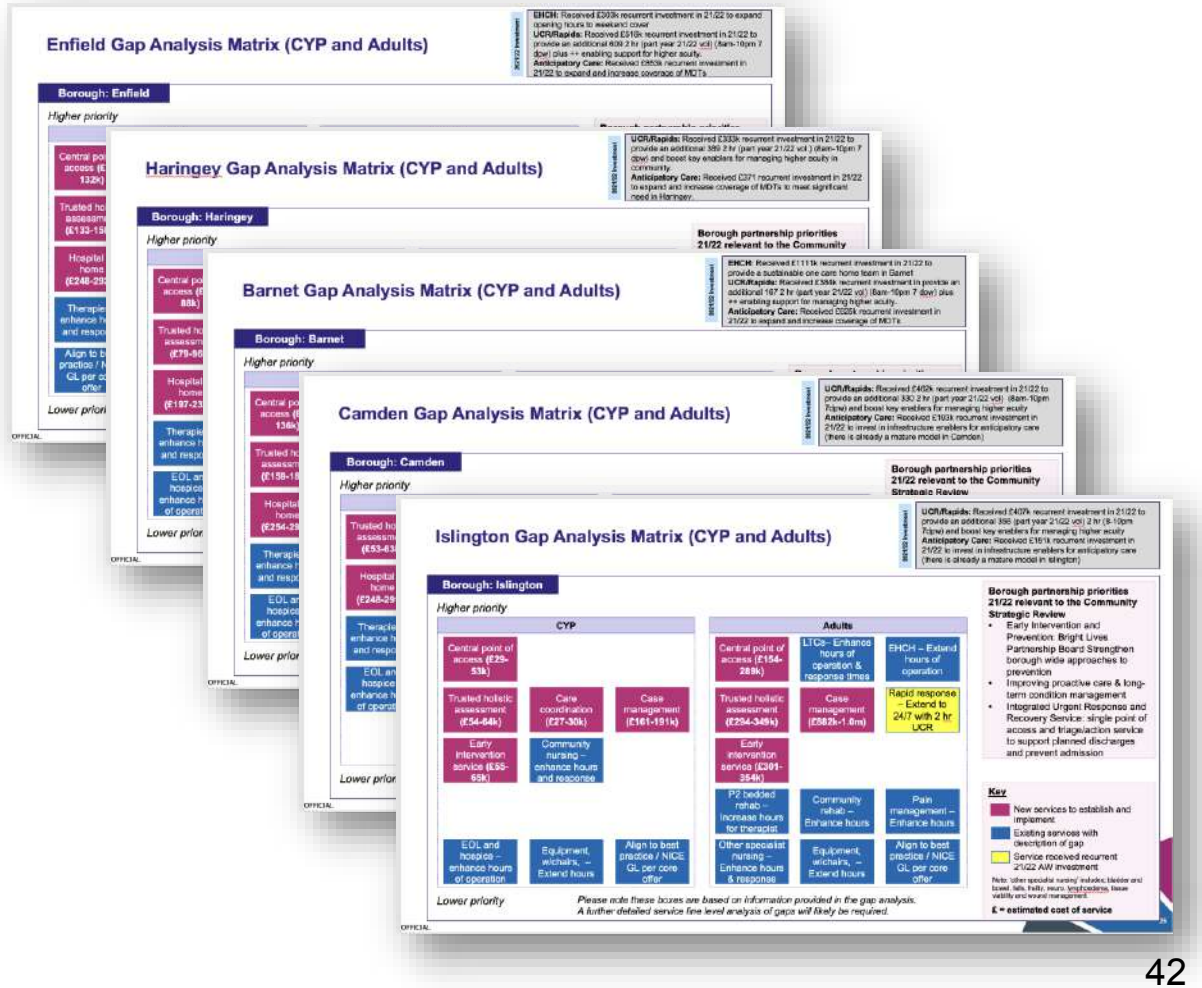
In **community services**, the biggest difference in the difference in gaps was between the Northern and Southern boroughs

In **CYP services**, there are significant gaps across board (except Islington which has relatively few)

In **mental health services**, the LTP mandates new thresholds so all boroughs require new investment

In some boroughs the gap analysis showed that there would need to be **greater capacity and skill mix** to fully participate in population health improvement work within neighbourhoods.

Example gap analysis of the core offer by borough



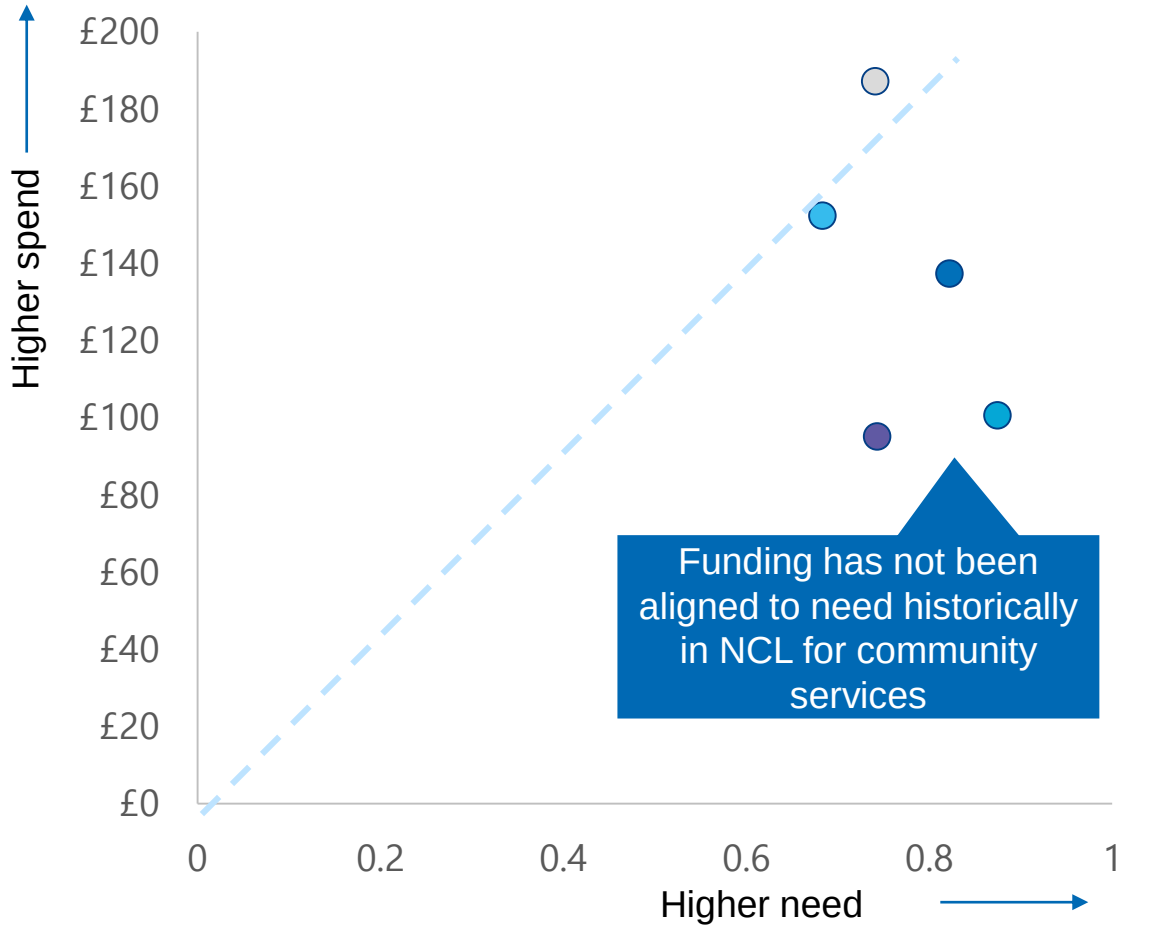
When compared with the level of need in each borough, we can see that current community health spend does not correlate with need

CCG	Population (GP practice registered as at March 2021)	Community spend (2020/21), less efficiency opportunity	Community spend per head (unweighted, 2020/21)
Barnet	433,182	£59,464,190	£137
Camden	304,078	£46,305,228	£152
Enfield	350,830	£35,274,193	£101
Haringey	326,527	£31,041,912	£95
Islington	271,712	£50,843,435	£187
NCL total	1,686,329	£222,928,957	£132

Key

Lowest spend per capita — Highest spend per capita

Correlation between NHSE needs index for Community health services (x axis) and spend per head on community health services (y axis)



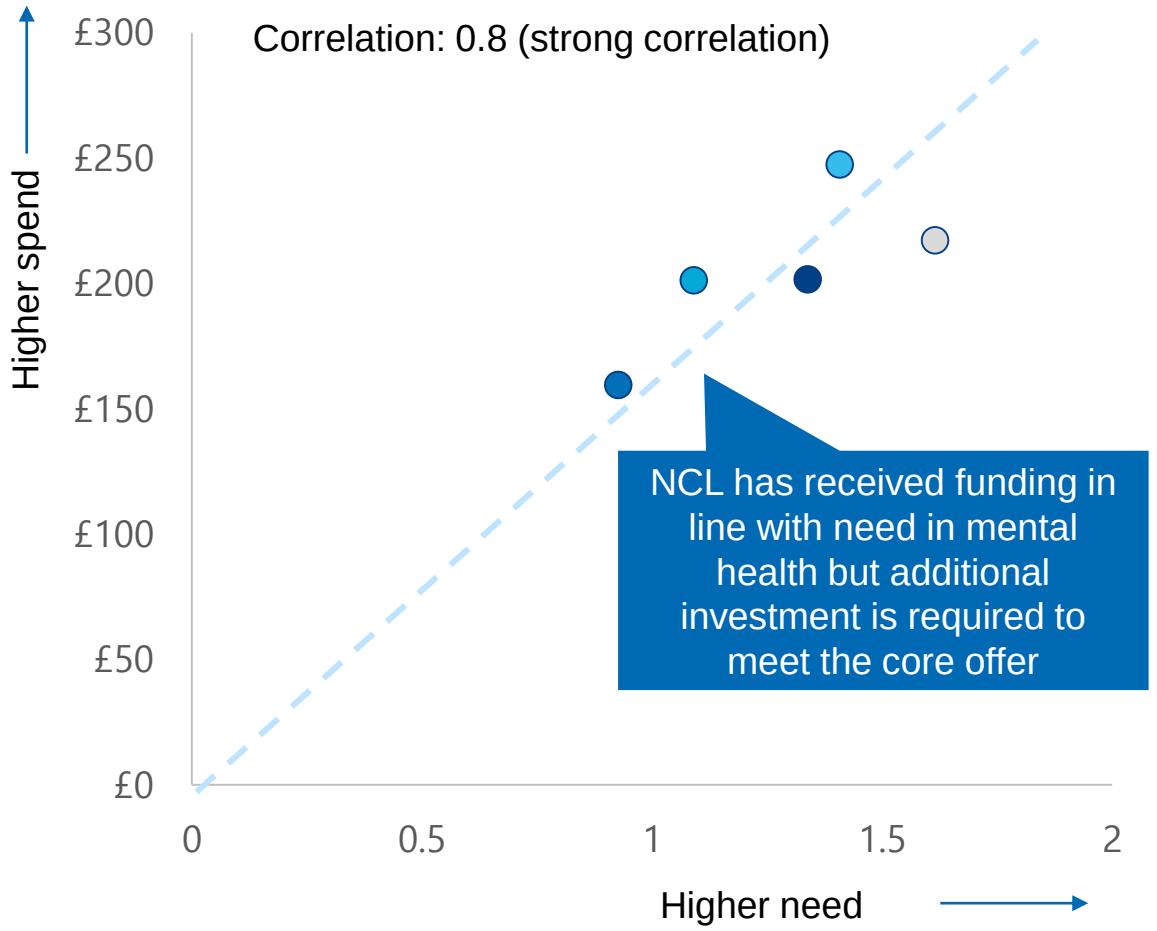
When compared with the level of need in each borough, we can see that current mental health spend broadly correlates with need

CCG	Population (GP practice registered as at March 2021)	Mental health spend (2020/21), less efficiency	Mental health spend per head (unweighted, 2020/21)
Barnet	433,182	£69,086,436	£159
Camden	304,078	£75,221,730	£247
Enfield	350,830	£70,578,216	£201
Haringey	326,527	£65,817,395	£202
Islington	271,712	£58,999,873	£217
NCL total	1,686,329	£339,703,650	£201

Key

Lowest spend per capita — Highest spend per capita

Correlation between NHSE needs index for mental health services (x axis) and spend per head on mental health services (y axis)



How implementation planning discussions with key system forums have strengthened our approach

Theme and *Forum*	**What we've done**
'How will we know that investment is making a difference?' *Finance Committee, System Chief Finance Officers Meeting and System Management Board*	Strengthened benefits realisation framework (see slides 29-30) including a six monthly review re. impact on unplanned care activity at acute providers
'Importance of strengthened focus on delivery to ensure benefits are realised' *Programme Boards*	Establishment of CEO chaired implementation steering groups and dedicated PMO resource
'Importance of strengthened focus on delivery to ensure benefits are realised' *Finance Committee, System CFO's*	Monthly finance subgroups established during implementation stage
'Significant waiting list challenges' *Borough level (include full version) SEND inspections*	Redesign and investment to tackle waiting lists in autism and children's therapy
'Importance of enabling population health improvement at neighbourhood level through tackling core capacity gaps in some community and mental health service gaps' *Implementation workshops*	Early stages of the programme will involve ensuring core capacity gaps in historically underfunded boroughs are tackled
'There is likely to be a workforce challenge due to national and regional shortages in some community and mental health roles' *System management board and programme boards*	Providers to work together in line ICS workforce programme re. innovative solutions; joint work on recruitment and retention with local authorities at place.

The year 1 investments to start implementing the core offer will have benefits across the system for patients and financial sustainability

Planned benefits of year 1 community investments

Reducing pressure on acute service

- Increased ability to **support discharge** at weekends
- Reducing unnecessary acute **hospital attendances**
- Reducing **hospital conveyances** from care homes through a geriatrician advice line for LAS
- Supporting people to stay in **control of their condition** out of hospital

Improving community services

- **Proactive care** approach that improves prevention
- Support, integrate and **navigate care** for service users across the layers of the core offer.
- Address **health inequalities,** improving **clinical outcomes** and providing capacity for population health improvement in neighbourhoods
- Enabling more people to be **cared for at home** in the community after hospital stays

Planned benefits of year 1 mental health investments

Reducing pressure on acute service

- Reduction in Adult **A&E attendances due to depression** of between 274-365 (10-13%)
- Reduction in Adult **A&E attendances due to psychotic symptoms** of 402-535 (15-20%)
- Reduction in **CYP A&E attendances due to depression** of between 101-135 cases (30-40%)

Improving mental health services

- Address **health inequalities,** improving **clinical outcomes** and providing capacity to participate in population health improvement in neighbourhoods
- Improves **patient experience** and reduces **waiting time**
- Increase average **IAPT access** by ~40%: 20k patients receiving transformed models of care
- Average reduction in **CAMH crisis admission** of between:11-15 (31-41%)

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Approach to investment over the life-cycle of the programme

Our approach to investment to fund the Core Offers

The case for change for community and mental health services

- The case for change highlights that there is **significant variation in spent per head** in different boroughs and this does not correlate with need (see slide 10), and that the boroughs with a lower proportion of spend on community health services tend to have a **higher proportion of spend on acute services** (see slide 7).
- The 'do nothing' scenario will result in an **increased acuity of patients** not receiving effective out of hospital care and increased acute costs in the long term, **increasing overall system deficit**.

Investment as an enabler of the Core Offers

- **Investment is required** to reduce system cost and **relieve pressure on our acute hospitals** through reduced Urgent Care activity, improving system sustainability in the long term.
- Investment will also support providers to **unlock productivity improvement initiatives** through initial investment via closer collaboration and transforming care delivery.
- Investment will also seek to **address historic inequities in funding** to improve outcomes and financial sustainability in boroughs that have received funding below their level of need.

Investment profiling

- The **mental health funding plan** sets out affordability using the MHIS and SDF funding. This reflects the strong alignment between delivery of the MH core offer programme and MH LTP. The phasing 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.
- **Community profiling is over a 5 year period** rather than a 3 year period due to feasibility of delivery. The step change in to Yr 2 (2023/24) in this model is more realistic in both planning and delivery terms. Initial Y1 funding has been provided in order to start to enable some of the highest priority gaps to be tackled to enable productivity and system savings initiatives that will benefit from Y2.

Delivering productivity and system savings

- **Financial planning and delivery of the savings will be the responsibility of providers**. Providers have signed up to a number of collaboration priorities between themselves and acute providers (e.g. P2 beds transformation and mental health crisis transformation respectively) to reduce system cost and increase productivity.
- Significant savings will be achieved through **investment and transformation planned** by providers, including Virtual Wards, Silverline and and mental health crisis support.
- The programme has agreed the **lower range of productivity and system savings** modelling to ensure deliverability.

The system has a blend of levers for implementing the core offer and must, alongside ICS funding, enable productivity and system savings

C&MH provider savings	Efficiency	Providers improve productivity and redesign ways of working to meet system 'best in class' to release funds e.g. reshaping care models, use of technology.
	Opportunities of Scale	We seek to deliver some services via Lead Provider models or similar to release efficiencies. This will also help address workforce issues in smaller or more fragile services.
	Service workforce re-design	Providers change the footprint over which they deliver services and/or share resources to effectively increase investment in areas that are under-invested.
Acute savings	System Savings	We will reinvest savings from elsewhere in the system that our work accrues. For example, via reducing acute demand, this would supports the flow of funds from Acute to Community.
ICS funding	Growth Monies	Growth monies to be allocated asymmetrically with more growth going to areas that have had historic inequities in investment.

…this is because system and productivity savings are a crucial part of funding the core offer from year 2 onwards

Overview of investment timeline for core offer implementation

Core Offer Development 2021/22	Year 1 Investment 2022/23 (Oct – Mar)	Years 2 & 3 Investment 2024/25 – 2024/25	Years 4 & 5 Investment 2025/26 – 2026/27
The purpose of the Core Offers is to address the inconsistency of service provision across NCL. System and productivity savings are required to fund the Core Offers	£3.8m (£7m FYE) of ICS funding has been secured for community year 1 investments. Mental Health investments of £11m are available for year 1. As a result of this approach, finance principles for Y1 investment included a focus on reducing pressures in acute hospitals in historically underfunded areas:	The programme will engage with boroughs to determine investment priorities and secure ICB sign-off for recurrent investment.	Community Services implementation plan spans 5 years to ensure that funding and delivery of investments are realistic.

1. Delivering a proportion of it through productivity savings
2. Borough gap analysis should be used to inform decision making
3. Investment should focus on historically underfunded areas and where there are historic inequities
4. Reduce admissions and improve discharge and elective recovery to release acute costs (particularly for community investment)
5. Preventative services
6. Take into account capacity to delivery and deliverability
7. How best to support coordinating functions in order to respond to significant public and patient feedback

Mental Health: phasing of investment to deliver the “core offer” over the next three years

Overall Affordability of MH Core Offer Phased & including inflation

£millions	Year 1 22/23	Year 2 23/24	Year 3 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
* New Recurrent MHIS Investment (incremental ask each year)		2.9	5.5
Application of Funding			
Adjustment for MH Need Analysis	-	-	-
Additional Costs to deliver full core offer	11.1	15.0	25.1
Total Investment	11.1	15.0	25.1
Year by year pressure / (surplus)	0.0	0.0	0.0

Justification for 3-year investment profiling

- 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 LTP.
- The MHIS and SDF **funding are to be confirmed formally** by NHSE for future years. The model assumes c. £**15m year on year MHIS funding** with half funding inflation costs and the remainder being available for new investments. The non-recurrent **SDF funding has been risk adjusted by 50%** in years 2 and 3.
- 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.

Community Services: phasing of investment over five years provides the most realistic financial framework

Overall Affordability of CS Core Offer Phased & including inflation

£s in millions	Year 1 2022/23	Year 2 2023/24	Year 3 2024/25	Year 4 2025/26	Year 5 2026/27	Total
Source of Funding						
Investment from ICS Growth pot per year (Recurrent)	3.8	5.2	8.6	8.6	8.6	34.7
Community Provider Productivity per year (Recurrent)	0.0	2.7	2.7	2.7	2.7	10.8
Acute Cost Reduction per year (Recurrent)	0.0	3.0	3.0	3.0	3.0	12.1
Total Source of Funding	**3.8**	**10.9**	**14.3**	**14.3**	**14.3**	**57.7**
Application of Funding						
Needs Based Investment per year (Recurrent)	0.0	7.8	7.8	7.8	7.8	31.3
Service Gap Investment per year (Recurrent)	3.4	3.1	6.5	6.5	6.5	26.0
Programme Costs (Recurrent)	0.4	0.0	0.0	0.0	0.0	0.4
Total Gross Investment	**3.8**	**10.9**	**14.3**	**14.3**	**14.3**	**57.7**
Net Year by year (gap)/surplus	0.0	0.0	0.0	0.0	0.0	0.0

Justification for 5-year investment profiling

- Profiling is over a **5 year period rather than a 3 year period** due to feasibility of delivery. The step change in to Yr 2 (2023/24) in this model is **more realistic in both planning and delivery** terms.
- Initial Y1 funding has been provided in order to start to enable some of the highest priority gaps to be tackled to kick start productivity and system savings initiatives that will benefit from Y2.
- Yrs 3-5 would continue to require recurrent incremental investment of c. £8.6m and continued **progress on productivity and acute cost base reductions**.

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What this means for Year 1 of the programme

Given the system's challenging financial position, the Programme Boards agreed the following principles for allocating Year 1 investments

The below principles set out our thinking for allocating investment in the financial year 2022/ 2023

1. Delivering a proportion of it through productivity savings
2. Borough gap analysis should be used to inform decision making
3. Investment should focus on historically underfunded areas and where there are historic inequities
4. Reduce admissions and improve discharge and elective recovery to release acute costs (particularly for community investment)
5. Preventative services
6. Take into account capacity to delivery and deliverability
7. How best to support coordinating functions in order to respond to significant public and patient feedback

Year 1 Funding Methodology

1. Revisited the gap analysis completed by providers and Borough leads last summer
2. Correlated gaps with financial principles and programme principles
3. Agreed investment areas in Collaboration and Programme Board meetings
4. Allocated funding asymmetrically with more funding going to historically under-funded Boroughs (community only)

- This data was collected for each Borough to determine current provision against the core offer
- Principles included: Strategic fit; Clinical impact; Health inequalities/ Inequality of access; Patient experience; Deliverability; System impact
- Assessment of investment areas against financial and programme principles was **tested and supported at CSR and MHSR Programme Boards**
- Current spend is not correlated to need
- Relevant for community but not mental health investments (see slide 10)

The provider collaboration workstreams are a significant enabler for creating sustainable services for the people of NCL

Objectives for collaboration

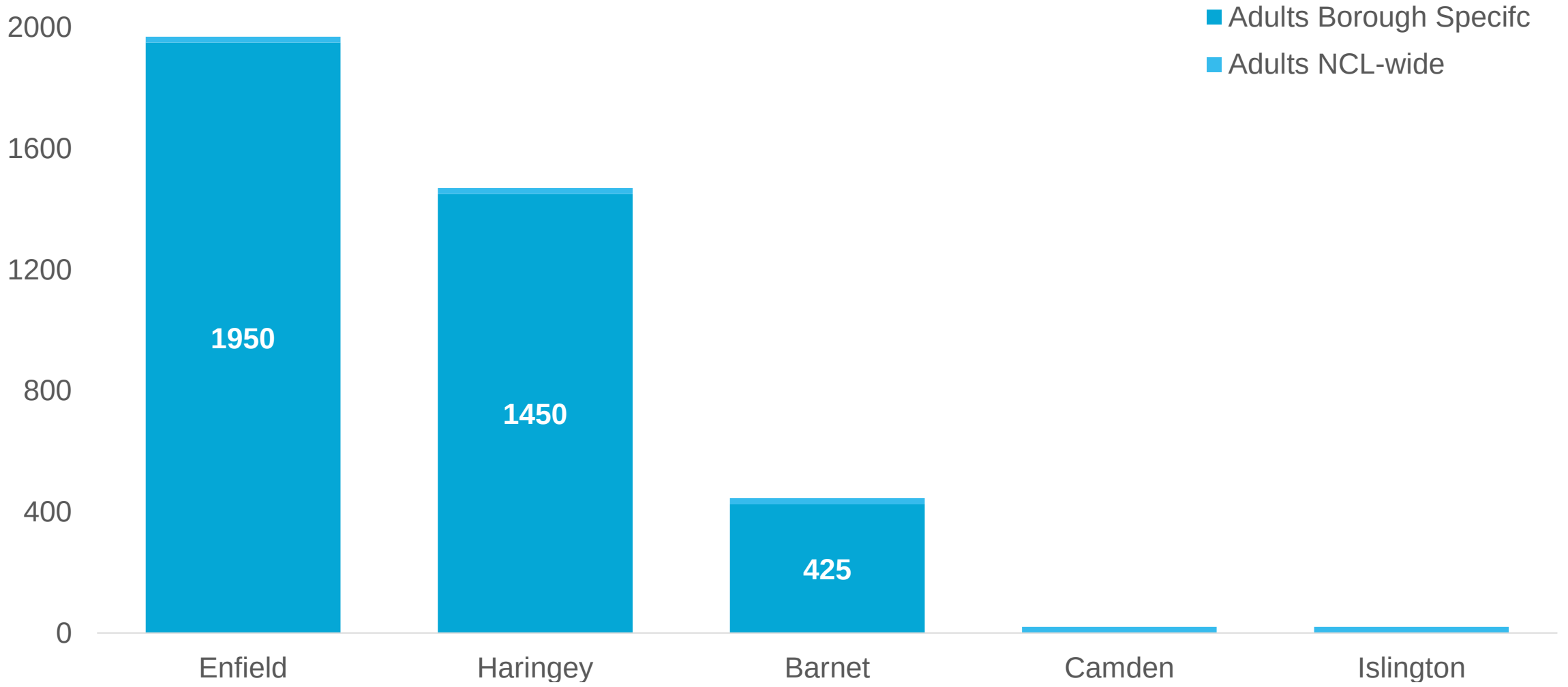
- Delivering **system savings** by reducing acute demand
- Delivering **productivity improvements** through redesigning care pathways and more collaborative ways of working between providers
- Improve **workforce resilience** by sharing capacity across the system
- Create **consistency in cross borough boundary hospital patient flows** to community and mental health
- Respond to patient and carer feedback around the **difficulty of navigating the healthcare system**

Provider collaboration areas

Adult Community Provider Transformation Programme Group	P2 Beds
	Virtual Wards
	Diabetes
	Tissue Viability
	Coordinating Functions
CYP Community Transformation Programme Group	ASD/Therapy Recovery
	ASD/ADHD Transformation
	CYP Nursing Transformation
	Therapy Service Transformation
	Paediatric Transformation
Adult and Child Mental Health Programme	CYP
	Community
	Crisis
	Inpatient
	IAPT
	Mental Health Programmes

Y1 additional adult community investment targets core capacity gaps in underfunded areas and reduces pressure on acute services

Allocation of community funding by Borough, £'000
Based on 2022/23 FYE investment - £3,925 new investment

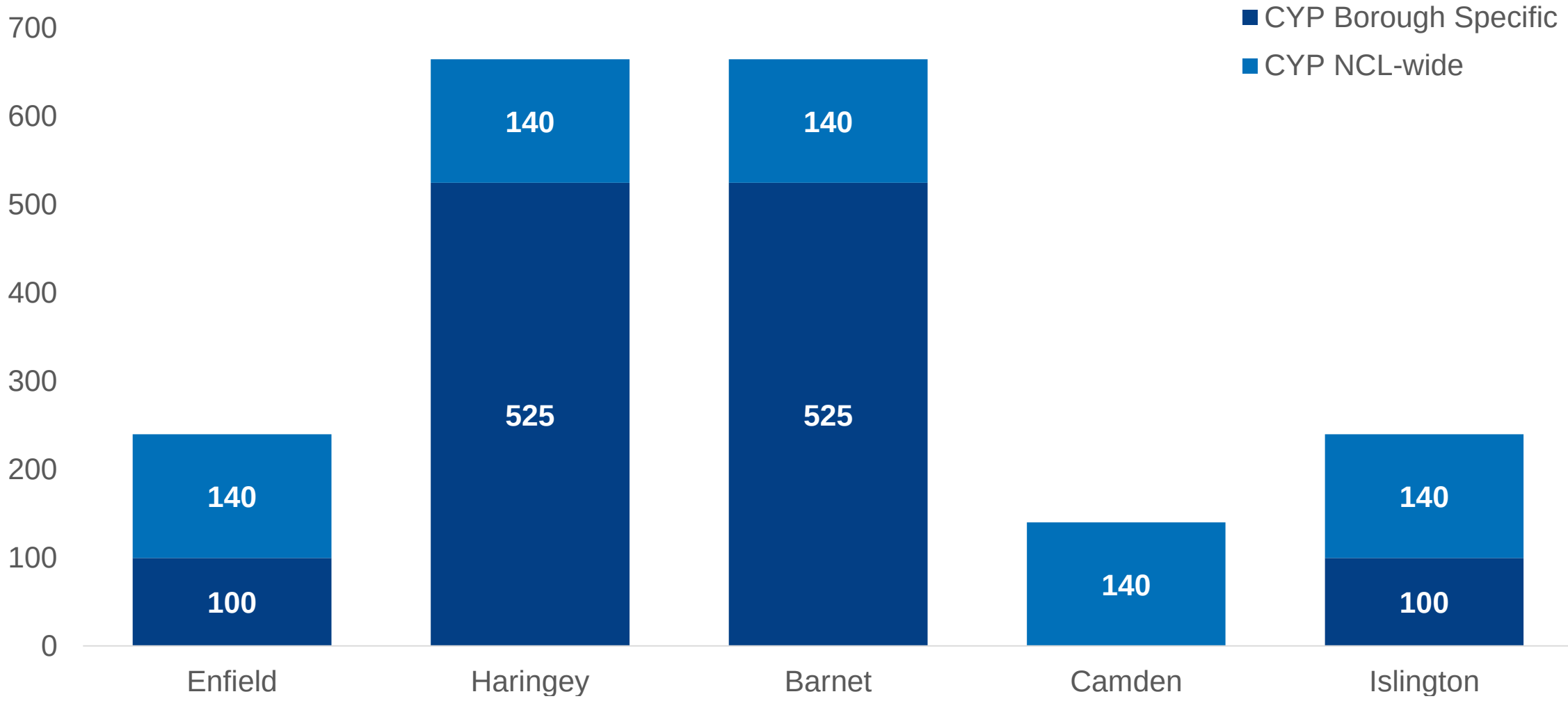


Y1 additional adult community investment targets core capacity gaps in underfunded areas and reduces pressure on acute services

Gap being addressed for Y1	System Benefit	Borough/s	FYE £000
Increasing skill mix and capacity in Community Nursing	Increased responsiveness; increased ability to support people to stay well and out of hospital; increased ability to support neighbourhood pop health improvement work	Enfield, Barnet, Haringey	£1,495
Rehab/recovery capacity through additional therapists	Increased ability to support discharge including at weekends and enabling recovery after hospital stays	Enfield, Barnet, Haringey	£1,530
Community diabetes service skill mix and capacity	Prevention and supporting people to stay in control of their condition	Enfield	£150
Establishing a pain management service	Key inequity vs. neighboring boroughs and reducing pressure on acute service; proactive care approach	Haringey	£500
Extra support to LD care homes	Supporting inequalities and reducing unnecessary acute hospital attendances	Haringey	£150
Establish Silver Triage service across NCL	Reducing hospital conveyances from care homes through a geriatrician advice line	All	£100
Adult Community Total			**£3,925**
CYP Community Total			**£1,949**
Coordinating Functions	Realising the potential benefits from implementing the core offers, acting to support, integrate and navigate care for service users across the layers of the core offer.		**£776**
Programme Costs	To reduce the risk of non-delivery		**£350**
TOTAL			**£7,000**

Y1 additional CYP community investment targets addresses CYP waiting times, improves clinical outcomes and tackles inequalities

Allocation of community funding by Borough, £'000
Based on 2022/23 FYE investment - £1,949 new investment

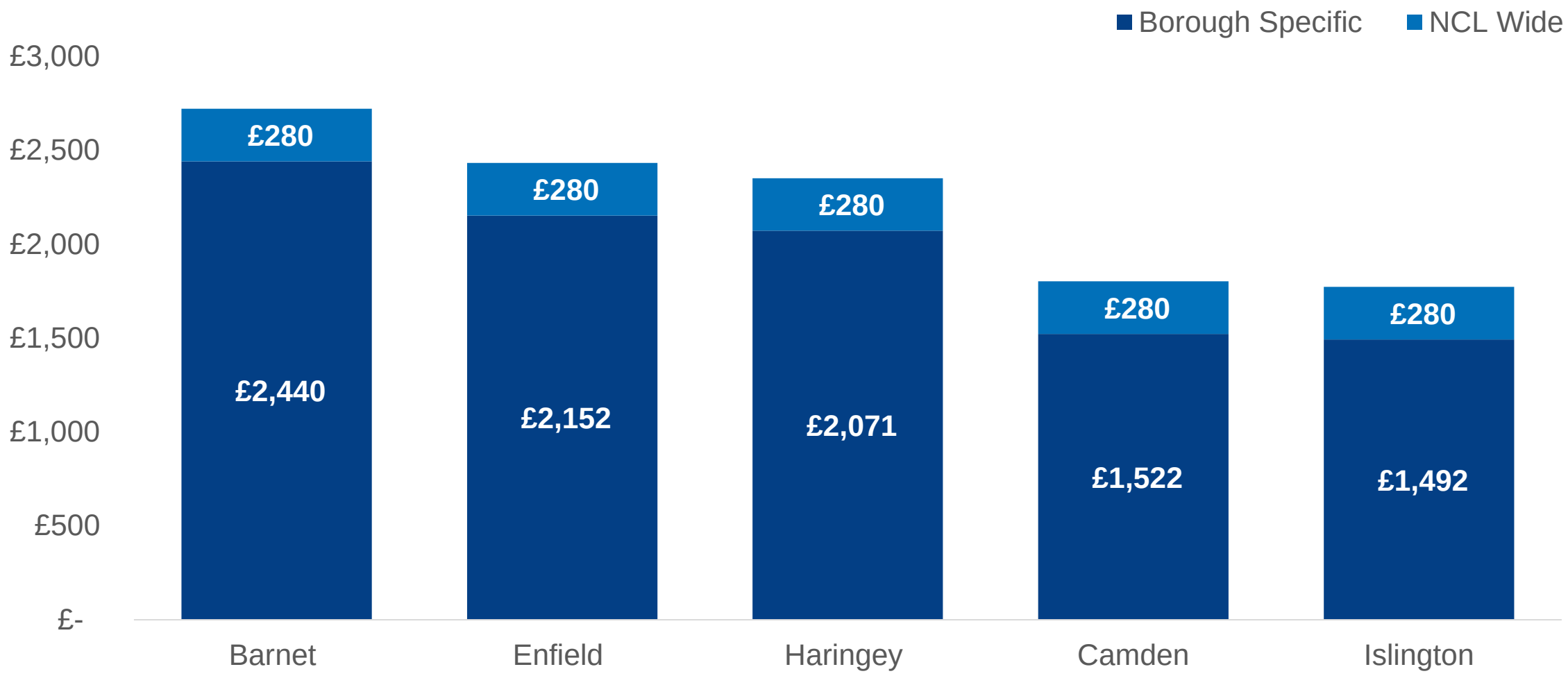


Y1 additional CYP community investment targets addresses CYP waiting times, improves clinical outcomes and tackles inequalities

Gap being addressed for Y1	System Benefit	Borough/s	FYE £000
Asthma nursing	Expediting discharges; reduce admissions; inequalities	Haringey, Barnet	£150
Enuresis service ensuring specialist community health pathways available in all boroughs	Strong clinical impact; pt exp	All (Prioritise Barnet)	£100
Increase children's therapy capacity to boost CYP therapies expedited recovery	Improved clinical outcomes; inequalities	Barnet and Haringey	£700
Increase autism diagnostic capacity	Improved clinical outcomes; inequalities	All (Prioritise Enfield)	£600
Boost skill mix and new roles for LAC service	Improved clinical outcomes; inequalities	All (excl Camden)	£399
CYP Community			**£1,949**
Adult Community Total			**£3,925**
Coordinating Functions	Realising the potential benefits from implementing the core offers, acting to support, integrate and navigate care for service users across the layers of the core offer.		**£776**
Programme Costs	To reduce the risk of non-delivery		**£350**
TOTAL			**£7,000**

Distribution of ICS investment for 22-23 to help deliver the Mental Health core offer

Allocation of mental health funding by Borough, £'000
2022/23 investment - £11,079 new investment



Year 1 mental health investment is focused on reducing waiting times, improving crisis response and community transformation

Service Core Offer Theme	System benefit	Borough	FYE £,000
Adult Community; Services receiving investment delivered in the community inc. Community Transformation	Reduces waiting times, addresses inequalities, patient experience, clinical impact, reduces acute activity. Increase average IAPT access by ~40%. ~20k patients receiving transformed community models of care	ALL	£7,229
Adult Crisis; Services receiving investment within the Crisis pathway inc. Crisis Houses / Cafes, MHLS	Reduction in Adult A&E attendances due to depression of between 274-365 (10-13%) and a reduction in Adult A&E attendances due to psychotic symptoms of 402-535 (15-20%). Improves patient experience and addresses inequalities.	ALL	£1,268
Young Adults; Additional workforce and new roles supporting transition	Reduces waiting times, addresses inequalities, patient experience, clinical impact	ALL	£1,170
CAMHS Community; Waiting Times recovery and transformation. New Home Treatment Teams	Reduces waiting times, addresses inequalities, patient experience, clinical impact	ALL	£811
CAMHS Crisis; Acute Trust MH nurse educators	Average reduction in CAMH crisis admission of between:11-15 (31-41%). Reduction in CYP A&E attendances due to depression of between 101-135 cases (30-40%). Improves Pt experience.	ALL	£190
CAMHs MHST; Embed new MHSTs in 2 boroughs in 22/23 as part of NCL expansion programme	Increases access, prevention, improves patient experience	ALL (C & H in 22/23)	Wave 7 £ TBC
Eating Disorders; Embed Community team and increase specialist Eating Disorder Service capacity	Reduces waiting times, addresses inequalities, pt experience, clinical impact	ALL	£411
Mental Health Total			**£11,079**

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Benefits of Implementation

Implementing the reviews enables the following benefits to be realised through shifting activity from acute to the community

Universally consistent provision for all of our residents	Addresses **significant variation** in access, responsiveness and intensity of different services
Supports community and mental health services to be more proactive, stay well at home and out of acute or crisis services	Reduces **system cost and relieves pressure on our acute hospitals** through reduced UEC cost inc. emphasis on prevention and early intervention
Increases capacity and skill mix	Enables services to have the **resources to support integration and population health management in neighbourhoods**, which in combination with our system-wide work on LTCs and Fuller will create a platform for sustainable population health outcome improvement.
Improved patient experience of care	**Reduced handovers in care** and a more personalised experience for our residents, as well as repatriating all OAPs into NCL
The unlocking of productivity opportunities including through digital transformation	Enables the further release of resources and funding to resolve “core offer” gaps

Our vision is that the work that takes place in partnership with primary care, the VCS and LA services in neighbourhoods enables the deployment of resources differently re. where we need differential effort to achieve population health outcomes. There will be an annual system review of activity undertaken in acutes to measure the effectiveness of the shift towards early intervention and prevention.

Community approach to benefits realisation

Community Outcomes Framework and associated indicators

For example:
- NCL Population Health Outcome: 'Older people live healthy and independent lives as long as possible' and associated indicators of how community services actions contribute
- Increase the number of people seen by rapid response in 2 hours [who would have been at risk of emergency admission]
- % of people (identified anticipatory care cohort) who have an integrated care plan

Reporting: monthly with borough, Trust and NCL-level view to ISG and ICPs with assurance to finance sub-group and PB*

Project or workstream level KPIs on productivity

For example:
- Conveyances avoided from care homes due to Silver Triage each month
- P2 bed days saved due to reduction in variation in LOS
- % of extra community nurses recruited to borough x vs target
- Increases in community nursing activity associated with TV/PEGs/IVs/Catheters across all hours of the day including overnights

Reporting: monthly to ISG with assurance to finance sub-group and PB

System level analysis

For example:
- Annual analysis on whether the proportions of spend per borough in acutes hospitals (in relation to UEC) are reducing as a result of increased community investment
- Refreshed service spend analysis against latest NHS Needs Index by borough

Reporting: Finance sub-group with reporting to PB (annually, with summary updates to ICB finance committee and SMB)

*once established: est. 6-12 months

Mental Health approach to benefits realisation

Mental Health Outcomes Framework and associated indicators

NCL ICS will be collecting population health outcomes for mental health to measure the impact and effectiveness of delivering the MH core offer. For example, under each domain there will be associated outcomes and indicators of how mental health services contribute toward improvement:

- **Start well**: Every child has the best start in life and no child left behind; Young People and their families are supported to their transition to adult services E.g. Reduced number of referrals and length of stay for admissions to a Tier 4 CAMHs and LD ASD cohort inpatient beds.
- **Live well**: Reduction in early death from cancer, cardiovascular and respiratory disease; Reduction in the need for inpatient care through the provision of increased / transformed early intervention and prevention services in the community and the provision of crisis alternative services E.g. Reduction in % of patients admitted as an emergency via A&E, police or non blue light conveyance
- **Age Well**: 1. Older People live healthy and independent lives as long as possible and are connected and thriving in their local communities. E.g. Increase in % of people with dementia reviewed regularly and offered therapeutic support, advice and sign posting.

Reporting: monthly with borough, Trust and NCL level view to ISG and ICPs, with assurance to finance sub-group and PB

Project or workstream level KPIs on productivity

For example:

- Are we effectively repatriating system spend out of area e.g. OAPs to reinvest into NCL community mental health services
- Are we improving efficiency of mental health services such as bringing together mental health secondary care services to reduce variation and avoid duplication.
- Are we improving efficiency of specific services e.g. bringing together of 2 crisis lines into 1 and associated efficiencies.
- Are we decreasing crisis presentations and moving activity towards early intervention and prevention.

Reporting: monthly to ISG with assurance to finance sub-group & PB

System level analysis

For example:

- Have we met this Mental Health Investment Standard (MHIS)
- Are we increasing the workforce in line with investment and are we reducing our vacancy rate
- Have we achieved efficiencies expected in the financial plan
- Have we effectively reallocated slippage in investment
- Are we achieving the performance metrics in the outcomes framework to effectively and efficiently deliver the mental health core offer service improvements

Reporting: Finance sub-group with reporting to PB (annually, with summary updates to ICB finance committee and SMB)

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Next steps

The following actions are progressing during the remainder of 2022/23

Borough Implementation workshops	Delivery planning and mobilisation	Implementation of investments	Benefits realisation tracking at place and ICS
Workshops have been taking place during July-early September to enable deeper integration at borough level to put in place foundations of population health improvement. The workshops will shape and drive implementation at place.	During August and September providers have been leading delivery planning with partners for both NCL wide projects and place based implementation of Y1 service gap priorities and collaborative transformation initiatives.	From October: subgroups to the programme boards have been set up for project implementation to report to. Providers will give regular updates to place based partners re. implementation and barriers to deliver that partners need to overcome together.	Clear KPIs and reporting is being put into place as part of delivery planning. Both programmes are progressing outcomes frameworks in line with the NCL Population Health Outcomes indicators (over the next 6-12 months).

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Appendix

Programme board standing memberships

CSR Programme Board

Name	Organisation
Frances O'Callaghan	NCL Integrated Care Board
Sarah Mansuralli	NCL Integrated Care Board
Nnenna Osuji	North Middlesex University Hospital NHS Trust
Jo Sauvage	NCL Integrated Care Board
Caroline Clarke	Royal Free Group
Helen Brown	Whittington Health NHS Trust
Jinjer Kandola	Barnet, Haringey and Enfield Mental Health NHS Trust
Vanessa Odlin	Central North West London NHS Foundation Trust
Anne Whateley	Central London Community Healthcare NHS Trust
Phill Wells	NCL Integrated Care Board
Geoffrey Ocen	Bridge Renewal Trust
Ian Brettman	NHS North Central London Clinical Commissioning Group
John Hooton	London Borough of Barnet
Dawn Wakeling	London Borough of Barnet
Tamara Djuretic	London Borough of Barnet
Jess McGregor	London Borough of Camden
Martin Pratt	London Borough of Camden
John Everson	London Borough of Islington
Stephen Taylor	London Borough of Islington
Susan Otiti	London Borough of Haringey
Oliver Anglin	NCL CCG

MHSR Programme Board

Name	Organisation
Frances O'Callaghan	NCL Integrated Care Board
Sarah Mansuralli	NCL Integrated Care Board
Phill Wells	NCL Integrated Care Board
Jinjer Kandola	Barnet, Haringey and Enfield Mental Health NHS Trust
Darren Summers	Camden and Islington NHS Foundation Trust
Paul Jenkins	The Tavistock and Portman NHS Foundation Trust
Dale-Charlotte Moore	Whittington Health NHS Trust
Linzi Roberts-Egan	London Borough of Islington
Jess McGregor	London Borough of Camden
John Hooton	London Borough of Barnet
Dudu Sher-Arami	London Borough of Enfield
Sue Hogarth	London Boroughs of Camden and Islington
Ann Graham	London Borough of Haringey
John McGrath	NCL Integrated Care Board
Chris Caldwell	The Tavistock and Portman NHS FT & NLP in Health and Care
Arnold Palmer	NHS North Central London Clinical Commissioning Group
Katherine Barrett	N/A
Jennie Claxton	N/A
Julia Britton	Open Door
Dan Morgan	NCL Integrated Care Board

Implementation steering group standing memberships

CSR Programme Board

Name	Organisation
Nnenna Osuji	North Middlesex University Hospital NHS Trust
Sarah Mansuralli	NCL Integrated Care Board
Mo Abedi	Barnet, Enfield and Haringey Mental Health NHS Trust
Jo Stronach	Barnet, Enfield and Haringey Mental Health NHS Trust
Katherine Millard	Central North West London NHS Foundation Trust
Sarah Hulme	Central North West London NHS Foundation Trust
Alison Kett	Whittington Health NHS Trust
Vanessa Cooke	Whittington Health NHS Trust
Kay Isaac	Central London Community Healthcare NHS Trust
Azom Mortuza	North Middlesex University Hospital NHS Trust
Sita Chitambo	North Middlesex University Hospital NHS Trust
Ross Graves	Central North West London NHS Foundation Trust
Richard Taylor-Elphick	North London Councils
Elisha Coates	North London Councils
Rachel Lissauer	NCL Integrated Care Board
Alex Smith	NCL Integrated Care Board
Dan Morgan	NCL Integrated Care Board
Anthony Browne	NCL Integrated Care Board
Kathy Parker	NCL Integrated Care Board

MHSR Programme Board

Name	Organisation
Jinjer Kandola	Barnet, Haringey and Enfield Mental Health NHS Trust
Sarah Mansuralli	NCL Integrated Care Board
Vincent Kirchner	Barnet, Haringey and Enfield Mental Health NHS Trust / Camden and Islington NHS Foundation Trust
Natalie Fox	Barnet, Haringey and Enfield Mental Health NHS Trust / Camden and Islington NHS Foundation Trust
Darren Summers	Barnet, Haringey and Enfield Mental Health NHS Trust / Camden and Islington NHS Foundation Trust
Jess Lievesley	Barnet, Haringey and Enfield Mental Health NHS Trust / Camden and Islington NHS Foundation Trust
Sarah Morgan	NCL Integrated Care Board
Clare Scott	Barnet, Haringey and Enfield Mental Health NHS Trust
Seonaid Henderson / Raj Sardana	NCL Integrated Care Board
Anthony Browne	NCL Integrated Care Board
Dave Wragg	Barnet, Haringey and Enfield Mental Health NHS Trust / Camden and Islington NHS Foundation Trust
Richard Taylor-Elphick	North London Councils
Elisha Coates	North London Councils
Louise Miller	NCL Integrated Care Board
Katherine Barrett	N/A
Jennie Claxton	N/A

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
27 September 2022

Report Title	NCL Quality Vision	**Date of report**	13 September 2022	**Agenda Item**	2.2
Lead Director / Manager	Dr Chris Caldwell	**Email / Tel**		chris.caldwell@nhs.net	
Board Member Sponsor	Dr Chris Caldwell				
Report Author	Dee Malone *et al.*	**Email / Tel**		Deirdre.malone@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Not applicable.			
Report Summary	The paper sets a strategic vision for health and care quality for NCL ICB. The vision has been co-created in collaboration with our system partners to ensure that quality is at the core of what we do as an Integrated Care System (ICS). This process has been led by the ICB Director of Quality with oversight from the ICB Chief Nurse working in partnership with the ICB CMO. Our vision is aligned with the strategic aims of the ICS, and will inevitably continue to develop and evolve as we develop our relationships across North Central London Health and Care Partnership and as we progress the implementation of our Population Health strategy. This vision was further developed following work with the Quality and Safety Committee on 7 September at the first meeting of the Committee, where committee members debated and provided constructive feedback that has been incorporated into this latest version. Following the approval of the vision by the ICB Board of Members, a quality strategy will be developed with annual objectives and a set of metrics to guide and monitor progress. Given the constantly shifting context of health and care, both our vision and strategy will be dynamic documents and will continue to evolve over the coming months and years.				
Recommendation	The Board of Members is asked to **APPROVE** the quality vision.				

Identified Risks and Risk Management Actions	Not applicable.
Conflicts of Interest	Not applicable.
Resource Implications	Not applicable.
Engagement	Not applicable.
Equality Impact Analysis	Not applicable.
Report History and Key Decisions	The quality vision was presented and discussed at the North Central London Quality and Safety Committee on 7 September 2022. The committee supported the direction of travel set out in the vision.
Next Steps	The Quality Strategy will be developed based on the vision for quality, acknowledging that this will be a dynamic strategy.
Appendices	Not applicable.

NHS
North Central London
Integrated Care Board

North Central London Integrated Care Board Quality Vision

Dee Malone

September 2022

Introduction

The establishment of Integrated Care Systems (ICSs) represents an important step in the journey of improvement across health and care, at the heart of which must sit quality.

The document represents the vision for quality care at the current point in time as co-produced with a wide range of health and care partners, recognising that we are on a journey as we shape our services across North Central London (NCL) to reflect the needs of our diverse and multi-cultural communities, focus on reducing health inequalities and supporting of staff to deliver high quality safe care, while providing them with the skills and support to do so. There is still more engagement ot be undertaken, especially with colleagues outside the NHS and with patients, local residents and the groups which represent them.

The establishment of the Integrated Care Board (ICB) means that the work undertaken by our internal quality resource and the way we all work together as an ICB with our ICS on quality needs to change. Processes for assurance and oversight must now be more integrated, so that we work collaboratively alongside our providers and other regulators, with a focus on quality at system and population level.

To achieve this we will also need to place a greater emphasis on developing a culture of openness, trust, collaborative learning, continuous learning and quality improvement, as well as celebrating innovation to make sustainable improvements to the delivery of health and social care across NCL. Colleagues in the ICB quality function will other ICB colleagues, including those within our communications and engagement team to ensure that we listen to, and utilise the information our residents share with us, regarding what is important to them in relation to health and social care across NCL.

Refinement of the vision will be enabled through a quality strategy setting out how we plan to deliver this work, alongside our colleagues working in other ICB Directorates such as Development & Population Health Directorate and Performance and Transformation, as well as teams within our provider organisations and other regulators. The strategy will include annually reviewed objectives and metrics to measure delivery and impact.

This is a dynamic document which will evolve as our relationships with partners develop in response to the development of the ICS. We will review our vision in January 2023, to assess where we are on our journey and revise our vision and strategy, as appropriate.

Vision for Quality

We are committed to ensuring that our resident population across North Central London have access to high quality, safe care based on the fundamentals of Quality, as set out by the National Quality Board (NQB).

Domain	Key Comment
Safe	Minimise errors, maximise doing it right, reduce risk
Effective	Consistent, relevant, address inequalities
Positive Experience	Empowerment, self design, inclusive and equitable
Caring	Compassion, dignity and mutual respect
Well Led	Collective compassionate leadership
Sustainably resource	Optimum outcome, value for money
Equitable	Reducing variation and inequalities

This compliments the NCL ICS aim to improve outcomes and wellbeing, through delivering equity in health and care services for local people. Our accompanying quality strategy will focus on strengthening integration, aligned with making sustainable improvements across population health and reflect what matters most to the resident population of NCL in relation to quality of health and social care services.

The Safeguarding team are a core component of the Quality Directorate, working collaboratively with the teams to ensure that there are effective safeguarding arrangements in place, to prevent and protect individuals from harm or abuse, regardless of their circumstances.

Supporting people to Start Well, Live Well and Age Well, while supporting our local people who are employed across health and social care to Work Well. We will achieve this by supporting those working in care systems to deliver care by working in partnership with local people and communities, co-designing solutions and services around their priorities, needs, experience and strengths as part of our ICS.

Model for delivering our vision for Quality

We will utilise the principles set out in the Juran Trilogy, this model forms the basis for most quality management practices around the world. The model is based on three universally accepted processes:

1. Quality Planning (Quality by Design)
2. Quality Control (Process Control & Regulatory)
3. Quality Improvement (Lean Six Sigma)

Vision

- To improve outcomes and wellbeing, through delivering equality in health and care services for local people.
- Working collaboratively with colleagues on our Population Health Strategy, focusing on reducing health inequalities and improving health outcomes for the residents of NCL.

Quality Planning

- Develop our quality strategy, aligned with the ICS Clinical strategy.
- Develop an integrated approach to quality governance and oversight, working collaboratively with commissioning colleagues working within Continuing Health Care, Mental Health, Learning Disability and Autism.
- Establish our System Quality Group.
- Collaborative working with the Specialised Commissioning teams at NHSE, in preparation for the planned devolution of a number of specialist services to ICSs from April 2023, this will include Dentistry, Ophthalmology and Community Pharmacy.

Quality Control

- Work with partners and people with lived experience to co-design services that meet the needs of the population of NCL.
- Review population based data, and provider performance against the quality metrics set out in the NHS Outcomes Framework to help improve the quality of services across NCL.
- Develop quality metrics to measure improvements.

Quality Improvement

- Working with our Patient Safety Specialists across all providers to develop a culture of continuous learning.
- Working the NCL training hub to support Quality Improvement work in areas such as, IPC, Antimicrobial stewardship.
- Supporting the development of a quality dashboard within Primary Care aligned with the System Oversight Framework.

Quality strategy

Our quality strategy will be developed using the NQB seven steps to delivering quality care, building on the quadruple aims to improve patient outcomes; improve patient experience; improve staff experience and provide services that offer value for money.

Delivering quality care in systems: seven step model	
1. Setting clear direction and priorities.	Our health and care services must respond to local needs, invest in keeping people healthy and out of hospital. Set clear priorities for our population across NCL, including a commitment to reducing health inequalities.
2. Bringing clarity to quality.	Establish clear standards for what high quality care and outcomes look like, based on what matters to people and communities.
3. Measuring and publishing quality.	Measuring what matters to people using services, monitoring quality and safety consistently, sharing information in a timely and transparent way, using data effectively to inform quality improvement and decision-making.
4. Recognising and rewarding quality and learning.	Recognising, celebrating and sharing outstanding health and care, learning from others and helping others learn, recognising when things have not gone well.
5. Maintaining and improving quality.	Working together to maintain quality, reduce risk and drive improvement.
6. Building capability for improvement.	Providing multi-professional leadership for quality; building learning and improvement cultures; supporting staff and people using services to engage in coproduction; supporting staff development and wellbeing.
7. Staying ahead	By adopting innovation, embedding research and monitoring care and outcomes to provide progressive, high-quality heath and care policy.

Specific areas of focus

These areas of focus were from previous work in the CCG and remain immediate key areas of focus for the ICS.

1. Maternity services.
2. Service pressures in acute care, including Urgent & Emergency Care, cancer and elective care recovery, alongside Primary Care.
3. Sickle Cell Disease.
4. Addressing the physical as well as the mental health needs of people presenting to EDs with Mental Health illness.
5. Restraint/seclusion for people with Mental Health illness in our acute Mental Health providers and ED departments across our acute providers.

NCL ICS Quality Governance: Escalation Process

Each of our acute, community, Mental Health and specialised providers have well established Quality and Safety/ Governance committees in place, where local oversight of quality, safety and safeguarding processes occurs. The quality team attend these meetings for their respective boroughs.

Next steps

1. Develop the NCL ICB Quality Strategy.
2. System Quality Group meetings to be scheduled in for the year.
3. Strengthen integration with our partners, internally and externally.
4. Focus on system quality improvement.
5. Strengthen links with colleagues working within population health.

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
27 September 2022

Report Title	Start Well: Update Paper	**Date of report**	17 September 2022	**Agenda Item**	2.3
Lead Director / Manager	Sarah Mansuralli, Chief Development and Population Health Officer	**Email / Tel**		sarah.mansuralli@nhs.net 07557 319123	
Board Member Sponsor	Sarah Mansuralli, Chief Development and Population Health Officer				
Report Author	Anna Stewart, Start Well Programme Director	**Email / Tel**		anna.stewart3@nhs.net 07867 141588	
Name of Authorising Finance Lead	Anthony Browne	**Summary of Financial Implications** This is a summary of the clinical case for change and subsequent engagement. At this point in the programme there are no financial implications to highlight to the Board. The NCL financial context is set out within the document, including the governance arrangements to take forward the consideration of financial implications. It is important to note the considerable 'in kind' system resources that have contributed to the development of the case for change and this phase of the programme. Specifically, clinical leadership and involvement with the programme, participation of operational and clinical staff in workshops, involvement in communications and engagement leads in collaborative planning, as well as finance and analytical workstreams.			
Report Summary	The Start Well programme ('Start Well') was initiated in November 2021. It was set up to ensure that hospital-based maternity, neonatal and children and young people's services in NCL are fully meeting the needs of those that use them. Following a period of significant clinical engagement, quantitative data analysis, review of best practice standards and a review of qualitative views of patients and residents, a Case for Change was produced and published in June 2022 for a 10-week engagement period. The evidence outlined in the Case for Change highlights a number of opportunities to improve the way services currently work and the engagement period sought to understand if the findings and opportunities for improvement set				

	out in the Case for Change resonated with patients and the public, staff and wider stakeholder and what was important to them in providing good care. The purpose of this paper is to: • Summarise key themes arising from the work to date as described in the Case for Change • Reflect on the feedback from the engagement period and what this means for the next phase of the programme • Outline proposed governance arrangements to support the next steps of the programme • Highlight some of the next steps for the programme, taking into account the work to date on both Case for Change and engagement **Case for change: opportunities for improvement** The Case for Change was approved by NCL CCG Governing Body at its meeting on 30 June 2022. Taking a strong population health focus, the Case for Change identifies what currently works well and areas where there may be opportunities for improvement. The full Case for Change can be viewed here: https://nclhealthandcare.org.uk/get-involved/start-well/ Alongside the many examples of excellence, the report also identified challenges and opportunities to improve, address areas of inequity and achieve better outcomes and experience for patients, their families, carers and staff. Opportunities for improvement in maternity include: • Ensuring excellent experience, equitable access and optimal outcomes for pregnant women and people • Better utilisation of maternity capacity offered in NCL, in particular obstetric-led care is often stretched and midwifery-led care less well used • Supporting maternity workforce sustainability • Having the right maternity and neonatal estate to support service delivery and patient experience Opportunities for improvement in neonatal services include: • Matching neonatal care capacity and demand, in particular our most specialist neonatal intensive care unit or NICU (level 3) capacity is over-stretched • Consider the sustainability of the Royal Free Hospital Special Care Unit (level 1), which has less than fifty per cent occupancy • Minimising avoidable admissions to neonatal units through more consistent availability of community capacity • Addressing workforce vacancies and variation in provision and access to AHPs Opportunities for improvement in care for children and young people include: • Increasing demand for emergency care, particularly lower acuity care • Improving long-term conditions management • Organisation of paediatric emergency surgical care, where the provision is variable and the pathways are often unclear • Reducing long waits for elective care • Improving transition to adult services • Recruitment and retention of paediatric workforce • Meeting national recommendations for the environment for paediatric surgical care

Engagement on the case for change (Summer 2022)
For a 10-week period (4 July to 9 September 2022), a period of engagement was initiated to seek the views of staff, patients, the public and wider stakeholders on the case for change through a diverse programme of structured engagement opportunities.

The Start Well team engaged with a wide range of stakeholders including patients and residents of NCL, staff working in maternity, neonatal and children's and young people's services and other key stakeholders including local authority partners, neighbouring Integrated Care Systems (ICSs) and the voluntary sector.

A range of materials were developed to support the engagement process:

- An information leaflet and Case for Change summary were made available which described the background to Start Well as well as highlighting opportunities to improve
- The information leaflet was translated into six of the most spoken community languages in NCL, as well as into an Easy Read format for those with learning disabilities
- A survey was also developed which could be completed online or on paper for staff, service users or other stakeholders to complete

In addition to the survey, there were a number of ways individuals or organisations could submit their views:

- Giving feedback verbally, during face-to-face engagement events
- Taking part in focus groups and discussions, both online and face-to-face
- Participating in staff meetings and giving views during the discussions
- Participating in workshops and other interactive opportunities (such as a Youth Summit)
- Filling in an online survey or requesting a printed version
- Writing to the programme either via the post or via email
- Calling a Freephone number to give verbal feedback

During the engagement period face-to-face and online feedback opportunities were put in place to capture views on the Case for Change. At each event participants either gave direct feedback to the Start Well Team or were encouraged to complete and submit an online or paper questionnaire depending on the circumstances of the event. Stakeholders were also able to submit direct feedback via a programme email address. All the information captured and submitted was analysed as part of the report summarising the engagement outcomes.

Engagement reach
During the engagement period a total **43** engagement events took place, reaching a total of **518** residents. **207** of the conversations were in-depth, with people sharing their views and experiences. In total **389** people completed the survey by answering at least one of the questions.

A full breakdown of those participating in the engagement can be found in the detailed engagement narrative report which is shared with this paper.

Overview of the outcome of the engagement

The survey presented those who had read the Case for Change with the opportunity to comment on the opportunities for improvement for maternity and neonatal services and children's and young people's services as identified within the document. A scale of 1-5 was used to score levels of agreement with strongly disagree having a score of 1 and strongly agree a score of 5. The results show

	that broadly the Case for Change resonated with those and answered the survey. The high-level findings from these questions were: • **51%** of survey respondents had read the Case for Change or information leaflet • Overall, **79%** of all respondents either strongly agreed or agreed with opportunities identified in the Case for Change to improve maternity and neonatal services • **77%** of all respondents either strongly agreed or agreed with opportunities to improve children and young people's services identified by the Case for Change Respondents also set out additional information and other opportunities that should be considered in taking forward the programme and these are set out in the report which are attached. The high-level themes that have emerged as priorities can be summarised as: • Maternity care: safe and compassionate care and good communications • Neonatal care: the best possible services delivered by specialists and good communications • Emergency care for children and young people: care close to home, being seen quickly and having good communications • Planned care for children and young people: having the best care even if it is further from home and good communications There was rich qualitative feedback from the events and feedback received, including some detailed observations from parents with learning disabilities, parents of children and young people with Sickle Cell disease and further feedback from staff. These are set out in the report, and will need to be considered as additional areas for focus and consideration in taking forward the programme. **Next steps** Through the Case for Change aspects of care around maternity, neonatal and children and young people's services have been brought to the fore by placing them together in a broader context. There is a need to review delivery and ensure progress within the overall context of the Start Well programme, however where work is already being progressed accountability remains with established programmes. The next steps for the opportunities identified in the Case for Change therefore fall into two categories: • Opportunities and actions for which there are clear delivery owners (either at an organisation, place or system level) • Opportunities which raise questions about the current organisation of maternity, neonatal and children and young people's services. Here, further work is needed to explore the intervention needed to build on the opportunities, and whether a change to the organisation of services is appropriate, or if alternative solutions exist. The next steps for the programme, include: • Reflection on the themes and additional areas for consideration which have been highlighted through the engagement period • Compilation of a detailed action plan collating work through existing programmes of work to be overseen through the Start Well Programme Board • Further work and analysis needed to make a recommendation to the ICB Board on any actions required around the organisation of services.

	Governance In the case for change, the governance arrangements for the initial stage of Start Well were outlined: with the programme reporting to the ICS Children Young People Maternity and Neonates (CYPMN) Board. To support the next phase of the programme and reflecting the change in activities that need to be undertaken, refreshed governance arrangements will need to be put in place. It is proposed that a dedicated Start Well programme board is established. This board will oversee the programme and report into the NCL ICB Board. A number of workstreams will support the delivery of the programme, some are already in place from the first phase of the programme others will need to be established. The papers sets out the refreshed governance arrangements and leadership for the programme in the context of the newly appointed ICB Board members.
Recommendation	The Board of Members is requested to: • **NOTE** and comment on the Case for Change themes and feedback from the engagement period • **ENDORSE** the governance arrangements for the next phase of the programme which including the Start Well Board to oversee the programme and a number of workstreams reporting into the programme board • **NOTE** that the programme board will need to have particular responsibilities set out within its terms of reference to pay particular attention to the duties of public sector organisations relating to groups with protected characteristics set out in the Equality Act and NHS Act and to ensure that robust engagement of patients, carers, staff and wider public continues to be central to the design and delivery of the programme • **NOTE** that next suggested steps will be taken forward through the governance arrangements outlined • **NOTE** future reporting arrangements to the Board at its next meeting with a proposed recommendation around next steps for the programme.
Identified Risks and Risk Management Actions	A full risk register is in place covering the development of the Case for Change and engagement period and reported through the programme. The two highest scoring risks from that period are: • *System pressures such as RSV (Respiratory Virus), Covid surges together with other winter pressures lead to challenges with clinical staff engagement and subsequent delay in developing the case for change.* Mitigation: Working in partnership with the appointed consultancy who will support the development of the case for change, a flexible plan will be developed that builds in additional time and alternative processes for meaningful staff engagement should the system experience significant pressure across winter 2021/22 • *Staffing uncertainty regarding further changes risks destabilising the NCL workforce leading to:* *i) difficulty recruiting and retaining staff ii) Lack of engagement in the process to develop the case for change.* Mitigation: i) the case for change will be developed through a clinically collaborative process ii) a clear communications plan will be implemented that evolves as the programme progresses ensuring staff are aware of the aims and objective of each stage of the process iii) an OD approach will ensure system leaders from across NCL have the right skills to engage staff supporting the creation of a shared NCL vision for CYPMN services iv) Each workstream is led by representatives from NCL providers.

	The risk register will need to be updated for the next phase of the programme and these risks will be reported through to the Programme Board and ICB.
Conflicts of Interest	None to note. A comprehensive declaration of interest register for all Programme Board and workstream members and attendees is in place, the detail of which are taken to each meeting of the Board and workstreams to ensure full transparency.
Resource Implications	The programme costs are an ICS system cost and funding has been identified to support this programme from ICS system budgets in the 2022/23 planning round.
Engagement	A comprehensive communications and engagement plan is in place, with communication and engagement leadership fully embedded in the programme team and close working with partner communications and engagement teams in Trusts. The plan covers: • Staff engagement and communication – with regular updates coordinated through a group of the communication leads from ICS partners who meet on a fortnightly basis • Stakeholder engagement – with briefing and updates to key stakeholders, including MPs and local authority colleagues. • Public engagement – including the plans for the patient and resident engagement on the case for change (including with children and young people).
Equality Impact Analysis	The data analysis carried out for the Case for Change has a central focus on equality considerations, including patients with protected characteristics (particularly ethnicity) and a focus on deprivation. A full chapter in the case for change draws together the focus on equalities dimensions and this informed the approach to public engagement on the Case for Change over the summer of 2022. A number of recommendations around equalities are set out in this chapter of the Case for Change.
Report History and Key Decisions	August 2022 – themes from the Start Well Case for Change were presented at an ICB Board Seminar
Next Steps	• Further reflection on the feedback obtained through engagement on the Case for Change and how any new opportunities to improve services will be addressed by the ICS • Commence the more detailed work set out in section 6 of the main report to understand how best to build on the opportunities that may be associated with the organisation of services • The development of a detailed holistic action plan for the opportunities from the Case for Change that we believe will be owned either at a system or place level • It is envisaged that this work would take place over the coming two months and we would bring a further update to the ICB Board in November 2022 with a recommendation of how to progress
Appendices	• Start Well – Update for the NCL ICB (September 2022) • Start Well Narrative Report on Engagement (Verve September 2022)

NCL Start Well

Update for NCL ICB Board September 2022

1 Contents

2 Introduction and background

The Start Well programme ("Start Well") was initiated in November 2021. It was set up to ensure that hospital-based maternity, neonatal and children and young people's services in NCL are fully meeting the needs of those that use them.

There were a number of drivers for starting the programme which included:

- The opportunity to give babies, children, and young people the best possible start in life and to deliver the ICS priority action to start well
- The clear calls to action set out in the NHS Long Term Plan and the initial Ockenden Report
- The learnings from the temporary changes to local children and young people's services in NCL during the COVID-19 pandemic
- External reviews of services by the CQC, and NHS England and NHS Improvement
- The health inequalities further highlighted through the pandemic and the urgent need to address them
- The opportunity to build on existing partnership working as we move into becoming a formal integrated care system
- Wanting to ensure there is a resilient and sustainable maternity, neonatal and paediatric workforce

Following a period of significant clinical engagement, quantitative data analysis, review of best practice standards and a review of qualitative views of patients and residents, a Case for Change was produced and published in June 2022 for a 10-week engagement period.

The evidence outlined in the Case for Change highlights a number of opportunities to improve the way services currently work and the engagement period sought to understand if the findings and opportunities for improvement set out in the Case for Change resonated with patients and the public, staff and wider stakeholder and what was important to them in providing good care.

The purpose of this paper is to:

- Summarise key themes arising from the work to date as described in the Case for Change
- Reflect on the feedback from the engagement period and what this means for the next phase of the programme
- Outline and seek endorsement for proposed governance arrangements to support the next steps of the programme
- Highlight some of the next steps for the programme, taking into account the work to date on both Case for Change and engagement

3 The Case for Change

This section outlines the process for developing the Case for Change and includes a summary of the opportunities for improvement that were highlighted in the document.

This is a summary of the longer Case for Change document which can be found via this link.

3.1 Developing the Case for Change

The first phase of Start Well involved assessing the current state of services across NCL. To help inform this assessment the following three questions were used to inform the approach:

- Are we delivering the best services to meet the needs of children, young people, pregnant people and babies?
- Are we responding to calls to action set out in the Long Term Plan, Ockenden Report and learnings from the pandemic?
- Are we achieving the Start Well ambition and reducing health inequalities?

3.1.1 Scope of the Start Well programme

The services in and out of scope of this current state assessment are highlighted in figure 1.

In Scope	Out of Scope
All NHS funded children and young peoples elective (i.e. planned) care pathways (meaning elective services delivered within a hospital setting for children and young people aged 0-19 years)	Children and Young People's community services
All NHS funded emergency children and young people's care pathways (meaning emergency services delivered within a hospital setting and part of an acute stay or children and young people aged 0-19 years)	Mental Health including CAMHS
All NHS funded maternity and neonatal services delivered in both community and hospital settings	Specialist provision: e.g. standalone eating disorder service at RFH and specialist inpatient and day-case provision at UCLH
	Cancer haemato-oncology including and complex adolescents and POSCU location
	Primary Care contracts
	Local Authority Commissioned Services with the NHS
	0-19 Services Delivered by Local Authorities

The interface between secondary and tertiary providers means that neonatal and some children and young people's services at specialist hospitals at GOSH, RNOH and Moorfields are in scope

Figure 1: The service in and out of scope of the Start Well programme

It is important to note that relevant areas such as child and adolescent mental health services (CAMHS) and children's community services are out of scope of the Start Well programme. Due to the interdependencies between these services and those services within the scope of the programme, the interface has been considered or referenced, alongside, where relevant.

Of particular note here is the strategic review of NHS-funded mental health services, and the separate review of NHS funded community services, which commenced in January 2021 by NCL CCG in collaboration with ICS system partners. Both reviews covered services for both children and young people and adults and have started to address long-standing inconsistencies in service offer, access and outcomes for the NCL population. As such, these services are out of scope for the Start Well programme. The outcomes of both strategic reviews are important interdependencies for the Start Well programme and will continue to be carefully considered.

As set out in the Case for Change, another key interdependency for Start Well is the management of cancer services where there are significant overlaps with general paediatric services both in terms of staff and infrastructure. There have been recent changes to the commissioning specification for Cancer Primary Treatment Centres[1] which have implications for the arrangement of cancer treatment in NCL for children and young people.

Whilst cancer services are out of the direct scope of the Start Well programme, given that there are significant interdependencies at service and site levels, agreed recommendations by the ODN will need to be taken into account in any future service design.

3.1.2 How the case for change was developed

To support developing the Case for Change there were a number of activities undertaken that aimed to present a rounded picture of the way services are currently working. This was done through both quantitative data analysis and qualitative stakeholder engagement:

- Lines of enquiry were agreed through the creation of an 'analysis tree' which informed a more detailed analysis plan
- Detailed quantitative analysis was undertaken to understand areas such as: demand, population health, clinical outcomes, workforce and finance
- Over 70 staff were involved in three clinical workstreams which met four times between January and March 2022. At these meetings members provided feedback on and validated data analysis, identified interdependencies with other services and reviewed best practice standards in relation to care delivered in NCL
- Five surgical 'deep-dives' were undertaken to gain a better understanding of the specific challenges faced by some surgical specialties
- Close to 60 clinical leaders from across NCL took part in one-to-one interviews. The interviews were an opportunity to explore the needs of NCL's population and to identify both strengths and challenges in how services are currently delivered
- An online form was promoted on Trust intranets, accompanied by regular communications and e-bulletins to invite all staff to give their views of services. Questions on this form mirrored those used in stakeholder interviews
- In early March 2022 two half-day virtual workshops were held with around 100 workstream clinical reference group members and wider clinical and operational representatives – one workshop covered maternity and neonatal services, and another covered planned and emergency care for children and young people. At these workshops staff explored current patient care pathways in more depth and reflected on themes that had emerged through the clinical workstreams, interviews and data analysis
- Patient experience and insights were also gained through: a review of existing patient insight and feedback; an online panel of 50 patients and residents; two

[1] https://www.england.nhs.uk/publication/childrens-cancer-services-principal-treatment-centres-service-specification/

focus groups (which were undertaken with 6-8 recruited local people with experience of services); and some targeted engagement (which was undertaken with specific groups who may not normally participate or who may be disproportionately disadvantaged)

The themes from the insights and information gathered through this engagement and analysis were brought together into a Case for Change document. Given the collaborative nature of its development it was fundamental that the content of the document reflected the views of partners involved. To facilitate this, partners had opportunities to input into the document throughout the drafting of the Case for Change.

The document was endorsed by all Trust Boards with a significant proportion of their services in scope, and by the Specialised Services Regional Oversight Group (who currently hold responsibility for commissioning of neonatal services). In advance of publishing the document to support more extensive stakeholder engagement over a 10-week period, the Case for Change was approved by the NCL CCG Governing Body on 30 June 2022.

After the approval of the Case for Change by the CCG Governing Body, and with the change in statutory responsibilities, from 1 July 2022 the Start Well programme is now within the formal commissioning responsibilities of NCL Integrated Care Board (ICB).

3.2 Opportunities to improve identified in the Case for Change

An important part of developing the Case for Change was to develop an in-depth understanding of the population in NCL and therefore a population health lens was used to review services, with a particular focus on ethnicity and deprivation, which supported a focus on inequalities. The high-level population demographics for pregnant women and people and children and young people in NCL are summarised in figures 2 and 3.

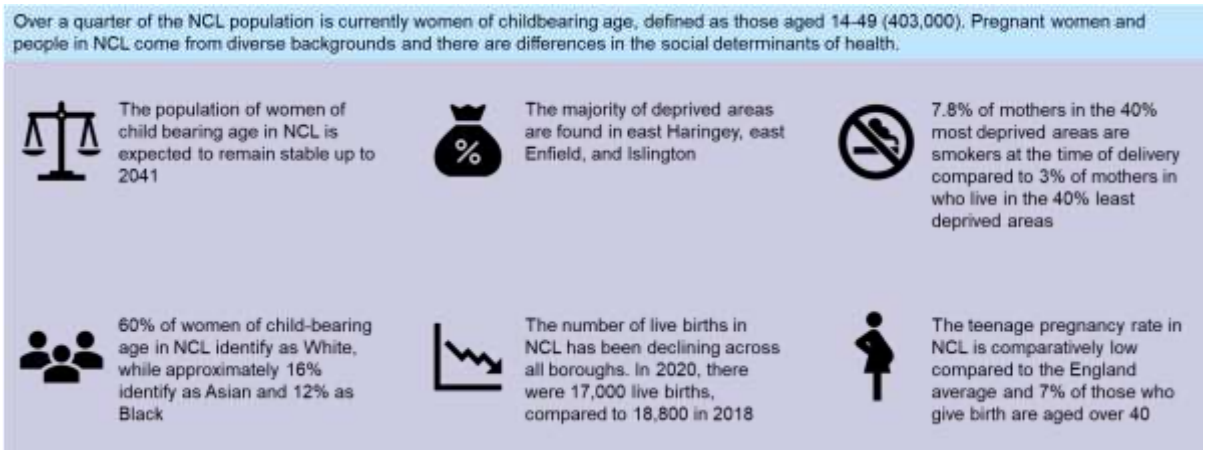


Figure 2: Population health demographics for pregnant women and people as described in the Start Well Case for Change

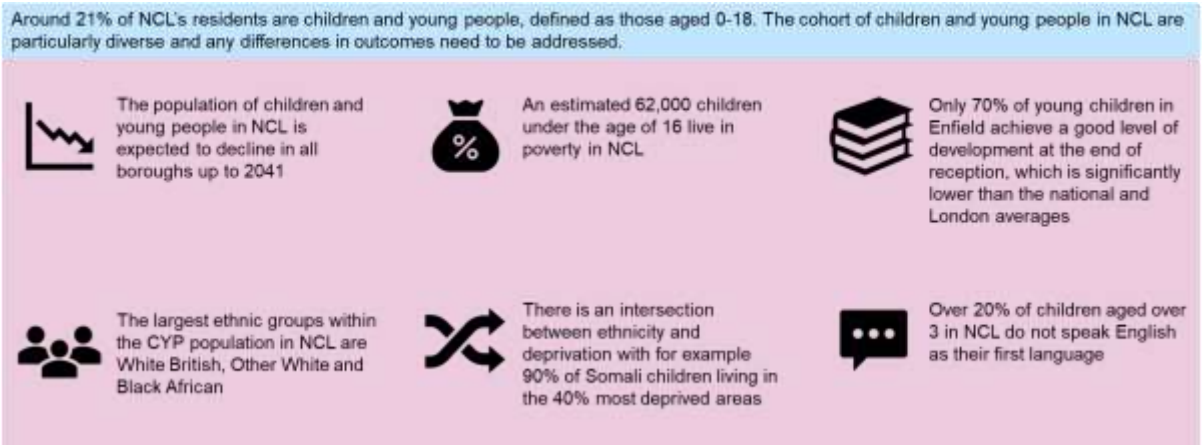


Figure 3: Population health demographics for pregnant women and people as described in the Start Well Case for Change

Whilst including a number of examples of where services in NCL provide excellent maternity, neonatal and children and young people's care, the Case for Change also identifies a number of opportunities to improve services. In presenting these opportunities they have been grouped into opportunities to their relevant service areas: maternity, neonatal services and children and young people's services. These are summarised in figures 4-6.

3.2.1 Maternity

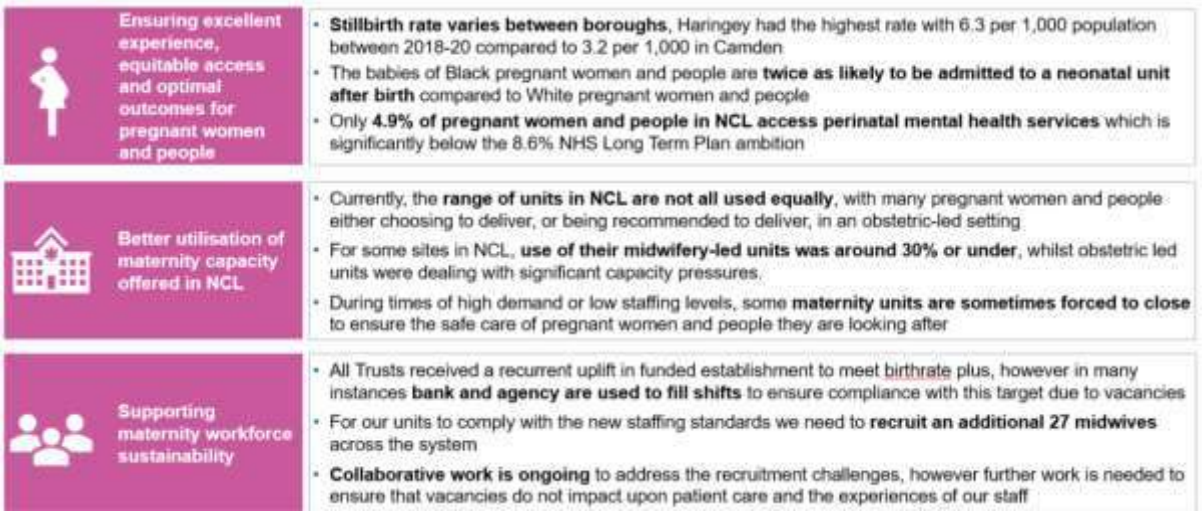


Figure 4: Opportunities for improvement in maternity services as described in the Start Well Case for Change

3.2.2 Neonatal services

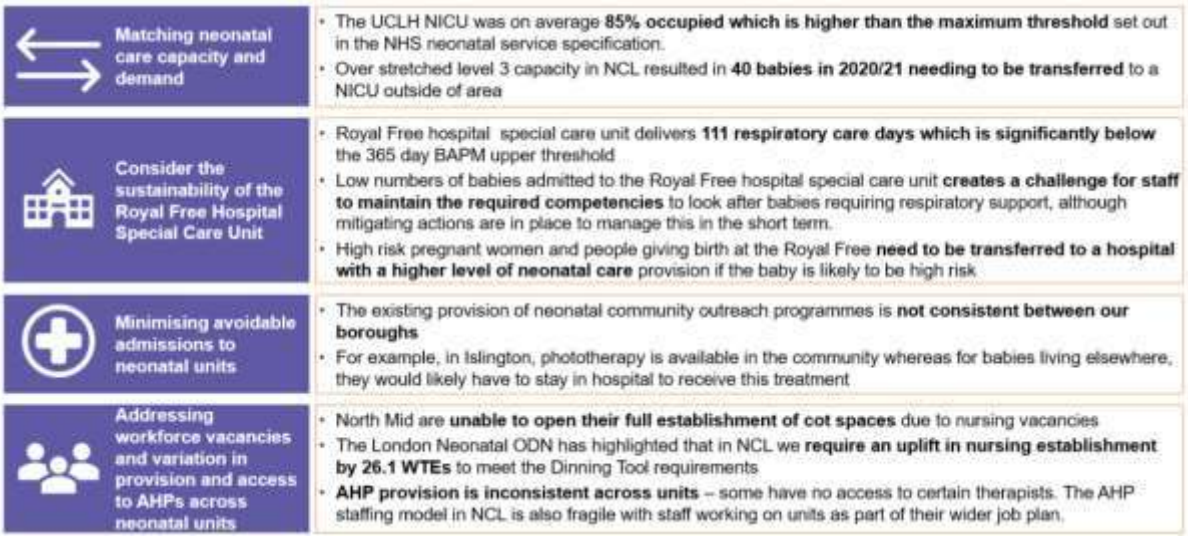


Figure 5: Opportunities for improvement in neonatal services as described in the Start Well Case for Change

3.2.3 Children and young people's services

Figure 6: Opportunities for improvement in children and young people's services as described in the Start Well Case for Change

4 Section 3: Start Well Case for Change engagement

This section provides a summary of the longer report on engagement, appended to this paper.

Following approval by the CCG Governing Body on 30 June 2022 a 10-week programme of engagement commenced on 4 July 2022. The engagement aimed to:

- identify whether the themes highlighted in the case for change resonated with patients, residents, staff and stakeholders
- capture the views of patients, residents, staff and stakeholders on the opportunities to improve care in NCL

Later in this section there is further detail of how the engagement was undertaken and the findings from the engagement, however the high-level themes that have emerged as priorities can be summarised as:

- **Maternity care:** safe and compassionate care and good communications
- **Neonatal care:** the best possible services delivered by specialists and good communications
- **Emergency care for children and young people:** care close to home, being seen quickly and having good communications
- **Planned care for children and young people:** having the best care even if it is further from home and good communications

4.1 Engagement process

The Start Well team engaged with a wide range of stakeholders including patients and residents of NCL, staff working in maternity, neonatal and children's and young people's services and other key stakeholders including local authority partners, neighbouring Integrated Care Systems (ICSs) and the voluntary sector.

A range of materials were developed to support the engagement process:

- An information leaflet and Case for Change summary were made available which described the background to Start Well as well as highlighting opportunities to improve
- The information leaflet was translated into six of the most spoken community languages in NCL, as well as into an Easy Read format for those with learning disabilities
- A survey was also developed which could be completed online or on paper for staff, service users or other stakeholders to complete

4.1.1 How people could give their feedback

In addition to the survey, there were a number of ways individuals or organisations could submit their views:

- Giving feedback verbally, during face-to-face engagement events
- Taking part in focus groups and discussions, both online and face-to-face

- Participating in staff meetings and giving views during the discussions
- Participating in workshops and other interactive opportunities (such as a Youth Summit)
- Filling in an online survey or requesting a printed version
- Writing to the programme either via the post or via email
- Calling a Freephone number to give verbal feedback

During the engagement period face-to-face and online feedback opportunities were put in place to capture views on the Case for Change. At each event participants either gave direct feedback to the Start Well Team or were encouraged to complete and submit an online or paper questionnaire depending on the circumstances of the event. Stakeholders were also able to submit direct feedback via a programme email address. All the information captured and submitted was analysed as part of the report.

4.1.2 How engagement was promoted and undertaken

During the engagement period a total **43** engagement events took place, reaching a total of **518** residents, **207** of which conversations were in-depth, with people sharing their views and experiences. In total **389** people completed the survey by answering at least one of the questions. Details of each element of the engagement (including how it was conducted and what we heard) are set out in the sections below.

Patients and residents

Over the engagement period, the Start Well team sought views from patients and residents on the Case for Change through a diverse programme of structured engagement opportunities. A range of groups were contacted, for example those representing: early years, carers, autism and mental health. In total 188 organisations were contacted, giving details of how people could feedback.

Opportunities for engagement were promoted to all patients and residents, however, deeper engagement was sought with individuals and groups who had previously used services, those with protected characteristics (per the Equality Act 2010), and those more likely to experience inequalities, ill health or deprivation.

Engagement opportunities and the ways they were promoted, included:

- An online survey, available on the NCL ICS website; this was promoted on email, news items, social media and other fora
- Community newsletters
- Correspondence to residents' associations and similar bodies
- Voluntary sector meetings
- Drop in events and stalls at community events
- Attendance at community groups for parents and carers, such as Baby and Toddler groups
- Presentation and feedback sessions at community and formal meetings (both online and face-to-face)
- Online small group discussions and focus groups with parents and carers

- Targeted events to capture the views of more vulnerable residents such as advocacy groups for parents with learning disabilities and those who had experienced domestic violence
- Dialogue via posts using online fora, canvassing responses
- Attendance at hospital outpatient and antenatal clinics
- A targeted Facebook campaign promoting the opportunity to feedback via the online survey. 18 postcode sectors were selected based on reaching some of NCL's more deprived areas (using indices of multiple deprivation). This resulted in 804,082 page impressions and 3,946 clicks on the link to find out more

The team worked closely with the local VCS and Councils, and established networks and groups. Activities were delivered at times and in places that were convenient and appropriate for each group. Depending on the most appropriate approach for the specific audience, the engagement activity/content they were delivered by the Start Well programme team, specialist providers, or a VCS partner.

Ongoing dialogue was established with a small number of key groups who contributed to feedback. The aim of this was to provide a foundation for further, long-term, input to the programme. This included:

- Questions posted on the Start Well online patient forum, of around 50 people
- Two facilitated conversations with a group of eight patient representatives, who expressed an interest in a deeper, ongoing, engagement with the programme
- Two face-to-face events and one online event involving in total up to 40 young people, facilitated by a company called Participation People. These are referred to later in the report as 'youth summits'. The young people self-selected to be part of the programme and represent a diverse range of 12–18 year-olds from across the five boroughs of NCL. Some of the participants had long-term conditions
- Focus groups – one for parents who had experienced neonatal care and two for parents and carers with experience of Sickle Cell services

Across NCL 43 activities took place, reaching a total of 518 patients and residents. 207 of the conversations were in-depth, with people sharing their views and experiences.

The below table summarises the events in each of the NCL boroughs and some which were NCL wide:

Borough	Number of meetings	Total number of contacts
Barnet	11	156
Camden	11	101
Enfield	5	49
Haringey	5	118
Islington	3	31

Borough	Number of meetings	Total number of contacts
NCL wide	8	63

Figure 7: Engagement undertaken during Start Well engagement period, split by borough

Staff

The approach to engagement for staff directly working in NCL Maternity, Neonatal and Paediatric Services was developed and delivered in partnership with Trust communication leads through a Start Well communications and engagement working group.

Prior to the beginning of the formal engagement period on the Case for Change, director-led staff briefings were held with staff working in children and young people's, maternity, and neonatal services at North Mid, UCLH, Whittington Health and Royal Free London – including Royal Free Hospital, Barnet Hospital and Chase Farm Hospital. Early briefings enabled staff to see a high-level summary of the opportunities for improvement contained in the report before it was published, to hear about how staff had been involved extensively in the development of the Case for Change, to discover the various ways they could feedback their views, and to ask any immediate questions.

Trust communication leads determined the most appropriate way to work with their staff groups. Some feedback sessions were held at Trusts during the engagement period where staff could ask questions and make comments. This included a mix of all staff sessions and targeted briefings for particular specialties or staff groups.

The Start Well team also reached out to wider NCL staff, professional groups and working groups in interdependent disciplines to highlight the programme and encourage feedback. Examples of some of the groups contacted were:

- Primary care
- Staff side
- Ambulance services
- NHSE Regional Improvement Programme for Children and Young People
- NCL Safeguarding lead

Stakeholders

Feedback was sought from a wide range of local and national stakeholders to ensure impacted and interested parties had an opportunity to comment on the Case for Change. Key stakeholders included:

- MPs representing constituencies in NCL
- Local Authorities (lead members and health and care and children's services)
- Professional bodies
- Joint Health Overview and Scrutiny Committee
- Neighbouring ICSs
- London's Clinical Senate and Clinical Senate Patient Representative Group

4.2 What we heard

4.2.1 Survey feedback

The survey

A survey was developed by the Start Well team and hosted on the NCL ICS website. The survey was also available on paper; people could request a paper copy and paper copies were made available at engagement meetings. Paper copies could be returned by Freepost.

The questions in the survey focussed on areas highlighted in the Case for Change where there were particular opportunities to improve services. There were free text spaces in each substantive section to allow people to raise issues of importance to them. The survey content is summarised in the figure below.

Question	Sub-question
In what role people were responding to the survey	
The borough they lived in (or the borough their organisation was based in)	
Which hospitals people were most likely to use for children's, young people's or maternity services	
Whether the respondent had read the Case for Change, or the summary, or the information leaflet	• To what extent people agreed with the opportunities for improvement for maternity and neonatal services • To what extent people agreed with opportunities for improvement for children's and young people's services • Whether other information should be considered which hadn't been included in the documents • Whether there are other opportunities for improvement in maternity, neonatal or children's and young people's services that had not been presented in the documents
Ranking of the top 3 most important aspects of maternity care from 9 choices	Choosing the single most important aspect of maternity care
Ranking of the top 3 most important aspects of neonatal care from 7 choices	Choosing the single most important aspect of neonatal care
Ranking of the top 3 most important aspects of emergency care for children and young people from 10 choices	Choosing the single most important aspect of emergency care for children and young people
Ranking of the top 3 most important aspects relating to surgery for children and young people based on 6 choices	Choosing the single most important aspect relating to surgery for children and young people
Ranking the top 3 most important aspects relating to care for children and young people with long-term conditions based on 7 choices	Choosing the single most important aspect relating to care for children and young people with long-term conditions
Demographic information about respondents	

Figure 8: Summary of the questions included on the Start Well engagement survey

Numbers taking part in the survey

389 people completed the survey by answering at least one of the questions (completed questionnaires). Data from the completed questionnaires was analysed and is summarised in this section.

The answers relating to the role in which people were responding to the survey is below:

- 180 were current or recent service users
- 32 were carers/family members of service users
- 45 were members of the public
- 89 were members of staff providing maternity, neonatal or children's and young people's services in NCL
- 29 were other care professionals, members of NHS staff, NHS Trust or provider organisations
- 4 were from other public bodies/stakeholders or political representatives
- 3 were from voluntary organisations or charities
- 1 was from a private health and care provider organisation
- 6 identified as 'other'

The boroughs of the participants that responded were as follows:

Borough	Number of participants
Barnet	102
Camden	103
Enfield	41
Haringey	64
Islington	32
Other	47

Figure 9: Summary of the respondents to the Start Well survey, split by borough

Analysis shows that patients and residents that responded to the survey reported usage of services across the range of hospitals in NCL.

Feedback from the survey relating to views on the Case for Change

The survey presented those who had read the Case for Change with the opportunity to comment on the opportunities for improvement for maternity and neonatal services and children's and young people's services as identified within the document. A scale of 1-5 was used to score levels of agreement with strongly disagree having a score of 1 and strongly agree a score of 5. The results show that broadly the Case for Change resonated with those and answered the survey. The high-level findings from these questions were:

- **51%** of survey respondents had read the Case for Change or information leaflet
- Overall, **79%** of all respondents either strongly agreed or agreed with opportunities identified in the Case for Change to improve maternity and neonatal services
- **77%** of all respondents either strongly agreed or agreed with opportunities to improve children and young people's services identified by the Case for Change

The survey also asked respondents if there was additional information that should be included within the Case for Change. Just over a third of respondents who answered this question (the majority being staff), felt that there was additional information which

should be considered. Participants were given the opportunity to write in more information on why they thought other information should be considered in the Case for Change. The top three clusters of areas cited were:

- Prevent duplication of support services/improve the ability to share clinical data/Digital tools
- Solve workforce issues with more staff not consolidation of services
- Focus on inequality/fair access

Survey participants were then asked whether they considered there were any other opportunities in maternity, neonatal or children's and young people's services which were not presented in the documents. 40% of people who responded thought there were other opportunities for improvement, with the majority of those respondents being staff. The top three areas cited were:

- Greater growth of integrated care clinics (e.g. with GPs) reduces outpatient referrals and improves quality/speed of referrals
- Improve treatment of patients in antenatal and post-natal services
- Need to understand/identify how AHP (Allied Health Professional) services could be incorporated

The full report on engagement (which is appended to this one) contains a more in-depth analysis of the answers to these questions and a breakdown by both respondent type and borough.

It should be noted that through the qualitative feedback two areas were raised by staff for additional review in relation to the Case for Change. That there should be a greater focus on the needs of pregnant women and people and further exploration of the maternal medicine pathway and model of care.

Feedback relating to what is considered to be important in the delivery of maternity, neonatal and children and young people's care

The feedback from the survey reveals helpful details about respondents' views on what is important to them about maternity, neonatal and different aspects of children and young people's care. The analysis also reflects where there are differences between groups of respondents in some answers around priorities, particularly between staff and residents, and this provides an area for further exploration.

For each of the areas, the criteria found to be most important to respondents has been highlighted in the figure below. This is a summary of all respondent views and breakdown by respondent type is available in the full engagement report.

Survey question	Criteria deemed most important by all respondents
Maternity care	Having the right specialists available if a patient's health deteriorates during pregnancy or birth
Neonatal care	Care is delivered by staff who care for a lot of unwell or premature babies
Emergency care for children and young people	Being able to access care quickly once a child or young person becomes unwell

Survey question	Criteria deemed most important by all respondents
Surgery for children and young people	Emergency surgery is delivered by healthcare staff who routinely operate on children and young people
Care for children and young people with long term conditions	Care is always delivered by staff who have highly specialist knowledge of long-term condition

Figure 10: Criteria deemed most important by all survey respondents, by service area

4.2.2 Qualitative analysis themes

The next section explores the themes that arose as a result analysis of the qualitative data collected through attendance at either face-to-face or online engagement events through the 10-week period.

This part of the engagement used qualitative methods to ensure that people's views and experience could be explored in detail. This approach means that in collating the analysis the numbers of people holding particular views or experiences are not collected. The purpose of the qualitative analysis is to define and describe the range of emergent issues and to explore linkages, rather than to measure their extent. This is a summary; the full analysis is contained within the engagement report.

Communication in delivering clinical care

The importance of communication in the delivery of clinical care was highlighted throughout the engagement period by respondents across all care settings. This included both communication between patients and staff, as well between healthcare professionals working within and between organisations.

Examples given by participants during engagement included: ensuring information is communicated using accessible language, the availability of interpreters for those for whom English is not their first language, receiving consistent information from healthcare professionals, availability on the phone of a healthcare professional for advice and support, being listened to and taking parents' concerns about their children seriously and for parents of children in neonatal care having clear explanations from staff about care and possible outcomes even if news was not good.

Maternity care

In feedback residents and patients said that safe and compassionate care were paramount in maternity care. They felt that good communications were a vital component of good maternity services; information needed to be offered by health professionals at the right time without patients having to ask a lot of questions. Further, it was important that health professionals took care to understand them and their needs and wishes - for example, when first languages were not English and when patients had learning disabilities.

The qualitative analysis showed that people commonly chose maternity care based on one or more of three factors:

- Recommendations from friends and family

- Proximity to home
- Familiarity with hospital

We heard that hospitals were deemed to be familiar to service users if they had used them for any reason in the past, or because they had lived in an area for a long time and knew about a hospital by reputation.

Consistency of care in maternity was also found to be a theme – patients and residents during the engagement felt it important that wherever possible pregnant women and people saw the same midwife and team. Where this is not possible for everyone those at greatest risk of complications should be prioritised to have consistency.

In the staff feedback received, Royal Free staff were keen to emphasise the value of the specialist services, for example, interventional radiology and vascular services. Staff submissions from UCLH highlighted the need to balance patient choice alongside the needs of the population.

Neonatal care

Qualitative data showed that people wanted babies in need of neonatal care to be given the best possible services by specialists. It was important to people that neonatal services were co-located with maternity services so that there was seamless care before and after a baby was born, and so that babies did not have to be moved to other hospitals for neonatal care.

The qualitative data showed that several things were important in delivering good neonatal care to patients and residents:

- Neonatal services being co-located with maternity services so that babies did not have to be moved to other hospitals
- Having all the technology needed for neonatal care, and staff with the right expertise
- When it is known that a baby will need neonatal care, having continuity of care throughout pregnancy and birth to enable planning for the baby's needs
- Having mental health support for parents

There were also a number of areas that were highlighted to be important that would improve the experience for parents and families:

- Parents being able to stay with their baby so that they could learn how to care for them, and to help with bonding and to make breast feeding easier
- Having support for parents and other family members, including siblings
- Having facilities such as showers, hot drinks and food available even for parents who cannot stay with their baby, but who spend long periods of time in a neonatal unit

In the separate staff feedback received, Royal Free Hospital staff held the view that women and pregnant people often chose maternity units with higher than level 1 neonatal units in case their babies needed neonatal care. UCLH staff highlighted two areas around the interface and regional, national and specialised services. The first being that UCLH struggle for capacity at the highest level of neonatal care and staff

felt that this needs to be increased to support the needs of the NCL population and also for the surrounding areas and noted the need for appropriate resources to support this. In addition to this they felt that, investment in more downstream capacity (especially community care) would be beneficial.

Emergency care for children and young people

During engagement for Start Well people were asked both about emergency care (accessing EDs) and emergency surgery. No one spoken to as part of the qualitative engagement had experience of their child undergoing emergency surgery.

Patients and residents valued having emergency care for children and young people close to home. They said that having specialist paediatric emergency departments available was important because they felt that their children would get care from staff experienced in dealing with children and young people, which was reassuring for parents and children alike.

Participants in the Youth Summit said that good and compassionate communication was important. They felt that clinicians should look at the whole person and should take them and their concerns seriously. They would like to have clarity on what they could expect from their care.

There were mixed feelings about the use of the 111 services – with some people saying that getting advice in real time and helping them to decide whether their child needed to be taken to an ED was important, and other saying that they did not have confidence in taking advice on the telephone because their child was not being seen.

Some parents felt that there could be more information available to them on what they should do if their child is sick, including alternatives to going to EDs. Some people said that they thought not being able to get a GP appointment was a reason some parents took their children to EDs when they were ill.

Planned care for children and young people

Generally, people were willing to travel further than their local hospital to have specialist care for children and young people. There could be long waits for appointments, and between different types of appointment, so consolidating appointments would be welcomed to reduce waiting times in clinics and between appointments. The participants of the Youth Summit raised that long waits for care had a significant impact on patients and their families. Some people, had concerns that travelling further for appointments would be financially difficult, and could cause problems for parents who had other children to take care of.

Good communication with and from medical teams was deemed by those to be very important, with the view that knowledge is key to managing long term conditions. Many parents of children and young people with long term conditions said that they got a lot of information from charities and organisations relating to specific long term conditions such as sickle cell disease. There was a view that better access to routine diagnostic tests and screening would be beneficial and could reduce the need for emergency admissions if changes in conditions were picked up quickly.

UCLH staff in their separate feedback agreed that the management of long-term conditions is a key priority and highlighted the need for increasing access to psychological and mental health support for this group. They also supported work to address paediatric referrals to secondary care and the need to have a system wide approach in addressing the backlog for planned care, including surgery, to support equitable access to services, especially where services are located relatively close together.

4.2.3 Reflecting and acting on the engagement feedback

The feedback obtained over the 10-week engagement period has been extremely valuable to the programme. We are grateful to everyone that took the time to engage and participate. The engagement provides Start Well with a clear platform to move forward with a better understanding of the experiences of patients, residents and staff and think about how themes arising from the engagement can be incorporated into the next steps to improve services.

As the engagement period closed close to the time of writing this update report (9 September 2022), the programme team will be reflect on the feedback have received and how to address the nuanced points raised.

In addition to understanding views on the opportunities identified in the Case for Change, the purpose of the engagement was to seek further feedback on services and understand if there were other opportunities for Start Well to explore and take forward to improve services. There are a number of these identified within the engagement report such as improving communication and information sharing between healthcare providers and the role of integrated primary and secondary care paediatric clinics. There is also a very clear theme around good communication with patients and service users which comes out across all services areas.

Through discussion with the Programme Board we will reflect on the feedback heard and understand the best route to follow-up. There may be areas which are appropriate to carry out further engagement or to reflect on the service priorities through the work being progressed on best practice care models (explained further in the following section of the paper). There may be areas where trusts want to incorporate feedback into their plans at an organisational level or working together at a system level.

We propose to update bring an update to the Board at their November which will outline how the feedback through the engagement period has been incorporated into the work of the programme.

5 Next steps for opportunities identified in the Case for Change

As has been outlined, the Case for Change was written following a period of evidence gathering and data analysis. The engagement aimed to interrogate if what was identified in the case for change resonated with those that engaged. This section will explore the next steps for the opportunities identified by the Case for Change.

5.1 Opportunities to improve that were identified in the Case for Change

The outcome of the engagement outlined above provides clear endorsement for the opportunities identified in the Case for Change, alongside some areas for further exploration.

Many of the areas identified within the case for change are in areas where there are already established programmes of work and existing mechanisms for delivery. Through the Case for Change aspects of care around maternity, neonatal and children and young people's services have been brought to the fore by placing them together in a broader context. There is a need to review delivery and ensure progress within the overall context of the Start Well programme, however where work is already being progressed accountability remains with established programmes.

The next steps for the opportunities identified in the Case for Change therefore fall into two categories:

- Opportunities and actions for which there are clear delivery owners (either at an organisation, place or system level)
- Opportunities which raise questions about the current organisation of maternity, neonatal and children and young people's services. Here, further work is needed to explore the intervention needed to build on the opportunities, and whether a change to the organisation of services is appropriate, or whether they can be resolved in a different way

5.1.1 Opportunities and actions for which there are clear delivery owners

There are a number of opportunities that do not need further interrogation before arriving at a recommendation about next steps and there should be no delay in commencing or progressing existing work to address them. The actions around these opportunities fall within two broad categories which are outlined below.

Place-based focus	Action that may be needed to be co-created at a more local level involving a smaller number of providers or borough partnerships where issues have been identified as more of a local challenge and do not involve change to the provision of services at any particular site
System collaboration	Action that is needed at a system level and requires work between multiple partners within the ICS to achieve, but does not involve change to the provision of services at any particular site. For most areas this involves building upon an existing programme of work, or working in a more collaborative way and the Start Well programme has provided further impetus to accelerate this existing work.

Figure 11: Categories for actions needed to build on Start Well Case for Change opportunities

An example of action which will be delivered at a place-level is:

- Understanding the drivers for the high rate of stillbirth in Haringey between 2018 and 2020. Highlighted through the development of the Case for Change this work is owned by the Local Maternity and Neonatal System and an audit is being commenced to explore the drivers and understand what may need to be done to better support women and pregnant people; and

- Improving the maternity data– with each maternity unit (in conjunction with the LMNS digital midwife working with the ICS Digital Programme) to put in actions to improve data quality to ensure that NCL has a robust maternity data set and is able to report and benchmark key metrics, e.g. CORE20PLUS5 maternity indicators.

Examples of actions at a system level are:

- Ensuring that as many children as possible are treated outside of hospital through the roll out of 'hospital at home' across NCL, this already forms part of the implementation of the Community Services Review;
- Continuing work led by the children and young people's regional improvement programme to work with the NCL diabetes network to improve the consistency of pathways for children with diabetes in NCL;
- Through the LMNS understanding how continuity of carer can be further rolled out safely across NCL, and
- Progressing additional investment in perinatal mental health services to increase access to services across NCL, which is led through the Mental Health Programme Board.

A detailed action plan will be collated in conjunction with existing NCL programmes and local teams such as the NCL Local Maternity and Neonatal System, the NCL Children and Young People's Regional Improvement Programme and Borough Partnerships to support the implementation of the actions identified. This holistic plan will be overseen in the context of the Case for Change by the Start Well programme board (see section below).

5.1.2 Organisation of services

There are a number of opportunities identified by the Case for Change that raise questions about the current organisation of maternity, neonatal and children and young people's services. Further work is needed to explore how these are best addressed, and whether a change to the organisation of services may be needed or if alternative solutions exist.

The opportunities from the Case for Change that may fall into this category are:

- Better utilisation of the range of maternity capacity offered in NCL (including the full range of birth settings available in NCL)
- Matching neonatal intensive care capacity and need
- Consider the sustainability of the Royal Free Hospital SCU
- Having the right maternity and neonatal estate
- Addressing increasing emergency demand and lack of capacity at EDs
- Improving the organisation of paediatric surgical care
- Improve the environment and infrastructure for paediatric surgical care
- Improving transition to adult services
- Support the recruitment and retention of workforce
- Addressing workforce vacancies and variation in provision and access to allied health professionals across neonatal units

In order to make a fully informed recommendation to the ICB Board about the proposed next steps for opportunities outlined we suggest commencing some further work and analysis which is detailed below. These activities will take place alongside reflection on the themes and additional areas for consideration which have been highlighted through the engagement period.

We would seek to undertake this enabling work over the coming two-month period and return to the ICB Board in November 2022 with a recommendation about the actions needed to build on the opportunities that relate to the organisation of services.

Further analysis

Gaining a better understanding of current service organisation through additional analysis which was not completed, or needs to be updated since developing the Case for Change.

Examples of activities that will be undertaken to support this are: further work to support demand and capacity modelling, an up-to-date workforce baseline, a comprehensive estates baseline and patient travel time analysis.

There are also some more specific service areas that feedback on the Case for Change highlighted needed to be explored in more detail, for example: the arrangements for maternal medicine services and understanding the role of some interdependent hospital services.

Developing best practice models of care

Work has already commenced to develop best practice models of care covering maternity, neonatal and children and young people's pathways. This work is being undertaken collaboratively involving colleagues from across NCL and beyond. Further work is needed to ensure the models have had the right input from a varied range of staff groups, as well as patients and the public and to ensure that the emerging care models reflect the feedback and priorities outlined through the engagement on the Case for Change.

The activities that will be undertaken to support the development of these models of care are: specific engagement with particular professional groups (for example primary care, surgeons and anaesthetists), seeking input from relevant professional bodies, working with local authorities to ensure they are integrated with the models for services that they provide, testing models with patients and the residents and hosting a further Youth Summit to get feedback from young people.

6 Proposed governance arrangements to drive next steps and oversee the programme

This section outlines the proposed governance which will provide the oversight and drive for the next phase of the Start Well programme.

In the case for change the governance arrangements for the initial stage of Start Well were outlined: with the programme reporting to the ICS Children Young People Maternity and Neonates (CYPMN) Board. To support the next phase of the

programme and reflecting the change in activities that need to be undertaken, refreshed governance arrangements will need to be put in place. The governance arrangements and leadership arrangements for the programme will also need to be refreshed in the context of the newly appointed ICB Board members.

It is proposed that a dedicated Start Well programme board is established. This board will oversee the programme and report into the NCL ICB Board.

The programme board will have executive level representation from each of the NCL Trusts that deliver these services, as well as specialised commissioning, local authorities and attendees invited to attend from neighbouring ICSs. The group will be chaired by the ICS Chief Medical Officer, Dr Jo Sauvage and has two other voting ICB Board members in Phill Wells (Chief Finance Officer) and Chris Caldwell (Chief Nursing Officer), alongside Sarah Mansuralli (Chief Development and Population Health Officer) who is Joint SRO for the Start Well programme and a member of the ICB Board.

The Start Well programme board will be responsible for the strategic direction of the programme and making collective recommendations to the ICB Board about the programme. Once formally constituted, full terms of reference will be drafted to reflect the important role of this group in the oversight of the programme.

The proposed governance structure to support the next steps of Start Well is shown in figure 12.

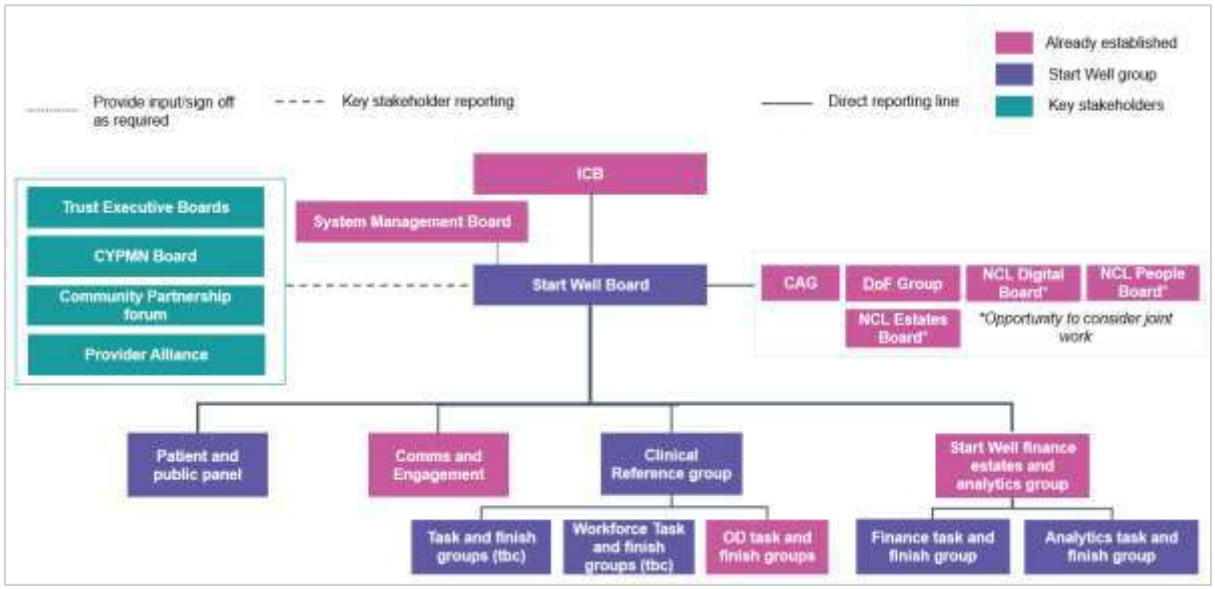


Figure 12: Proposed governance for the next phase of the Start Well programme

To enable the programme to progress, expert groups will be convened that will report into the overarching programme board.

Further details of the groups are outlined below:

6.1.1 Start Well Clinical Reference Group (CRG)

The CRG was established over the summer to support the development of best practice models of care. It will ensure a broad membership of clinicians from many

different disciplines and organisations (from the ICS and the broader system – such as the neonatal ODN, Health Education England, neighbouring ICSs and local authority). It will be chaired by the joint SRO for Start Well and ICS lead for children, young people, maternity and neonates, Dr Emma Whicher. The group will be represented on the programme board by its chair.

6.1.2 Start Well finance, estates and analytics group

The finance, estates and analytics group will be chaired by the finance lead for Start Well Kevin Curnow (Chief Finance Officer, Whittington Health). It builds on the group that met to support the development of the Case for Change and is made up of senior finance and analytics leads from across NCL providers, as well as specialised commissioning. The ICB membership would be refreshed for the next phase of the programme. The group will be represented on the programme board by its chair.

6.1.3 Start Well patient and public group

The Start Well patient and public group will report into the programme board. The group will be chaired by a community member and will have representation from across the five boroughs, including an invited Healthwatch representative. It will ensure that there is robust challenge in considering the impact of this programme of work on the public, patients and service users, including women and pregnant people, babies, children, young people, families and carers. The group will be represented on the programme board by its chair.

6.1.4 Start Well communications and engagement leads group

The communications and engagement leads group is already established and has been meeting regularly since 2021, supporting the first phase of the programme over the development of the Case for Change and subsequent engagement. The group membership is made up of the communications leads from all acute trusts and is chaired by the Start Well communications and engagement lead. It will be responsible for ensuring there is a thorough and robust communications and engagement plan for staff, stakeholders and the public and service users and that feedback from engagement activity is fed back to the programme board to inform decision making. The group will be represented on the programme board by the chair.

7 Conclusion, next steps and recommendations

7.1 Conclusion

This paper has highlighted that through work undertaken on the Start Well programme to date, a number of opportunities to improve maternity, neonatal and children and young people's services have been identified. These have been drawn from the data and evidence gathered in developing the Case for Change, and extensive engagement with patients, residents and staff through the engagement period that ran from July – September.

The areas that were identified in the Case for Change were found to have resonated and therefore actions to build on these opportunities will be taken forward – either through work at a system and place level or to understand the most appropriate next steps through the additional activities that are outlined in section 5.2.

There are a number of additional areas identified through engagement that need to be given further thought about how they are taken forward, either within the direct scope of Start Well or by other programmes or organisations that make up the ICS.

7.2 Next steps

We propose the following next steps take place:

- Further reflection on the feedback obtained through engagement on the Case for Change and how any new opportunities to improve services will be addressed by the ICS
- Commence the more detailed work set out in section 5 and 6 to understand how best to build on the opportunities that may be associated with the organisation of services
- The development of a detailed holistic action plan for the opportunities from the Case for Change that we believe will be owned either at a system or place level
- It is envisaged that this work would take place over the coming two months and we would bring a further update to the Board in November with a recommendation of how to progress

7.3 Recommendations

We are seeking the following from the ICB Board members:

1. NOTE and comment on the Case for Change themes and feedback from the engagement period
2. ENDORSE the governance arrangements for the next phase of the programme which including the Start Well Board to oversee the programme and a number of workstreams reporting into the programme board
3. NOTE that the programme board will need to have particular responsibilities set out within its terms of reference to pay particular attention to the duties of public sector organisations relating to groups with protected characteristics set out in the Equality Act and NHS Act and to ensure that robust engagement of patients, carers, staff and wider public continues to be central to the design and delivery of the programme
4. NOTE that next suggested steps will be taken forward through the governance arrangements outlined
5. NOTE future reporting arrangements to the Board at its next meeting with a proposed recommendation around next steps for the programme

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
27 September 2022

Report Title	NCL ICB Working with our People and Communities Strategy and Working with our VCSE Sector Strategy	**Date of report**	27 September 2022	**Agenda Item**	2.4
Lead Director / Manager	Francesca McNeil, Assistant Director of Communications and Engagement, NCL ICB	**Email / Tel**		francesca.mcneil@nhs.net	
Board Member Sponsor	Ian Porter, Executive Director of Corporate Affairs, NCL ICB				
Report Author	Elizabeth Stimson Alexandra Watson	**Email / Tel**		estimson@nhs.net Alexandra.watson@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Both Strategies describe commitments and principles regarding developed ICB approaches that champion sustainable investment, aligning and making best use of resources and investing strategically in community engagement and empowerment programmes and our VCSE to improve the health of our local populations.			
Report Summary	NCL ICB is committed to delivering community engagement and empowerment approaches that will support achieving the aims of the ICS Population Health Improvement Strategy, and meet our statutory duties. Two ICB Strategies - *Working with our People and Communities* and *Working with our VCSE* – have been developed to maximise the opportunity of forming an ICS: to support community-based development, collaborate with communities to build social capital and assets, and ensure people and communities can 'have their say' on the development of the highest quality care services and issues which are important for them. We are committed to acting on community and patient feedback and to working in partnership with the Voluntary and Community and Social Enterprise (VCSE) sector. Both Strategies have been developed with significant input from partners and build on existing best practice and expertise, including Local Authorities. While these are ICB Strategies, there is strong support from ICS colleagues for the aims, principles and approaches. The ICB is in the process of developing 2022/23 (Year 1) Delivery Plans. The Delivery Plans will focus on practical action to enable and embed strong community engagement and empowerment practices through our ICB. They will				

	link into Borough Partnership plans and will build on the existing best practice at a local level. The Plans include a focus on development areas: ensuring strong community and VCSE voice in governance; aligning activity for maximum impact and efficiency; developing outcome measures and evaluation methodologies; and ICB assurance of community engagement and empowerment work.
Recommendation	The Board of Members is asked to **APPROVE** the Working with our People and Communities Strategy and the Working with our VCSE Sector Strategy.
Identified Risks and Risk Management Actions	Insufficiently prioritising or resourcing delivery of the Strategies could result in a negative annual assurance rating from NHS England, stakeholder criticism, failure to deliver statutory ICB duties (with the potential to be referred for Judicial Review). To mitigate these risks the ICB will produce an annual delivery plan for both strategies, formally reported annually to the ICB Board of Members and overseen by an ICB Engagement and Involvement Steering Group. The Community Partnership Forum and VCSE Alliance will be closely involved.
Conflicts of Interest	No conflicts are identified at this stage. ICB governance policy and processes will be followed to manage any potential conflicts arising in future.
Resource Implications	No cost pressure related to the Strategies for 2022/23, as Corporate Affairs budget has covered essential costs. The ICB retains the principle that commissioning teams should include engagement costs within programmes budgets.
Engagement	Both ICB Strategies have been developed collaboratively with input from ICB, Council, Healthwatch and VCSE colleagues. The VCSE Strategy has been co-designed with the NCL VCSE Alliance. Both have been brought to key forums including: Community Partnership Forum, Population Health Improvement and Health Inequalities Forum, Personalisation Steering Group, Local Care Forum, NCL CCG Community Members meeting, and the borough VCSE forums.
Equality Impact Analysis	The strategies will support the organisation in the delivery of our Equality Duties. Any future investment decisions related to the strategies will be subject to EIAs.
Report History and Key Decisions	• VCSE Alliance - October 2021 to June 2022 co-design period for VCSE Strategy, • Community Partnership Forum, December 2021 – engagement on development of both Strategies • Community Partnership Forum, May 2022 – provisionally approval of Strategies and agreement to recommend approval by the ICB post July 2022 • System Transformation Board, May 2022 - it was provisionally approved by the Board to take to Integrated Care Board for formal adoption post 1 July 2022
Next Steps	The ICB will continue to work with partners, including the VCSE Alliance and Community Partnership Forum, to finalise the 2022/23 deliver plan for both strategies and will support the successful achievement of these over the remaining six months of this financial year. Key areas of focus are set out in the Conclusion section of both Strategy documents.
Appendices	1. Working with our People and Communities Strategy 2. Working with our VCSE Sector Strategy

NHS
North Central London
Integrated Care Board

Working with our People and Communities Strategy 2022/23 to 2025/26

September 2022

Contents:

1. Context

The purpose of this strategy is to outline North Central London Integrated Care Board's (NCL ICB) commitments, approach, and principles to community engagement and empowerment. Transitioning to an Integrated Care System (ICS) and ICB has provided us with a unique opportunity to fundamentally change the way we work as a system and improve the quality of life and health of all in our diverse communities.

We have the opportunity to address health inequalities, acknowledge and support community-based development, collaborate with communities to build social capital and assets, and encourage people and communities to come forward to 'have their say' on the development of the highest quality care services and issues which are important for them.

As a system we recognise and value the benefits of this community-focused approach, in particular through our work at Place; our Working with People and Communities Strategy harnesses the thinking and best practice already being shaped by our Borough Partnerships, as well as at a pan-borough level.

This strategy has been developed in collaboration with our partners, including Healthwatches, Voluntary, Community and Social Enterprise (VCSE) sector and with people and communities across north central London (NCL). This collaborative approach is central to our future ICS commitment to placing people and communities at the heart of what we do.

2. Introduction

We are committed to investing in community engagement and empowerment approaches to ensure our plans and local services reflect the needs and priorities of our population, to tackle the inequalities still experienced by some communities and to ensure we are listening and acting upon the wide-range of community and patient feedback we receive by commissioning and providing high-quality services for all in our NCL population. These strategies support the delivery of the NCL ICS Population Health Improvement Strategy.

Working with communities to co-design solutions that prolong good health, prevent avoidable ill health and address health inequalities will help our services to meet local demand and build assets within our local communities. To be an effective health and social care system it is essential that we adopt this approach - understanding that partnership working with our local communities and VCSE now will ensure a financially stable and resilient system for the future.

The strategy is intended to provide a strategic framework to shape and inform how the ICB approaches, plans, resources and evaluates community engagement and community empowerment programmes. It is designed to serve as an overarching framework to ensure that high-quality community empowerment work is embedded across the ICS at a multi-geographical footprint: at NCL, borough and neighbourhood level. The strategy will support the ICB to focus the right resource in the right places to achieve our aims and uphold the principles set out below. We cannot do this without our VCSE partners. They are crucial partners in championing, engaging with and ultimately delivering this approach. As such, we have also developed a Working with VCSE Strategy, which gives more detail around our commitments to building a strong and thriving VCSE across NCL.

We have included best practice examples throughout this document to demonstrate how we are already addressing and delivering the principles and ways of working laid out in this strategy.

3. Working as an Integrated Care System

The statutory duties of North Central London Clinical Commissioning Group (NCL CCG) relating to public involvement transitioned to the NCL ICB on 1 July 2022 and this document lays out how we will meet those duties. We want to build on the strong foundations laid by NCL CCG, our local councils, NHS trusts and Primary Care Networks (PCNs), to both expand and improve our approach to community engagement. We will do this through a variety of mechanisms designed to facilitate strong community engagement and empowerment and support the development of VCSE as a key strategic partner of the NCL ICS.

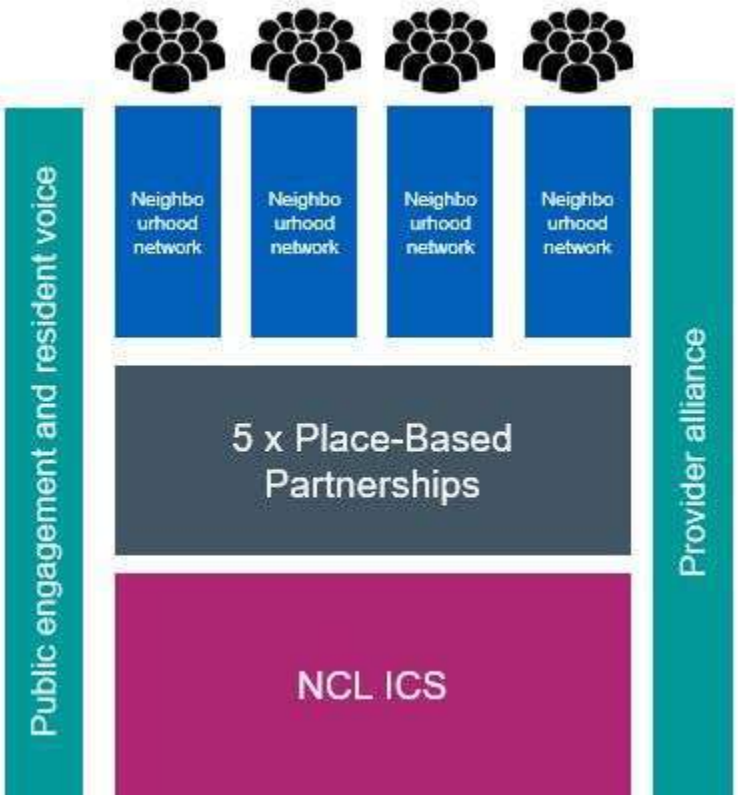
NCL ICB, as a partner within the NCL ICS, is committed to supporting delivery of the ICS's aim to help residents to 'start, live and age well'. This holistic perspective on communities' lives recognises that a range of wider determinants have a significant impact on individuals' health, wellbeing and life chances, and emphasises the importance of taking a strength-based approach to motivate and support people to make changes themselves, e.g. enabling self-care or being more physically active.

We know we could do more to encourage some people, often from under-served communities or groups, to access services earlier and before a crisis such as a hospital attendance or admission. The reasons for this are wide-ranging and complex, but we know we need to improve equity of

access, outcomes and experience. Through listening to and working with local communities, plus partnering on programmes with our VCSE, we can take a more holistic view of communities' needs and skills and crucially, start to address these needs. This is vital to building sustainable and thriving communities. What we describe in this strategy not only supports the development of social value within our local communities, but also has a positive financial impact on the whole system, thereby ensuring that we adopt an approach that will see long-term return on investments.

An important focus will be how we work with people and communities through the Borough Partnerships in our five boroughs; Barnet, Camden, Enfield, Haringey and Islington. These Borough Partnerships - which includes our Trusts and PCNs, Councils and VCSE - proactively promote community engagement and empowerment approaches so that we can ensure we are delivering high-quality services which meet care needs and building social capital through a range of mechanisms, such as ensuring individuals' voices are heard and listened to, and the co-design and production of services and solutions.

All partners across the ICS have responsibilities to engage and work with their residents and patients. We will be working in partnership to ensure we make the best use of our resources and that we align how we engage and work with our local communities.



4. Vision and Principles

Vision

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

Principles of working with people and communities

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

5. Approach: How are we going to do this?

We will use a range of mechanisms for engaging and empowering the diverse people and communities that live in NCL. We commit to using the best method(s) and activities to reach and work with our local communities, elevating their voices and harnessing their unique skills and experiences to develop and design local services and solutions, and to support people to successfully look after their own health and wellbeing. We will do this throughout the ICS – working across NCL on system barriers and solutions, working at Borough and working at Neighbourhood in collaboration with our Primary Care Networks (PCNs).

As NCL ICB, and through the ICS, we will:

5.1 Inform and communicate

We commit to regularly informing people about what we are working on and how we are working together across the ICS.

We pledge that local communities and people will know how they can be involved and the range of ways they can help to shape the way we are working at Neighbourhood, Borough and NCL level. Most importantly, we will ensure this information is available through a variety of media, including but not limited to, websites, newsletters, webinars, face-to-face meetings and sessions, social media, and through our staff and partners.

We will ensure the information available is culturally sensitive and accessible – and that it is developed in formats that meet the communication needs of our local communities.

We also commit to using clear and jargon-free language to describe what we mean.

We will work with local people and communities to understand their views and feedback on the ways in which these views have shaped services. We will consistently work to raise the voice of local communities in all that we do and improve our communications and engagement to better accommodate their needs.

5.2 Raise the voices of our local communities

We will ensure that local people can engage with us in a way that suits them, by taking a multi-faceted approach, and ensuring that our engagement is inclusive by proactively reaching out to those who have the greatest barriers to accessing services and having their voice heard. We will do this through:

5.2.1 Engagement

We commit to seeking and hearing the voices and experiences of local communities, thereby developing rich insight into our local communities' lives, their concerns, needs, understanding and skills. Engagement will be undertaken in a variety of ways, including public events, focus groups, surveys, and more contemporary and creative social, digital and mixed media approaches.
We will ensure community insight and research informs and shapes our commissioning, transformation, and integration plans, improving the quality of local health and care services and our communities' experiences within them.

We will ensure we build on COVID-19 pandemic learnings and embed what has worked well in terms of online engagement, but also ensure that digital inclusion issues are given significant weight when planning engagement work.

Best practice example: Enfield Patient Participation Group Networks
Patient Participation Groups (PPGs) work in partnership with GP practices to improve services for patients in primary and community care: every member practice in Enfield has an active Patient Participation Group, with a quarterly network meeting for all PPGs in Enfield chaired by an elected patient. The network was started in 2014 to enable the election of a PPG member onto key decision-making boards. The elected PPG Chair continues to be an active participant of the Enfield Borough Partnership, and sits on a number of committees and meetings to represent the patient voice.

Enfield has recently received additional funding, through an NCL Health Inequalities Fund, for a PPG development programme in 2022/23. Chair of Arnos Grove Medical Practice and the elected PPG network chair is leading on this project with the Enfield engagement lead.

The programme is supporting PPGs to understand their development needs and offering support to meet these and to improve diversity of the membership of PPGs, particularly in the most deprived wards and to help the PPGs reach out to registered patients, either in their own practices or across the neighbourhood Primary Care Networks.

Alongside this, we are improving the way PPGs communicate with each other and work across the borough – strengthening the patient voice within primary care and within Primary Care Networks – by strengthening this network approach. The PPGs work together as a network on certain

engagement topics with patients. This year the focus will be on understanding patients' experiences of access to NHS services.

5.2.2 Co-production

Communities are fundamental to building social capital and community assets, and should be integral to designing and delivering collaborative solutions and services, with the statutory sector.

Co-production is a way of working with people and communities in equal partnership to design services. We will work with people at the earliest stages of service design, development and evaluation, acknowledging that people with lived experience and their carers are expertly placed to advise on what support and services will make a positive difference to their lives.

We will champion this way of working across the ICS.

5.2.3 Consultation

Consultation is a formal and statutory process we must undertake if we propose a significant change to, or decommission, a service.

We commit to speaking with and listening to local communities at the very start of the process; this includes those who most use the services, face significant barriers to accessing services or face the highest health inequalities, alongside those people who may benefit from a service but who are not doing so through choice. We will also make sure that we are engaging with the diversity of voices and communities reflective of NCL and commit to ensuring that we engage across the breadth of the nine protected characteristic and social inclusion groups.

We explore their needs, concerns and hopes for services and this becomes a crucial part of evidence, shaping any proposed service changes. Additionally, we use the intelligence we already have from community engagement, so that we make the most of people's time and respect their valuable contributions.

As a final step in the consultation process, we are committed to sharing proposed plans for service change with local people, evaluating their insight on the details of the proposed service change and demonstrating how their feedback (alongside other evidence base and needs) has shaped the proposals.

5.2.4 Deliberative and participative models

We will utilise deliberative and participative models, such as Citizen Assemblies, as part of our wider engagement approach. We will include this approach as part of large-scale service transformation programmes. As these models are considered, developed and adopted we will ensure they are informed by culturally competent methodologies and so do not replicate current gaps in engagement with diverse and under-served communities.

Best practice example: NCL Residents' Health Panel

In 2019, we launched an online citizens' panel, known as the NCL Resident's Health Panel, recruiting approximately 900 members who are broadly representative of our local communities. The NCL Residents' Health Panel is one route through which the ICB is able to engage with a diverse range of people and to hear from people that are seldom heard. It is one of the tools we use to seek representative, robust views and reliable evidence to support decision-making on service change/design, including formal consultation.

Enhancing our Residents' Health Panel is integral to our Working with People and Communities Strategy. As part of our work plan for 2022/23 we will further develop our panel to ensure better use and involvement in a wider range of activities at both local and system level, including:

- *Undertaking a review of how our panel has been used to date, levels of participation from members, where engagement activities have worked well and identifying gaps where benefits have not been realised.*
- *Developing and implementing a formal system to gather feedback about how panel insights have been used in commissioning decisions to improve outcomes.*
- *Developing a coordinated programme of work in line with partners (NHS trusts and primary care, our five councils, VCSE and Healthwatch) and collating a forward view of projects and programmes of work.*
- *Looking at cross-cutting themes such as digital inclusion and health inequalities, to align with our system priorities.*

5.3 Support our communities to live well: empower people and communities

We are committed to working with local people and communities to understand what matters to them for their health and wider quality of life. In partnership, we want to develop sustainable and innovative solutions that bring support and services into communities, rather than expecting our diverse communities to come to us.
The COVID-19 pandemic exacerbated and shone a light on long-standing inequalities and deprivation within communities. Alongside this, there has been much wider recognition of the latent power and untapped assets that exist in these communities.

The impact of the pandemic has changed the way we work across all sectors in NCL, including how we work with each other and the local communities we serve. Together with our new ICS responsibilities, this will mean a fundamental shift in our engagement approach, the way we deliver services and the way we share voice and power with our local communities.

We are at the start of this journey, but our ambition is to build the foundations for this approach, working across our ICS to identify opportunities to strengthen local decision making. By focusing on supporting communities to live well and addressing health inequalities, we commit to empowering our local communities.

Best practice example: Community Research & Action Programme
It is widely recognised that certain communities face specific barriers to accessing statutory health and care services, which plays a significant factor in widening health inequalities and contributes to poorer health outcomes. The Community Research & Action Programme raises the voices of local communities and invests in grass-roots VCSE and communities, to deliver a community-asset-building and engagement programme to tackle health inequalities. The programme supports local communities to access the health and wellbeing support they need through key signposting, and co-designed community interventions. Through it, we gather vital insight into our communities' lives, and their lived experiences of accessing health and care services and wellbeing support, to underpin ICB and ICS, and Borough Partnership priorities and decisions. It creates a systematic approach to working with our local communities and to collating and evaluating their experiences.

The approach originated in Islington in 2014 and is now being developed locally across all five boroughs in NCL. It includes a collaborative of VCSE organisations, with a lead facilitating organisation and a range of grass roots VCSE (who receive funding through the programme.)

Outcomes of the programme include:

1. *Research and evaluation of the lived experience of our local communities: their needs, skills and assets to inform, shape and design ICB and ICS work programmes.*
2. *Upskilling VCSE through both peer training and additional training (via workshops) on the local NCL health and social care system.*
3. *Navigation: supporting local communities to access statutory services and a range of health and wellbeing borough-based support and information.*
4. *Community capacity building / co-designing community interventions: offering hands-on interventions so that local communities can access the support they have identified they need. The impact of these interventions is measured via a wellbeing intervention measure, which measures how a person's confidence has increased. Outputs: better access to services and improved health and wellbeing amongst our most disadvantaged communities.*

5.3.1 Community empowerment approaches

If we are really to tackle the issues which matter to local people and communities – particularly those who face the highest health inequalities and live in areas of greatest deprivation – we must begin to shift our focus to working with our communities to address their needs and priorities, and most importantly, to recognising the skills and strengths they bring.

If we can recognise local people as active participants in their own wellbeing and that of their communities, rather than recipients of a service, we have a far greater chance of tackling health inequalities in a way that is meaningful for our communities. This approach gives local people choice and control over how they manage their health and demonstrates that local people have responsibility for their health and wellbeing.

In NCL, our response to the pandemic highlighted that where we had already developed and resourced programmes which worked with and empowered local communities through the improvement of access to statutory services, connecting local people into wellbeing support and building local community resilience we were able to immediately mobilise – collectively across statutory partners, local VCSE and communities – to address the immediate crisis needs of the pandemic such as supporting most vulnerable in our communities through delivery of medicines & food and empowering local communities with clear health messaging, training to accessing online services & developing meaningful online social connections.

We commit to building on this approach and the areas of best practice across NCL so that we can collaborate with our local communities in the design and delivery of hyper-local wellbeing initiatives and strong public services. It is an approach which starts with people's strengths rather than their deficits, and builds on community resilience, research and insight, lived-experience and the assets that exist in the community.

Best Practice Example: Healthy Neighbourhoods

Healthy Neighbourhoods is a collaboration between the statutory sector – primary care, NHS and council – and voluntary sector engaging and working with local people aimed at promoting individuals' health, wellbeing and life chances in a way that makes sense to them because the approach and solutions are designed with communities and their representative groups. The model

is initially being rolled out in east Haringey (around the 20% most deprived neighbourhoods, often the most diverse) as part of the NCL Health Inequalities Fund programme.

The objectives of Healthy Neighbourhoods is to collaborate to:

- *Build capacity and infrastructure for ongoing community engagement to understand health-related issues in communities, to co-develop solutions, and to build capacity within the community to deliver care and support. This engagement not only develops the solutions associated with Healthy Neighbourhoods, but also encourages individuals to 'have their say' on a range of other health- and care-related topics, e.g. on primary care, their local hospital etc.*
- *Deliver a set of co-designed and targeted initiatives to address the identified health-related priorities in these communities developed between grassroots community, VCSE and statutory sectors locally.*

We are currently in the mobilisation phase of the model, and are working collaboratively with VCSE, local people and communities to blueprint our approach. For example, VCSE local representatives helped design how we might approach support for people with low mental wellbeing: rather than label the solutions as 'mental health solutions' we have invested in activities based around interests, hobbies and leisure people may enjoy. We build relationships with local people and through these can also discuss their low mood. Often relationships are built with someone from a similar background. This approach represents practical help to address their wellbeing, e.g. the link between physical activation and improved mental wellbeing or connecting to others, as well as a way of building trust to discuss mental health issues and thus reduce perceived stigma.

6. Accountability and transparency

Integrated Care Board

As an ICB, we commit to meeting our statutory duties and the requirements set out by NHS England in the *ICS Working with People and Communities Guidance.* Our community engagement and empowerment work will be reported to, and assured through, the ICB Board. The overarching areas we will report on, for assurance, include:

- Activity, outputs, outcomes and spend on ICB community engagement, research and community empowerment programmes.
- How the outputs and outcomes of this work have influenced decision making, service design and development, assuring quality of services, resource allocation and transferring resource to maximise the value of engagement.
- Priorities or needs identified as part of community research that were not identified by statutory services, and the community action taken in response to this; and

All ICB committees will ensure that proposals and decisions are rooted in local communities' needs and aspirations and that they follow best equalities practice as per our *Equality & Diversity Strategy.* Papers brought to committees will be required to demonstrate robust evidence of community engagement and empowerment approaches.

Integrated Care System

A range of ICS forums have been developed, through which we can report and be held accountable on meeting statutory duties around community engagement and empowerment. Key forums include:

- NCL Community Partnership Forum: meeting since September 2021, with membership including the ICS Chair, ICB Chief Executive, VCSE partners and NCL VCSE Alliance members, Healthwatches, public members, people with lived experience and partners from across the ICS. This forum will be key to ensuring effective community and citizen participation in the work of the wider ICS. The aim is for it to be an active expert reference group on community engagement, as well as a forum for discussion and debate on emerging proposals and strategies. Members of this forum will also have the opportunity to be involved in other key strategic groups across the ICB – as community participants. Members of the forum have been involved in the development of this strategy.

- The five NCL Healthwatches will play a key role in working with us as an ICB - providing rigorous assessment to the way community voice shapes our approach and services. We are providing additional resource to support the five HealthWatches to work with us strategically across NCL and ensure their local community knowledge and insights can inform our work as an ICB and ICS.

- NCL VCSE Alliance: we have developed and are continuing to build on a VCSE Alliance model for NCL Integrated Care System. As a first step, the five VCSE umbrella organisations across NCL came together, and in early 2022 the Alliance broadened to include a representative organisation from each borough for mental health, homelessness, disability, deprivation, refugee and migrant and LGBTQ plus communities. We are working with the Alliance to ensure they can raise the voice of the VCSE within NCL ICS, support us to identify key system priorities and the barriers and blocks for the VCSE to work with ICB and ICS - informing our system development. They act as a facilitator between Borough Partnerships VCSE and NCL ICB and NCL ICS – with strong engagement and roots at Borough and Neighbourhood. The Alliance has endorsed this strategy. For more detailed information on how VCSE will be involved in our governance please see NCL ICB *Working with our VCSE Strategy*.

- NCL ICS Population Health Improvement and Health Inequalities Forum: plays a pivotal role in helping understand the needs of our population, setting priorities aligned to these needs and exploring how we can respond using evidence-based insight and intelligence to help improve population health. We will use this Committee to raise the voice of, and explore issues that, specifically affect communities who face high health inequalities. This will include communities' and VCSE ideas around what we prioritise and how issues might be addressed. This reflects our commitment that community voice is heard within the decision-making forums of the ICB.

- NCL ICB engagement steering group: we are forming a new steering group which will have assurance and oversight for delivering the commitments made in this strategy and our Working with our VCSE Strategy. This will include overseeing the strategies' delivery plans and all ICB community engagement & empowerment work. Through this the group will assure that ICB has a clear investment plan for engagement, makes best use of resources, invests strategically in the VCSE & community engagement programmes, develops

community programmes that have clear measurable outcomes and to assure that our community engagement drives forward improvements in population health for our local communities and raises the voices of local communities in the design, planning & delivery of health & care system. Membership will include representatives from across Engagement, population health, Communities and wider commissioning directorates including borough partnerships, NCL HW role and VCSE Alliance.

- Developing a communications and engagement network for the North Central London ICS: we are developing a network approach to communications and engagement across the ICS, which will include clear principles, approaches and processes to underpin collaborative working across partner organisations. Through an in-depth review with partners, we will define how NCL ICS communications and engagement priorities will be set, how activity will be collaboratively planned, delivered and reported, and also, collectively resourced by ICS partner organisations.

Borough Partnerships

All five Borough Partnerships have a board that oversees, amongst other areas, working with communities and VCSE. All boards have VCSE and Healthwatch representation and are exploring local community input either via a community panel or community participants.

7. Resourcing and funding

We are committed to sufficient ICB staff resource and funding to deliver the aims and approaches set out in this strategy. We will continue to invest in delivering community engagement and community empowerment programmes as an ICB, as an integral part of our commitment to improving population health and addressing health inequalities.

We commit to ICB commissioning teams budgeting for sufficient engagement and co-design activity related to their programmes. We will also develop and deliver these activities with partners in the ICS, in order that we make the maximum use of our collective resource as an ICS.

The ICB Communications and Engagement team and ICB Communities team will support the organisation to forward plan, deliver and report on best practice engagement and community empowerment methodologies and programmes that tackle health inequalities and make sure local communities are at the heart of all we do. We will work in partnership with colleagues across the various organisations which make up the Integrated Care System.

We envisage local VCSE involvement in a range of community engagement and empowerment work. When we ask these sectors to support community engagement activity, resource proportionate to the level of activity will be made available for this. More detailed information is available on our commitment into investment in VCSE, and the NCL VCSE Alliance, in the NCL ICB *Working with VCSE* strategy.

8. Support to deliver the strategy and approach

The vision, principles and approaches set out in this strategy will be championed at every level of our system, and in all that we do. As part of this the ICB Communications and Engagement team, in collaboration with our system partners, will offer training and tools to support colleagues and partners to deliver high-quality community engagement, co-design and empowerment.

Our aim is to develop a strong level of knowledge across the system around engagement and empowerment methodologies, and how to apply these when working with local communities and VCSE in setting priorities, creating solutions and the design, delivery and development of both the organisation and services. This will be aligned with training on delivering our equality duties, such as undertaking robust equality impact assessments.

9. Evaluate

We recognise the huge breadth of insight provided by our partners, including VCSE and Heathwatches, and will further develop our processes to evaluate community all engagement and empowerment work being undertaken by ICB – both at an NCL level and Borough level. As part of this, we will develop outcome measures that reflect our engagement principles, including evaluation of the inclusivity of our work.

We will build strong and trusted relationships with our communities and measure if the way we are working is genuinely improving people's experiences of care, and supporting our communities to lead lives that they define as 'well.'

We will involve other organisations such as Healthwatch, our VCSE partners, and our local communities in developing outcomes, both in defining outcomes and in assessing our delivery of these. We will also learn from innovative best practice around community research and evaluation models.

We commit to developing:

- Processes to centrally collect and report on insights to inform ICB and ICS plans, programmes and ultimately decisions, including developing an insights bank;
- Evaluation on the impact of our community engagement and empowerment work, learning from previous programmes and projects to continuously improve the reach and impact of our work with local communities.

10. Delivering our strategy in 2022/23

This document is intended to provide a long-term strategic framework to shape and inform how the ICB approaches, plans, resources and evaluates community engagement and empowerment programmes. We will collaborate with partners to develop a more detailed 2022/23 delivery plan, to progress and embed this in the ways we work as an ICB, and across the ICS.

Our approach and way of working will be underpinned by the development of a number of programmes, frameworks and toolkits to ensure we are consistent and aligned across the system. Development of these products will be co-designed with stakeholders and our local communities across 2022/23.

Key elements of the 2022/23 delivery plan will include:

1. The development of a range of tools, guides and policies that will underpin and embed the approaches outlined in this strategy, including:
   - co-production tools,
   - community empowerment approaches training,
   - guide to service development and service change engagement;
   - guide to public consultation;
   - public reimbursement policy and
   - evaluation, impact and feedback framework.

2. The delivery of a range of programme activity, including:
   - Development of detailed Borough Partnership plans for working with people, communities, and local VCSE, aligned to this strategy.
   - Delivery of a community research and action programme, working with local VCSE in each borough, targeted to raise the voices of local communities who experience high health inequalities and/or barriers to accessing services.
   - Identification of, and support for, relevant ICB programmes and projects where engagement, co-production or consultation is required, to ensure the best practice approaches in this strategy are embedded.
   - Further development of methods to ensure ICB decision-making processes support community empowerment (i.e. how this can be part of needs assessment, priority setting and resource allocation process)
   - Developing a new ICB process to collect and report community insight: to collect quantative and qualitative intelligence from all ICB community engagement and involvement work – combined with population health data as bi-annual borough reports with a NCL summary report on key themes. This will inform the Population Health Improvement Strategy and ICB plans and decisions, ensuring community and VCSE voice is at the heart of plans and decisions; and
   - Further development of assurance methods aligned to ICB governance, including the role of the VCSE Alliance and how VCSE and local communities are a part of decision making.

3. A focus on measuring and evaluating outcomes and impact, such as:
   - Using a ‘You said, we did’ approach to demonstrate an effective feedback loop.
   - Ensuring a strong link between implementation of this strategy and delivery of the NCL Population Health Outcomes Framework and Improvement Strategy;
   - Evidencing how local decision making can be enabled as a result of community engagement initiatives; and
   - Review and Refresh our delivery plan annually.

11. Glossary of terms: What is an Integrated Care System?

North Central London Integrated Care System (ICS) is the name of the NCL system as a whole. An ICS is a way of working, not an organisation.
Partners within the NCL ICS include:
Acute Trusts, Mental Health Trusts, Community Trusts, Local authorities (Barnet, Camden, Enfield, Haringey and Islington), Healthwatch and VCSE (Voluntary, Community and Social Enterprise) sector

NHS North Central London Integrated Care Board (or ICB) allocates NHS budget and commissions services. This is the organisation that NCL CCG staff will transfer to, and will be chaired by Mike Cooke, with Frances O'Callaghan named Chief Executive.

The **North Central London Health and Care Partnership**, is the Integrated Care Partnership, a joint committee with the councils across the five boroughs. This committee is responsible for the planning to meet wider health, public health and social care needs and will lead the development and implementation of the integrated care strategy.

System

Provider collaboratives involve NHS trusts and primary care (including acute, specialist and mental health) working together. UCL Health Alliance incorporates all NHS trusts and primary care in NCL.

Place

Place-based partnerships or **borough partnerships** include ICB members, local authorities, VCSE organisations, NHS trusts, Healthwatch and primary care.

Neighbourhoods

Primary care networks will expand to incorporate general practice, community pharmacy, dentistry and opticians.

If you would like to receive information included in this document in another format, or have any questions on this document, please contact the NCL ICB communications and engagement team via nclicb.communications@nhs.net

NHS
North Central London
Integrated Care Board

Working with our Voluntary, Community and Social Enterprise Sector Strategy 2022/23 to 2025/26

September 2022

Contents

Foreword from the NCL VCSE Alliance

As the VCSE Alliance for North Central London, we are delighted to be asked to write the foreword to the North Central London Integrated Care Board Strategy for working with the sector. Alongside other voluntary sector colleagues from across the five boroughs, we have been heavily involved in the development of this strategy, which we welcome as a positive development for the system.

Sector colleagues will undoubtedly have contrasting experiences from the past when there were five discrete Clinical Commissioning Groups, but there is now a palpable sense of things moving in a uniformly positive direction under the new Integrated Care System. Any work that takes place in the early 2020s will inevitably be informed by the COVID-19 pandemic, and we write this conscious that joint working across the system was both challenged, shaped, and ultimately strengthened by the way all partners worked together to respond to the unprecedented circumstances of 2020 and 2021. That unique period of time fostered new and better ways of working, demonstrated the ability of the sector to pivot quickly to respond to circumstances, and helped system partners to understand the unique strengths of the voluntary sector. Therefore, it feels like an auspicious time for a strategy of this nature to be produced, and there is a real hope that it will help to preserve the flexible, trusted, and productive partnership working that emerged through COVID-19.

Inevitably, there will be challenges. A real question, which systems up and down the country are currently grappling with, is how do we create truly equal partnership when money and power are distributed unequally between system partners? There are no simple answers to this, but we would urge our statutory sector partners to be ambitious in terms of involving and working with the voluntary sector. Through COVID-19, we demonstrated our reach into communities and our ability to add value, expanding the sense of what is possible. If all of us can hold onto that experience, and be genuinely open to more equal and innovative ways of working, we will all be able to play our part in transforming the offer to the citizens of North Central London.

Caroline Collier, Chief Executive Inclusion Barnet and Chair of the NCL VCSE Alliance.

1. Context

There are many thousands of Voluntary, Community and Social Enterprise (VCSE) sector organisations in North Central London (NCL), ranging from large national charities to much smaller local organisations, and with an incredible breadth of focus.

Collectively, the sector plays a crucial role in understanding, supporting and championing the needs of our communities. VCSE partners work closely with statutory health and care organisations across NCL to help shape plans, decisions and services, as well as providing a range of innovative local services and solutions themselves.

The COVID-19 pandemic has had a significant impact on the health and wellbeing of many residents living in our boroughs, and has exacerbated health inequalities in under-served communities. It has also underlined the unique and vital role that VCSE organisations play in reaching diverse communities; providing information, support and services, particularly to those who are under-represented in accessing statutory services and who experience the greatest health inequalities. The sector has been integral to the design and delivery of the COVID-19 vaccination programme, and led local activity to build trust to support equitable access and uptake. There is significant learning we can take forward from this in terms of how the health system works with VCSE.

As we form the North Central London Integrated Care Board (NCL ICB), working as part of the NCL Integrated Care System (NCL ICS), it is vital we build on existing strong relationships with the VCSE sector and on best practice approaches to partnership working, particularly harnessing the experience of local authority colleagues.

We must also look to remove some of the barriers that currently make it difficult for VCSE organisations to collaborate with us as strategic partners. Doing so will ensure the sector's unique capabilities are an integral part of how the new health and care system operates, and will allow us to work together to tackle health inequalities in a way that is meaningful for our communities.

2. Introduction

This strategy has been co-designed with the NCL VSCE Alliance and the commitments included have received significant support from VSCE organisations across north central London. The ideas and approaches described are based on learning and best practice from across NCL ICS partners, in particular local authority colleagues. There has been involvement and input from ICB colleagues, joint commissioners in our councils, borough teams and VCSE organisations, to develop the strategy.

This strategy will support both the new NCL ICB and our system partners (including the VCSE sector) to set an ambitious vision for the future. It is intended to align with, and build on, the significant work already taking place locally, as well as learn from approaches being taken in other areas of the country.

The strategy will provide a framework for working in partnership with the VCSE on shared objectives to improve population health and tackle inequalities, by:

- Ensuring VCSE organisations can participate as a strategic partner in the ICS.
- Providing best practice principles on working with the sector and individual organisations.
- Taking a strategic approach to resourcing and investing in collaboration with VCSE.
- Ensuring that opportunities for the VCSE can be realised in a very practical way across NCL, at both a borough and neighbourhood level.
- Through delivery of this strategy, we are committed to working together as an ICS to support a strong and thriving VCSE sector whose unique skills and contribution to the health and care system are recognised, respected and resourced appropriately. We recognise that our local VCSE are the conduit to addressing health inequalities, hearing from, supporting and ultimately empowering our most deprived and vulnerable local communities.

Through effective collaboration with our VCSE, we will achieve a greater and stronger reach into local communities, which in turn will amplify the work of local community services. Through better resourced community support and intervention before local people reach the health and social care system, we can ensure a reduction in the numbers of local people falling into crisis. This collaboration supports our local communities to manage their own health and wellbeing, so that they do not have to unnecessarily access services for preventable health and social care concerns. This strategy supports the delivery of the NCL ICS Population Health Improvement Strategy.

The strategy development is the start of the journey; delivering its ambitions will take long-term commitment. As we start to implement the strategy in 2022/23, the five Borough Partnerships (Barnet, Camden, Enfield, Haringey and Islington) will be vital to ensuring that local approaches and plans are mutually supportive.

This strategy should be read alongside our ‘Working with our People and Communities’ Strategy, recognising that the ambitions set out there will only be achieved through working closely with the VCSE sector.

3. Principles

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

4. Approach: our commitments to working with VCSE

The approaches and commitments set out in this section have been co-developed with our VCSE, with input from commissioning and local authority colleagues. They have been identified as key to ensuring a strong and thriving sector with the skills and capabilities to play a strategic role within the NCL ICS. They support a continued focus on building strong partnerships with VCSE and working together to deliver local services, improve diverse communities' access and experience of these, and empower our communities to improve outcomes and tackle inequalities.

The five areas described below are interdependent. We have separated them out for the purpose of this document, in order to clearly demonstrate our commitment to working with the sector and the approaches we will take for each area.

4.1 VCSE as an equal strategic partner

We are committed to the VCSE sector being an equal strategic partner in the ICS. We will ensure their voices are heard and have influence within both the ICS and Borough Partnerships, as these develop.

The thriving VCSE sector in NCL has multiple roles and is heavily localised at place and neighbourhood and targeted at specific groups and communities; this is a huge asset. We must harness this incredible network of knowledge, experience and perspectives to influence and shape NCL and borough priority setting and decision-making.

The NCL VCSE Alliance was formed in 2021/22, comprising the five VCSE umbrella organisations, plus a representative organisation from across the NCL boroughs for homelessness, disability, deprivation and refugee and migrant communities. We are committed to working with the Alliance to ensure the voice of the VCSE is heard within NCL ICS, support us to identify key system priorities and the barriers and blocks for the VCSE to work with ICB and ICS - informing our system development.

The role and place of VCSE is a key element within our governance arrangements for the ICB; this includes VCSE Alliance membership on our key ICB Committees, to ensure their ability to influence plans and priorities. We will also share cross-learning from the development of the GP and Provider Alliances.

We will continue to develop other effective two-way conversation channels, ensuring the VCSE sector is aware of ICB plans and programmes and can be involved in their development. We recognise the variety of the sector and so will continue to explore creative methods of engaging with VCSE. It is crucial we do not expect organisations to come to us but that we reach out to VCSE, ensuring that we can hear from grass roots organisations.

Ensuring the VCSE have a strong voice within the ICB and ICS development, will strengthen the voice of the diverse communities living across our boroughs. Our VCSE organisations provide crucial community insight into our local diverse populations and we want to build on these skills and relationships so that we systematically work with them to raise the voice of local people in the development of services, population health improvement and supporting local communities to live well.

We commit to working with the sector and our wider partners to:

1. Develop the NCL VCSE Alliance, as well as a strong network of VCSE forums in each borough, with two way information and engagement flow, and creative thinking around how grassroots organisations are involved in our work.
2. Ensure there is representation from the voluntary sector at the ICB and other appropriate governance arrangements, e.g. within Borough Partnership Boards.
3. Develop clear and collaborative processes to directly feed the voice and community insights of the VCSE into ICS and ICB and influence decision-making.
4. Co-develop clear outcomes and evaluation criteria for this VCSE Alliance model, which demonstrate what success looks like and can be measured against.

4.2 Working in partnership with VCSE to design and deliver innovative community-focused and strengths-based models of care

There are stark inequalities across NCL around access to and experience of care, and health outcomes, and we recognise that the current configuration of services and solutions could better meet the needs of our diverse communities. The COVID-19 pandemic has exacerbated the health inequalities faced by some of our communities, and further highlighted ways in which statutory services sometimes do not equally serve our communities, particularly those facing the highest health inequalities and deprivation.

The pandemic has also highlighted the importance of the relationships and support that exist around communities outside of traditional public sector services. The VCSE have been invaluable in supporting the most vulnerable in our communities through the pandemic, and this work continues. The sector mobilised across NCL to deliver medicines and food; when immediate needs had been met, they used this momentum to address the impact on wellbeing, offering befriending services, online coffee mornings, and WhatsApp groups. They worked to share messaging around staying safe, how to access services and supported the roll-out of the vaccine programme.

VCSE organisations across NCL are well-placed to work with our diverse communities to tackle the issues which matter at a neighbourhood level, through community-focused, strengths-based and place-based models of care. They are the experts in understanding that local people are active participants in their own wellbeing and that of their communities (rather than simply recipients of a service), and working with communities to address their needs and priorities. They have unique skills and perspective and many are part of the communities they work with.

In NCL, our VCSE sector is already integral to the design and provision of a wide range of services and solutions that support population health and wellbeing, and create community connections to statutory services. A range of VCSE-led community programmes already exist, some of which are commissioned through the ICB and local councils. These programmes include in-depth community research work to understand the impact of the pandemic, the NCL Health Inequalities Fund and Public Health investments. Many more are resourced through external funders, public fund-raising and community action.

Transitioning to an ICS and ICB presents a unique opportunity to work towards more strengths-based and community-based solutions and services, and to ensure a greater level of engagement, collaboration and mutual support between statutory and VCSE sectors in delivering these. This work will be informed by well-established approaches to working with and commissioning the sector already used by our local authorities, and also by actively seeking innovation.

Looking forward, as an ICB we will create a strategic investment approach to align the multiple opportunities available, support market development of the sector and champion innovation in how we invest and resource. This must enable working with the wide range of grass roots organisations. With the sector experiencing a high level of demand and with capacity constraints, their value and contribution must be recognised and fairly funded.

The ICB will work collaboratively with local authorities to support and champion the VCSE; developing stronger and more informed relationships with the sector.

We commit to working with the sector and our wider partners to:

1. Align community engagement and empowerment programmes for greater impact, including: NCL Health Inequalities Fund, NCL ICB Community Research & Action Programme, Community Connectors, vaccine community engagement programmes.

2. Help develop the plans of our five Borough Partnerships for community engagement and empowerment programmes, ensuring NHS approaches and investment aligns with local councils' current investment in VCSE.

3. Support the sector to collaborate with statutory and mainstream services to ensure diverse communities have access to care in a way that reflects their needs, recognising there are existing pockets of best practice to build on.

4. Develop innovative NHS investment arrangements which support a more preventative and strengths-based approach to delivering care and services, in collaboration with the statutory sector (building on existing work, such as the Health Inequalities Fund).

5. Be proactive in our collaboration with the VCSE sector, to adopt a system-thinking approach to investment in which we collaborate to develop, learn and improve solutions together, ensuring that the VCSE sector play a vital role in providing feedback on behalf of communities and groups.

4.3 Developing investment, procurement and contracting processes that support a strong and thriving VCSE

To achieve the ICS and ICB ambitions around tackling health inequalities, as a system we need to ensure resources are shared equitably and have the most impact, supporting those who are most vulnerable in our community. We also need to ensure local VCSE organisations are in a position to access the multiple opportunities that are now available within the health and social care system, encouraging community-based asset building and resourcing from external funding.

We can enable this by taking some practical steps to facilitate more effective collaboration around investing between the ICB and VCSE. These steps include ensuring that our commissioning and procurement processes do not act as a barrier to delivering innovatively with the VCSE, and that our tender processes are open and transparent, with sufficient lead-in times. We must also develop ICB colleagues' skills and expertise on working with the VCSE from engagement through to strategic investment.

We commit to working with the sector and our wider partners to:

1. Co-design a VCSE Investment Framework with the VCSE Alliance, which reflects and is aligned to Borough initiatives across NCL.

2. Collaborate across the ICB to develop a revised approach to VCSE procurement and contracting, including:
    a. Investment in more preventative and strengths-based approach.
    b. Long-term, sustainable investment for community and strengths-based projects (a minimum of three years) to ensure the work can embed in local communities.
    c. A well-thought through exit process for when funding is not to be renewed/continued. This should be in line with local councils' best practice.

3. Where appropriate, take a 'VCSE first' approach; investing in local NCL VCSE organisations, rather than external consultancy agencies. Where this is not possible, we will seek to fund in partnership with a VCSE organisation.

4. Developing ICB colleagues' skills and expertise in working with the VCSE, from engagement through to strategic investment. This will include staff training and best practice sharing (through the framework).

4.4 Support building infrastructure, resource and expertise across the sector

We commit to supporting the development of this sector; building on VCSE infrastructure and resources at Borough and Neighbourhood level and working with local authorities to ensure a joined-up approach, which aligns with the work they already do in this field.

We commit to sharing best practice through the VCSE Alliance and Borough networks/forums, and to continuing to embed the voice of the VCSE in the ICB's work programmes and governance structures.

We also commit to working alongside a range of organisations that reflects the diversity of our communities; supporting larger strategic VCSE organisations as well as community-focused and driven grass roots organisations.

As part of this work we will support the development of strong VCSE partnerships and collectives across the ICS, to amplify the voices of diverse communities and share skills and resources to the greatest effect.

Given the breadth of work the VCSE sector in NCL undertake, and the size and diversity of the sector, we appreciate the need for a nuanced approach to how we invest in solutions and services and how we understand impact. We will seek advice from the sector, to ensure we are working with the full range of organisations.

We commit to working with the sector and our wider partners to:

1. Support VCSE infrastructure development: a combination of common approaches/principles across NCL, aligned with Borough capacity building for the sector.

2. Support VCSE collaboration and partnership models in NCL to enable organisations within a borough to work together (coordinated through lead organisations, where appropriate)– making it easier to:
    a. be an active partner in Borough Partnerships and ICB programmes,
    b. collaborate on funding bids,
    c. manage contracting processes and sharing of funds across organisations,
    d. share skills and expertise across organisations,
    e. raise the voices of local communities.

3. Deliver annual events / engagement activity with VCSE partnerships to review the investment, priorities and outcomes, to ensure these remain inclusive and aligned to communities' needs.

4.5 Evaluate

We are committed to demonstrating the impact that working with our VCSE has, together with the social value they bring to the health and social care system.

We will establish a shared understanding of the needs of our communities and will continue engaging to measure if the way we are working is supporting a strong and thriving VCSE, and therefore genuinely improving people's experiences of care and supporting our communities to live good quality lives.

We will involve stakeholders such as Healthwatches and VCSE partners, and our local communities to define outcomes and assess our delivery of these. We commit to learning from innovative best practice around community research and evaluation models.

We will study current work underway nationally to develop local ways of measuring the long-term financial (positive) impact of investing in strength-based models and understand that we may need to invest more initially to see outcomes later.

We commit to working with the sector and our wider partners to:

1. Evaluate the impact of our community work, learning from previous projects to continuously improve the reach and impact of our work with local communities.

2. Work across the NCL ICS to share research skills and insights and support VCSE to gather robust data, evidence and evaluation.

3. Establish processes to centrally collect and report on insights to inform ICS and ICB plans, programmes and ultimately decisions, including the development of an Insights Bank.

4. Develop outcomes frameworks which are community-led.

5. Conclusion

Strengthening the way we work in partnership with the VCSE sector will help us achieve the aims of the NCL Population Health Improvement Strategy, to improve local communities' health and wellbeing and tackle inequalities.

This strategy has been developed with input from a wide range of stakeholders and reflects existing best practice, but also barriers identified as critical to tackle, to shape our future working with the VCSE sector. The Strategy build on the strong foundations already in place in each borough and a crucial part of delivery will be through the five Borough Partnerships, working with local VCSE and Councils. Delivering the aims of this Strategy will require resource in both funding and staff, and collaborative approaches across partner organisations.

The ambitions outlined here will require long-term commitment and we will start putting the strategy into action in 2022/23. A delivery plan for 2022/23 will be developed, involving our VCSE, ICS partners, and Borough Partnerships and ICB staff. This delivery plan will be reviewed and refreshed annually.

Work in 2022/23 will include, but is not limited to, the following:

- Developing a strategic approach to ICB investment in the VCSE sector;
- Developing a VCSE Investment Framework with the VCSE Alliance, which incorporates best practice VCSE contracting and procurement processes;
- Building on and developing Borough Partnership's community engagement and VCSE partnership plans, including effective processes to share insight and learning between borough-level VCSE forums and the NCL VCSE Alliance and developing VCSE involvement in priority setting and plans;

- Supporting the development of VCSE collaboration / partnership models in NCL to enable organisations within a borough to work together;
- Training for ICB staff on best community engagement and empowerment practices and on how to work with the VCSE.

If you would like to receive information included in this document in another format, or have any questions on this document, please contact the NCL ICB communications and engagement team via nclicb.communications@nhs.net

NHS
North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
27 September 2022

Report Title	Integrated Performance & Quality Escalation Report	**Date of report**	14 September 2022	**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	Richard Dale, Executive Director of Performance and Transformation Dr Chris Caldwell, Chief Nurse				
Report Author	Deirdre Malone Director for Quality (Interim) Ed Nkrumah, Director of Performance	**Email / Tel**		Deirdre.malone@nhs.net edmund.nkrumah@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 Integrated Performance & Quality Escalation 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. The report focusses on key pathways: • Mental Health (slide 3) • Planned/Elective care (slide 4) • Cancer Services (slide 5) • Urgent Emergency Care (slide 7) • Community Health & Primary Care Services (slide 10) As well as the three organisations in System Oversight Framework segment 3: • NMUH (slide 11) • Royal Free Group (slide 11) • Tavistock and Portman (slide 12)				

	This report, also provides an overview on key quality areas; COVID Vaccination Programme, Ockenden/Maternity and Sickle Cell Disease. The analyses includes a high level overview of actions being taken to address key changes and risks that are set out in the report, alongside detail on work undertaken to ensure the quality and safety of services where performance is falling outside expected targets. The 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 System Oversight Framework, Operational Plans, Long Term Plan and NHS Constitutional Standards. This is a new format of integrated quality and performance report, in line with the establishment of the ICB as a statutory organisation and close working of the ICB Performance and Quality teams. The report will continue to be developed in line with feedback from the board and stakeholders. With the aim of developing reporting based on outcomes alongside process measures, based on the NCL Outcomes framework which is still in development.
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: • PERF7 Failure to manage surges during heightened periods of pressure (including winter, Easter and other Bank Holidays) and impact on waiting time standards and capacity for elective pathways • COMM14 Failure To Achieve NHS Constitutional Targets - Urgent and Emergency Care (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 escalation report is underpinned by the Quality Report to the Quality & Safety Committee and the monthly 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 of quality and performance 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

Integrated Performance & Quality Escalation Report

September 2022

Report to the NCL ICB Board of Members

Authors;

NCL ICB Performance & Quality Teams

Executive Summary

The Integrated Performance & Quality Escalation 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.

The report focusses on key pathways:

- Mental Health (slide 3)
- Planned/Elective care (slide 4)
- Cancer Services (slide 5)
- Urgent Emergency Care (slide 7)
- Community Health & Primary Care Services (slide 10)

As well as the three organisations in System Oversight Framework segment 3:

- NMUH (slide 11)
- Royal Free Group (slide 11)
- Tavistock and Portman (slide 12)

This report, also provides an overview on key quality areas; COVID Vaccination Programme, Ockenden/Maternity and Sickle Cell Disease.

The analyses includes a high level overview of actions being taken to address key changes and risks that are set out in the report, alongside detail on work undertaken to ensure the quality and safety of services where performance is falling outside expected targets. The 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 System Oversight Framework, Operational Plans, Long Term Plan and NHS Constitutional Standards.

This is a new format of integrated quality and performance report, in line with the establishment of the ICB as a statutory organisation and close working of the ICB Performance and Quality teams. The report will continue to be developed in line with feedback from the board and stakeholders. With the aim of developing reporting based on outcomes alongside process measures, based on the NCL Outcomes framework which is still in development.

As an ICB we define quality through the concept of the quadruple aim – an equal and simultaneous focus on continuous improvement of safety, effectiveness and experience of individuals' care; system working to improve population health; cost effectiveness of care; and the experience and effectiveness of our staff involved in the provision of care.

In creating an integrated quality and performance report we are taking the first step toward our new vision, using the System Oversight Framework (SOF) to systematise both reporting and monitoring progress. Future reports will seek to integrate the ICB/ICP population health strategy and we will seek to embed learning as we go using quality improvement methodology.

The ICB Performance and Quality functions work collaboratively together to ensure the management of clinical risk and reduction of harm remains central to the performance management. This escalation report is underpinned by the Quality Report to the Quality & Safety Committee and the monthly Performance Report shared across the organisation and system.

Full Dashboards of quality and performance measures, and a glossary of terms used in this report are set out in the appendix for reference.

Mental Health Services

North Central London
Integrated Care Board

Improving Access to Psychological Therapy (IAPT) is a key priority for NCL. Approximately 9,000 residents accessed IAPT services across the sector in the first quarter of 2022/23, against an access target rate of 10,650 each quarter. Performance has been impacted by staff shortages and increased complexity in patients' clinical presentations. NCL ICB and providers are working together to ensure that additional capacity is commissioned from the voluntary and community sector, and digital providers to increase capacity. Additionally, the rollout of wellbeing outreach sessions which commenced during the last quarter of 2021/22 is expected to positively impact performance during 2022/23.

Waiting times to first treatment and recovery rates continue to exceed national ambitions at 87% (75% national ambition within 6 weeks, and 51% respectively (national ambition for recovery is 50%)

In quarter of 2022/23, 1058 **Out of Area Placement** (OAP) bed days were utilised against a plan of 1189. Key actions to reduce reliance on out of area beds include

- improving discharges including 7-day working,
- rapid access to enablement pathways,
- alternative housing options for people who are 'fit for discharge', and
- enhanced psychological therapies with support for high intensity users.

There has also been investments in the Oaks Ward to reduce reliance on OAPs as an interim measure.

Under normal circumstances, it is Trust policy to place in providers that are rated by the CQC as either Outstanding or Good however, in times of extreme capacity challenges, a risk assessment is undertaken based on the risks to the patient if they were to remain in the community.

NCL is performing well against the three metrics relating to the reduction of the number of residents with **Learning Disability/Autism** in inpatient facilities and expects to achieve year end targets for 2022/23. The Provider Collaborative continues to lead on the 6 weekly visits, with support from commissioners to manage of lengths of stay to reduce discharge delays. Care, Education and Treatment Review recovery action plans are in place to ensure specific needs of children and young people are met.

	April '22	May '22	June '22
IAPT Access *[Target: 3550]*	2855	3185	2735
Out of Area Placements *[Target: 1018 Bed Days]*	547	363	148
LD/Autism Inpatients (ICS) *[Year end target: 22]*	22	26	27
LD/Autism Inpatients (NHSE) *[Year end target: 16]*	16	17	17
LD/Autism Inpatients(<18yrs) *[Year end target: 5]*	9	8	7

Planned Care Services – RTT & Diagnostics

North Central London Integrated Care Board

The ICS has made significant progress towards eliminating the number of patients waiting more than 2 years to start treatment with the remaining cases (3) attributable to patient choice.

The ICS is also on track to eliminate all 78 week waiters ahead of the national target date of March 2023. An 80% reduction in this cohort was seen in the 12 months to August 2022. The total waiting list and 52 week breaches, however, remain relatively stable in recent months. Against the operational plan target to deliver 104% of elective activity reduce backlogs, NCL continues to out-perform other London systems with performance of between 101% and 107% in August 2022.

The NCL Elective Recovery Programme details the key interventions to reduce waiting times for patients under the following themes;

- **Referral optimisation** – ensuring GP referrals are managed by the most appropriate services and care settings first time.
- **Improving productivity** – improving the utilisation of theatres, outpatient clinics, and adoption of clinical best practice pathways
- **Increasing capacity** – securing additional sessions to deliver more appointments and procedures (including outsourcing),
- **Outpatient transformation** – adopting innovative ways to deliver outpatient care including digital and patient initiative follow-ups
- **Mutual aid** – reducing inequity in access through sharing of resources and redistribution of demand

The waiting list for diagnostic tests and the proportion waiting more than six weeks (backlog) has been stable in recent months at approximately 40,000 and 20% respectively. Key focus is on imaging and endoscopy which account for two-thirds of the total diagnostic backlog. Providers have developed short to medium term plans to further increase activity to reduce the backlog including waiting list initiatives, recruitment and outsourcing, to complement the ICS diagnostic programme which is delivering additional capacity through the two Community Diagnostics Centres. Activity levels relative to 2019/20 baseline stood at 109% in August 2022.

	June '22	July '22	August '22
RTT 104ww (cases waiting)	15	8	3
RTT 78ww (cases waiting)	1012	859	750*
RTT 52ww (cases waiting)	8099	7984	8100*
RTT Waiting List (Total cases waiting)	248,104	251,048	245,000
Elective Activity (% of 2019/20)	105%	101%	101%
First Outpatient Activity (% of 2019/200	108%	103%	107%
Diagnostic Activity (% of 2019/20)	111%	102%	109%

** Provisional data subject to further validation*

Planned Care Services – Cancer (1/2)

North Central London Integrated Care Board

Performance of cancer services remain variable. The number of missing cancers continues to reduce with an increasing number of treatments delivered each month. Challenges in the diagnostic phase of the pathway have, however, adversely impacted waiting times and performance against the 28-day Faster Diagnosis Standard. The number of suspected cancer patients more than 62 days on cancer waiting lists stood at 908 at the end of August 2022 – no material change on previous month and almost double the expected volume of 488 by end of March 2023. Faster diagnosis standard performance for July 2022 was static. Breast surgery, lower GI, and skin tumour groups continue to account for most the variance, coupled with temporary administration staffing shortages across teams.

The NCL Cancer Alliance is leading a transformation programme aimed at optimisation capacity and streamlining demand through alternative pathway for breast surgery services. Work is also underway to implement Teledermatology services within suspected skin cancer services in line with national guidance to optimise the limited capacity within dermatology services in NCL.

Individual Trusts are also putting plans in place to increase capacity (breast radiologist, dermatologist and endoscopy) to deliver improvements on a sustainable basis. Provisional data for early September also shows improvements partly attributable to data cleansing by waiting list administrators. To tackle the recurring administrative workforce shortages which adversely impacts on waiting list management, providers are undertaking details analyses of their establishment to ensure they match demand.

In response to a request recently received from NHSE London Region, the ICS cancer recovery plan is being refreshed including a revised backlog trajectory that still meets the national backlog reduction plan by March 2023 (i.e. return to pre-pandemic levels). The letter from NHS London Executive Director of Performance was instigated by the lack of improvement in backlog position at a system level. The plans and revised trajectories to be finalised by the end of September will focus on key actions in most challenged tumour groups and Trusts, where they are not already in place. Improvement actions in diagnostic services to underpin pathway improvements will also be included.

	May ’22	June ’22	July ‘22
Cancer 62-Day Backlog *[488 year end target]*	881	934	907
Cancer Diagnosis (FDS) *[July target – 72%]*	68%	69%	69%
Cancer Treatments *[July target - year end target]*	723	714	739

Planned Care Services – Cancer (2/2)

North Central London
Integrated Care Board

The NCL Standard Operating Process (SOP) for reporting breaches, including a clinical harm review, was finalised in November 2021. The SOP outlines a three stage process however it was agreed in March 2022, following enormous pressure on Trust cancer pathways, that the implementation of stages 2 and 3 continues to be placed on hold and the position will be re-reviewed in September 2022.

Therefore the current process in place remains to be for all Trusts to provide a quarterly high-level presentation to the NCL Cancer Performance Leadership Group for all patients that breach 62 and 104 days. The presentations are mandated to include an outline of the provider's clinical harm and breach governance process, an overview of clinical harm and breaches that occurred during the quarter and a summary of key themes, learning and actions to be taken forward. This agreed process embeds a process for shared learning, action and review of harm across our system.

The latest presentations for Q4 21/22 were received in June 2022.

Quarter 4 21/22 Breach Report Analysis (June 2022)

	62 day breaches reported	No of 62 day breaches reviewed for harm	Harm indicated
NMUH	124	61*	No harm
RFL	249	249	2 x moderate
RNOH	3	3	3 x low
UCLH	94	94	No harm
WH	36	45*	No harm
NCL Total	**506**	**452**	**5**

*Some providers experience an internal delay in receiving completed reports therefore there may be a surplus or deficit when compared to the breaches reported quarter on quarter.

Urgent & Emergency Care Services

North Central London
Integrated Care Board

Performance against the 4-hour A&E target in NCL during July 2022 was consistent with previous months at approximately 70%, and 71,000 attendances which was a 3% reduction on previous month and in line with the same period in the previous year. All NCL providers continue to experience significant pressures due to high acuity of patients, increased complexity of discharges and staff shortages leading to long lengths of stay, high levels of medically optimised patients and ambulance handover delays. Barnet and North Middlesex Hospitals remain the most challenged sites in NCL.

There is a renewed focus on a systematic approach to service improvements through the NCL UEC Flow Board. Key provider and system actions are as follows;

- Ensuring maximum utilisation of the Integrated Discharge Teams to support discharges
- Integrated Care Escalation single point of access hub remains open to referrals to support maximum utilisation of system-wide available community capacity.
- Increasing community stepdown beds, virtual wards, and admission avoidance pathways including of Rapid Response teams.

NCL has secured a funding bid to NHSE to increase capacity across the system though winter. The individual schemes are currently being reviewed and prioritised based on potential impact and deliverability. These will focus on ensuring flow through hospital sites including reducing length of stay, capacity in primary care and escalation beds at acute sites.

Following a national IT system outage in the NHS 111 service (provided by LCW) significantly impacted service delivery evidenced by the high calls abandonment rates (22%). LCW is working under manual business continuity processes whilst a phased restoration of the IT service is progressed. Improvements are expected from September .

In a letter issued in early August 2022, NHSE asked ICSs to develop plans to rapidly increase UEC capacity and resilience ahead of winter which will be aligned with Board Assurance Frameworks with assurance conducted by NHSE regional teams. The plan which covers workforce, discharge and admission avoidance is due to be submitted on 26 September along with trajectories for 6 nationally defined UEC metrics which will be monitored closely as a system priority.

	June 22	July 22	August 22
A&E 4-hour Waits *[National target – 95%]*	69%	68%	71%
Long Lengths of Stay (>21 days) *[Year end target – 380]*	556	538	520
Ambulance Handover Delays (>60 mins) *[Number of occasions over 60 mins]*	753	973	675
111 – Calls Abandoned *[National target <5%]*	18%	18%	22%
Number of 12 Hour Trolley Breaches *[From a decision to admit]*	972	1168	956

Urgent & Emergency Care Services – Safety focus areas

NHS North Central London Integrated Care Board

North Middlesex University Hospital (NMUH)

Ambulance handovers are currently rated as 20 on the Trust's Corporate Risk Register (August Trust Board Papers). Root causes of handover delays relate to delays discharging patients that are medically fit to be discharged. The Trust is working with system partners to refocus attention on timely discharge of patients, reducing the need to open escalation beds, reducing ambulance handover delays and 12 hour breaches within the ED.

Providing high quality, safe care is a key priority within the department with the Trust working collaboratively with the wider system, and internally to improve processes. Safety actions include; ensuring robust action focused Multi-Disciplinary Team (MDT) safety huddles occur two hourly in ED; ambulance handover delays are minimised and clinical handover is taken as soon as possible; staffing levels are planned to manage expected peaks in attendances. The wellbeing of the entire ED Team across all disciplines is a key area of focus for the Trust.

The CQC conducted an unannounced visit to the ED at the end of July 2022. The CQC have not yet published the outcome of this visit.

NMUH have seen an increase in the **number of patients waiting over 12 hours from a decision to admit to admission** in recent months. The majority of these patients waited for an inpatient bed for physical health reasons.

The reason for this includes very high bed occupancy of over 100% (due to continued significant use of escalation areas), very high proportion of available acute bed base occupied by patients with a length of stay of over 7 days and significant variation in daily discharge profile.

Actions include a focus on early senior review for all patients in ED with two medical consultants available in the department every morning, a review of all learning related to Mental Health 12 hour breaches discussed at the joint BEH MHT/NMUH Executive Meeting, Patient First focused improvement work on the care of the elderly wards to improve discharge time, a system wide programme of work to reduce the number of medically optimised patients and ongoing weekly clinical long length of stay multi-disciplinary review meetings.

Urgent & Emergency Care Services – Safety focus areas

NHS North Central London Integrated Care Board

Royal Free London (RFL)
The Trust have completed a number of rapid reviews identifying challenges in ED contributing to **continued delays with ambulance handovers**. Contributory factors, include large numbers of ambulances arriving in short time period, patients with Covid and limited isolation space, minimal flow out of the emergency department, difficulty discharging medically optimised patients and supporting patients with mental health illness in ED.

Actions taken include, the senior management team supporting flow when the department is at capacity, or has reached particular trigger point and an improved escalation process in place. Observations are completed hourly when handover is delayed, to ensure patients are safe and any deterioration is identified and escalated.

When an extended length of stay or handover delay results in a safety incident it will be reported and managed in line with the Trust's process for managing incidents. Any incidents that result in moderate or severe harm are reviewed at the relevant site based SIRP (safety incident review panel). All other incidents are reviewed via the divisional Quality and Safety board.

Community Health & Primary Care Services

North Central London Integrated Care Board

The waiting times for children and young people (CYP) and adult community services continues to improve steadily as represented by the marginal increase in the proportion waiting less than 18 weeks, and the reduction in the waits of 52 weeks in the table on the right. Service improvements are driven by a range of actions including waiting list validation, prioritisation of resources, and mutual aid with MSK, diabetes, podiatry and respiratory services identified locally as high priority. There is ongoing work to improve timeliness of data reporting also.

Adjusted for working days, the trend for primary care access improved marginally in July 2022 relative to previous months' average approximate 550k appointments. GP Practices continue to offer more face-to-face appointments as a proportion of all appointments. In July 2022 59% of appointments were face-to-face, up from 50% in July 2021, and 50% as same day appointments. The Extended Access Hubs cover urgent out-of-hours primary care appointments for practices, and for NHS 111 to book patients into on weekday evenings, Saturday evenings, Sundays and Bank Holidays.

Improvement in the number of health checks for residents with Serious Mental Health Illness (SMI) is expected during 2022/23 following investments made across NHS Trusts, primary care and voluntary sector teams in all boroughs to increase capacity. Initiatives include peer support and community outreach programmes in all boroughs to support individuals with access and follow up. Additionally, UCL Partners has been commissioned by the ICB to develop a strategic plan for improving physical health outcomes for people with SMI, including performance against this KPI and the critical follow-up activity which occurs after the health check is completed.

Annual health checks for residents with learning disability/autism are progressing steadily at a rate exceeding the ICB's operational plans.

The national ambition to ensure 67% of estimated dementia cases are diagnosed and reported of GP systems continues to be met by NCL. This ensures patients can be supported appropriated in primary care.

	May 22	June 22	July 22
Waiting Times % <18 weeks (CYP)	72%	73%	74%
Waiting Times >52 weeks (CYP)	36	15	12
Waiting Times % <18 weeks (Adults)	85%	85%	86%
Waiting Times >52 weeks (Adults)	136	110	41
Total GP Appointments *[2019/20 mthly avg.– 500k]*	580k	540k	589k
LD Health Checks *[Year end target – 27%]*	9%	13%	15%
SMI Health Checks *[Q1 target – 10142]*		10,142 Q1 Actual	
Dementia Diagnosis *[National Target -67%]*	69%	69%	69%

System Oversight Framework - Segment 3 Organisations

NHS North Central London Integrated Care Board

Royal Free London (RFL)

System Oversight Framework (SOF) arrangements are in place to support RFL's exit from Segment 3 of the national framework. Key areas requiring improvements with NHSE and ICS support are finance and UEC, cancer and RTT. A jointly agreed Exit Criteria specifying the trajectories underpinning improvement plans for exiting Segment 3 is being closely monitored with an emphasis of sustainability, system-working and relative improvement. Serious incidents, clinical harm reviews and significant quality alerts that relate to the SOF3 areas are discussed as part of the regular meetings.

Plans to improve UEC performance are in place although performance remains challenging, reflecting NHS-wide capacity constraints. Through robust management and escalation arrangements particularly at Barnet Hospital, the Trust's plans to reduce waits in department, long lengths of stay, medically optimised patients occupying beds and ambulance handover delays.

In relating to RTT, the Trust has delivered against the plan to eliminate 104 week waiters with the exception of 2 cases relating to patient choice. Equally, good progress is being made to eliminate 78 week waiters by March 2023. The ICB is awaiting the Trusts recovery plan which will detail the key interventions to deliver against plan to reduce 52 week waiters. This will include system support through mutual aid and the impact of ICS transformation programmes.

The Trust is delivering against trajectories for cancer 28-day Faster Diagnosis Standard and 104 day waits – one of the proxy measures for clinical risk. Refreshed plans are being developed to address to 62-day backlog which, remains high due to limited capacity to facilitate diagnostic phase of the pathways.

North Middlesex University Hospital (NMUH)

NCL ICB has agreed an approach to SOF arrangements similar to RFL. This includes a quarterly joint oversight meeting for RFL and NMUH chaired by the ICB CEO, partly in recognition of the existing partnership between the two organisations. Key areas requiring improvements with NHSE and ICS support are finance and UEC and RTT.

UEC performance remains challenged, due to increasing demand and capacity constraints relating to beds, and workforce. Trust plans focus on a wide range of initiatives including implementation of alternative pathways at the front door (same Day Emergency Care), use of virtual wards, improvements in internal processes to expedite discharges.

In relation to cancer performance NMUH was been placed in Tier 1 (national oversight) in addition to SOF segment 3 regime. The ICB is therefore working closely with NHS London, NHSE National, NCL Cancer Alliance to ensure the Trust is supported adequately to develop and deliver an sustainable improvements particularly in the diagnostic phase of the more challenged services - colorectal and urology. These plans are being complemented by system level transformation programmes relating to breast surgery and dermatology.

System Oversight Framework - Segment 3 Organisations

North Central London Integrated Care Board

Tavistock & Portman

In February 2022 the trust was moved into the category 3 in the NHS England System Oversight Framework (SOF), this is defined as “Co-ordinated support package and enhanced oversight required”.

Monthly SOF meetings commenced in March 2022, with an emphasis on the development of workstreams that align with the criteria for SOF3 set by NHS E/I namely, service and quality improvements, governance and finance.

An independent review into the provision of Gender Identity Services for children and young people in England has recommended the closure of the service provided by the Trust by Spring 2023. These services will be provided by a number of hubs across the country. Great Ormond Street Hospital for Children FT will partner with the Evelina London Children’s Hospital, which is run by Guy’s and St Thomas’ FT, and South London and Maudsley FT, to provide an “early adopter service” in the South.

The Trust commissioned an external review of its governance structures in 2021, and have restructured all committees following the recommendations set out in the review, strengthening leadership, governance and accountability to ensure that the Board are sighted on key risks.

As part of the SOF 3 process, we are working closely with both the Trust and National and Regional Colleagues to support the identification of interim solutions for waiting list management. As well as mobilising peer support across the other areas of the SOF criteria. As part of this support, we have identified a Clinical Director of Transformation to provide intensive support to help achieve improvement and service transformation.

We will continue to work closely with the trust to support, coordinate and oversee the programme of improvements in line with these criteria through the coming year.

COVID Vaccination Programme

North Central London
Integrated Care Board

Within North Central London (NCL) we have delivered 3,128,951 vaccinations as of 17 August 2022. These vaccinations have been given to patients, care home residents/staff and health and social care workers. This significantly contributed to the national target of vaccinating 90% of the adult population of England.

Within NCL, we have administered 1,053,465 first doses, with 80% uptake rates within our over 50s, clinically at-risk and Health and Social Care worker populations. We have administered 982,891 second doses, 716,243 booster vaccinations and 68,942 second booster vaccinations.

We continue to engage our vaccine hesitant and hard to reach groups to further increase uptake across patients and staff in all settings. We are also delivering first and second dose vaccinations to our younger cohorts, including 12-15 year olds and 5-11 year olds (clinically extremely vulnerable). In order to maximise the vaccination of these populations, we are delivering through our existing vaccination sites, as well as offering vaccinations in alternative settings such as community pop-up sites, education settings (such as universities, colleges and schools) and specialist paediatric clinics.

Quality Key Area of Focus: Maternity & Ockenden Review

North Central London Integrated Care Board

Maternity & the Ockenden Report

The interim Ockenden report into maternity care at Shrewsbury and Telford Hospital published in December 2020, identified seven immediate and essential actions (IEAs) that all maternity services were required to implement, to improve safety and outcomes for women and families. A regional quality assurance and peer review process was undertaken to determine the level of compliance for the seven IEAs in December 2021. Our four maternity providers across NCL continue to work towards achievement of full compliance against the EIAs, supported by the Local Maternity and Neonatal System (LNMS). Recurrent national funding has been made available for all maternity services to support standards and enable sustained change and improvement across the system. The London Regional maternity team are undertaking a series of Insight visits to maternity units from May 2022 onwards (UCLH – 17 May 2022, WH – 27 June 2022, NMUH – 12th August 2022. RFL scheduled for 19 September 2022). These visits include the Local Maternity and Neonatal Systems (LMNS) and will continue on an annual basis. It is expected from 2023, Integrated Care System Boards, through its LMNS will lead this process, with support from Regional Maternity Teams.

Quality and performance of our four maternity units is monitored through the North Central London Local Maternity and Neonatal System (LMNS), co-chaired by a Consultant Obstetrician.

Our Health and care organisations in NCL, have been working together on a long-term programme looking at children and young people's, maternity and neonatal services, called Start Well. The programme is focused on the delivery of planned and emergency care for children and young people, and maternity and neonatal services across NCL, as well as links with specialist providers.

Next steps

The Ockenden review recommended the role of the Independent Senior Advocate (ISA) to strengthen how families are listened to, driving quality in maternity and neonatal services and addressing health inequalities in the local community. NHSE are offering LMNS an opportunity to participate in a six month pilot and evaluation of this new funded role, ahead of the England-wide roll out of this role from 2023/24 onwards.

'Findings, Conclusions and Essential Actions from the Independent Review into Maternity Services at Shrewsbury and Telford Hospital NHS Trust' was published in March 2022 and includes a further 15 IEAs for maternity services. NHSE/I will await the outcome of an independent review into East Kent NHS Trusts to enable a unified approach and response to both reports. Trusts have started local gap analyses in the interim.

Quality Key Area of Focus: Sickle Cell Disease

North Central London Integrated Care Board

NCL Integrated Care System (ICS) Sickle Cell Disease (SCD) Improvement Work

NCL ICS has been working in partnership with commissioners at NHSE to deliver acute support to patients with Red Cell Disorders, such as Sickle Cell and Thalassemia. Recent improvement work in NCL includes:

- Network wide educational sessions focusing on SCD and thalassaemia. Patients with SCD participated in these sessions, sharing their experiences of care. A matron for SCD shared experiences of people accessing care and support in the community.
- Rolling "bite sized" teaching programme available pan network – aimed at nursing and other allied health professionals to teach basics of managing red cell patients.
- Children and Young person community event was held at White Hart Lane organised by the paediatric teams across all three hospital trusts at the end of June. https://www.uclh.nhs.uk/news/supporting-young-people-sickle-cell-tottenham-hotspur
- Health Education England (HEE) Training resources on SCD were promoted and shared with NCL GPs via NCL GP website at the end of July. https://gps.northcentrallondon.icb.nhs.uk/news/help-close-the-sickle-cell-patient-gap

NCL ICS are active participants of the NHSE-led London-wide and national SCD improvement programmes.

UCL Provider Alliance has set up a local programme, working collaboratively across our system with the North Middlesex University Hospital (NMUH) Chief Executive Officer as SRO. This work is being supported by the ICB Quality lead for SCD is being overseen by North Central London ICS's Chief Nurse.

An NCL SCD combined improvement plan is in development aimed at accelerating evidence of improvement in the experience of our local people with SCD, co-produced with the Red Cell Network. It was presented at a Red Cell Network Meeting on 09 September and there will be an update at the ICB Executive Management Team meeting in October.

A joint commissioner (NHSE/NCL ICB) insight re-visit to NMUH is scheduled for 16 September 2022. The purpose of the visit is to review the actions since the last Insight visit in 2021, and receive an update on the implementation of Care Quality Commission (CQC) recommendations following the inspection of SCD services in August 2021.

Appendix 1 - NCL ICS Overview of Quality Metrics

North Central London Integrated Care Board

Domain	Standard	Target	Apr-22	May-22	Jun-22	Jul-22
Safe	Serious incidents reported by NCL Providers*	N/A	13	19	16	15
	Never Events reported by NCL Providers*	0	2	1	1	2
	NCL Providers % of incidents causing harm (low-severe)	N/A	25.7%	24.5%	23.1%	
	VTE Risk Assessments	95%	*Data collection currently suspended*			
	NCL number of Cdiff	58**	30	33	14	
	NCL number of MRSA (hospital onset)	0	0	1	0	
	NCL number of MRSA (community onset)	0	0	1	1	
Caring	FFT respondents that would recommend - A&E; all NCL providers	90%	78%	77%	77%	
	FFT respondents that would recommend - Inpatients; all NCL providers	90%	93%	94%	94%	
	FFT respondents that would recommend - Mental Health; all NCL providers	90%	87%	87%	89%	
	FFT respondents that would recommend - Outpatients; all NCL providers	90%	92%	92%	92%	
	Mixed Sex Accommodation Breaches; all NCL providers	0	23	34	43	
Effective	A&E 12 Hour Breaches – Physical & Mental Health; all NCL providers	0	756	818	972	1168
	Cancelled Ops % rebooked within 28 days; all NCL providers	100%	Q1 22/23 81.4%			
	NCL SHMI - reporting year 2021/2022	>=1	0.86			
Well-Led	Number of inappropriate Out of Area Placements bed days	0	547	363	148	
	NCL Providers in Enhanced Surveillance	N/A	3	3	3	

*as reported in month on STEIS
**threshold to date (all NCL providers)

NB – data collection timetables vary by metric therefore some metrics will be available sooner than others

Appendix 2 – NCL Mental Health Dashboard

15 - North Central London ICS - Mental Health LTP/ICS Trajectories (Monthly)		TARGET 2021/22	2021/22									TARGET 2022/23	2022/23		
			July	August	September	October	November	December	January	February	March		April	May	June
Summary of Monthly Measures	IAPT access	25.0%	18.4%	18.6%	18.6%	18.5%	18.7%	18.8%	18.9%	18.8%	17.1%	42,600	34,000	34,375	TBC
	IAPT recovery rate	50.0%	50.0%	49.0%	52.0%	50.0%	50.0%	48.0%	51.0%	48.0%	49.0%	50.0%	50.0%	51.0%	TBC
	IAPT first treatment 6 weeks finished course rate	75.0%	90.0%	91.0%	91.0%	88.0%	89.0%	89.0%	88.0%	88.0%	87.0%	75.0%	88.0%	87.0%	TBC
	IAPT first treatment 18 weeks finished course rate	95.0%	98.0%	98.0%	99.0%	97.0%	98.0%	99.0%	99.0%	99.0%	99.0%	95.0%	99.0%	99.0%	TBC
	CYP access - One contact	22,234	15,640	15,740	15,860	15,770	15,700	15,655	15,715	15,765	15,885	23,291	15,790	15,910	TBC
	Dementia diagnosis rate 65+	66.7%	69.7%	69.4%	69.2%	69.4%	68.9%	68.8%	68.4%	68.8%	68.7%	73.0%	68.7%	68.8%	68.9%
	EIP entering treatment - treatment received <2wks	60.0%	73.0%	74.0%	74.0%	75.0%	68.0%	72.0%	67.0%	77.0%	83.0%	60.0%	88.0%	82.0%	TBC
	Number of inappropriate OAP days In period	0	348	264	339	83	180	391	350	253	436	0	547	363	148
	1 hour response time %	95.0%	90.1%	91.7%	91.7%	92.8%	94.0%	96.9%	96.1%	96.3%	93.3%	95.0%	93.3%	92.8%	93.3%
	24 hour response time %	95.0%	97.3%	96.7%	96.5%	96.8%	95.3%	97.8%	94.0%	95.6%	97.0%	95.0%	94.0%	94.9%	95.4%
	Women accessing perinatal mental health (PMH)	8.6% (Y/E)	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.1%	5.1%	2,002	1,030	1,060	TBC
	Learning disabilities - adult inpatients (ICB Commissioned)	24	n/a	n/a	34	n/a	n/a	21	n/a	n/a	22	22	22	26	27
	Learning disabilities - adult inpatients (NHSE Commissioned)	16	n/a	n/a	19	n/a	n/a	19	n/a	n/a	18	16	16	17	17
	Learning disabilities - CYP inpatients	7	n/a	n/a	4	n/a	n/a	4	n/a	n/a	12	5	9	8	7
	Learning disabilities - annual health checks	75% (Y/E)	15.5%	19.9%	25.4%	31.1%	37.7%	43.8%	50.8%	60.7%	69.8%	5,282 (75%)	147 (2.2%)	586 (8.7%)	1,012 (14.8%)
	MHSD - Data Quality Maturity Index Score	80%	76.2%	74.8%	74.4%	68.0%	69.3%	70.2%	67.8%	68.0%	74.7%	90%	75.7%	TBC	TBC
	Adult mental health inpatients receiving a follow up within 72hrs of discharge	80%	71.4%	70.2%	72.0%	73.6%	72.9%	71.0%	76.0%	79.0%	76.0%	80%	77.0%	80.0%	TBC

Appendix 3 – NCL Acute Dashboard

1 - NHS NCL ICB - Selected Acute Services		2021/22									2022/23		
		July	August	September	October	November	December	January	February	March	April	May	June
Urgent care	*A&E attendances plan*	*72,545*	*67,255*	*68,236*	*75,247*	*75,642*	*78,905*	*77,803*	*73,006*	*77,544*	*70,062*	*73,413*	*72,461*
	A&E attendances	70,729	64,756	70,071	72,098	68,301	62,021	62,494	62,040	74,041	67,867	75,335	73,557
	4 hour performance (95% Target)	82%	81%	78%	73%	74%	73%	73%	72%	71%	72%	71%	69%
	12 hour waits	53	77	85	118	273	375	661	639	1,144	756	818	972
	LAS Conveyances	7,968	7,483	7,037	7,168	7,374	7,295	7,396	6,938	7,117	7,124	7,555	6,898
	Ambulance handovers 30 min+	2,150	1,952	2,304	2,722	2,686	2,763	2,730	2,607	2,985	2,319	2,379	2,493
	Ambulance handovers 60 min+	379	331	497	802	766	817	825	758	1,045	576	608	753
RTT	*RTT Admitted Pathways plan*	*n/a*	*n/a*	*n/a*	*8,021*	*9,000*	*8,058*	*8,579*	*8,536*	*9,375*	*6,956*	*7,848*	*8,215*
	RTT Admitted Pathways	8,471	7,262	7,504	7,788	8,602	6,325	6,924	7,516	8,070	6,923	8,419	7,588
	RTT Non-Admitted Pathways plan	*n/a*	*n/a*	*n/a*	*34,154*	*37,543*	*34,642*	*36,398*	*36,420*	*40,413*	*33,899*	*37,656*	*36,868*
	RTT Non-Admitted Pathways	35,924	31,266	36,744	36,093	41,518	33,478	36,668	36,707	41,518	35,004	41,004	36,938
	Total referrals plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*68,561*	*75,459*	*73,414*
	Total referrals	65,091	59,560	63,661	64,433	67,760	59,310	65,371	66,293	77,027	64,786	72,772	67,843
	New RTT Pathways (Clockstarts) plan	*n/a*	*n/a*	*n/a*	*60,809*	*62,502*	*57,259*	*59,386*	*56,926*	*64,825*	*53,853*	*59,540*	*57,426*
	New RTT Pathways (Clockstarts)	n/a	n/a	n/a	55,571	60,882	49,814	54,516	55,534	64,047	54,513	62,373	57,711
	RTT incompletes plan	*n/a*	*n/a*	*n/a*	*230,915*	*235,064*	*236,265*	*238,853*	*239,807*	*240,624*	*251,276*	*250,657*	*250,487*
	RTT incompletes	221,287	220,952	227,167	231,163	232,608	236,685	236,620	239,068	240,641	244,429	245,881	248,104
	52+ waits plan	*n/a*	*n/a*	*n/a*	*12,034*	*10,609*	*10,269*	*10,594*	*9,663*	*10,204*	*8,393*	*7,285*	*7,085*
	52+ waits	12,333	11,566	11,773	11,367	10,706	10,668	9,845	9,071	8,300	8,353	7,888	8,099
	78+ waits plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*1,395*	*982*	*697*
	78+ waits	4,227	4,934	4,929	3,710	2,720	2,227	1,768	1,484	1,245	1,233	1,088	1,012
	104+ waits plan	*n/a*	*n/a*	*n/a*	*354*	*291*	*241*	*175*	*126*	*100*	*113*	*24*	*0*
	104+ waits	551	503	417	388	333	290	286	275	234	121	64	15
Diagnostics	*Imaging plan*	*51,291*	*46,385*	*50,491*	*53,597*	*53,432*	*48,703*	*51,758*	*52,873*	*53,885*	*51,401*	*54,018*	*52,447*
	Imaging activity	57,641	54,490	57,137	54,900	59,594	54,763	58,530	56,734	63,676	55,511	63,695	59,121
	Endoscopy plan	*4,193*	*3,681*	*4,042*	*4,230*	*4,255*	*3,569*	*4,153*	*4,273*	*4,422*	*3,743*	*4,433*	*4,265*
	Endoscopy activity	3,137	3,350	3,220	2,257	2,435	2,515	3,203	3,142	3,652	2,991	3,572	3,200
	Total Diagnostic 6+ weeks	4,571	5,160	4,432	3,478	3,855	5,081	5,418	3,568	3,760	5,068	6,141	6,084
Cancer	*Cancer treatments plan*	*729*	*740*	*733*	*721*	*720*	*641*	*687*	*640*	*698*	*673*	*677*	*688*
	Cancer treatments	671	572	663	585	657	717	640	619	754	642	723	714
	63+ backlog plan	*350*	*334*	*333*	*773*	*767*	*725*	*697*	*629*	*558*	*725*	*670*	*607*
	63+ backlog	438	618	698	773	797	909	885	757	665	834	881	934
	28-day faster diagnosis	70.8%	68.0%	66.4%	66.4%	67.6%	66.2%	61.1%	73.2%	72.6%	67.7%	67.7%	67.1%
Beds	*Average G&A beds occupied plan*	*2,299*	*2,284*	*2,359*	*2,353*	*2,367*	*2,334*	*2,415*	*2,399*	*2,392*	*2,349*	*2,368*	*2,357*
	Average G&A beds occupied	2,323	2,334	2,376	2,439	2,462	2,346	2,388	2,554	2,580	2,521	2,567	2,559
	Average G&A beds available plan	*2,490*	*2,492*	*2,503*	*2,522*	*2,524*	*2,520*	*2,583*	*2,564*	*2,568*	*2,527*	*2,536*	*2,540*
	Average G&A beds available	2,555	2,541	2,577	2,616	2,627	2,531	2,581	2,737	2,740	2,688	2,721	2,714
	Occupancy %	91%	92%	92%	93%	94%	93%	93%	93%	94%	94%	94%	94%
	Average Adult CC beds occupied plan	*152*	*150*	*153*	*148*	*147*	*146*	*148*	*148*	*147*	*146*	*146*	*146*
	Average Adult CC beds occupied	125	143	145	145	142	141	149	141	143	133	137	136
	Average Adult CC beds available plan	*184*	*184*	*184*	*175*	*175*	*175*	*175*	*175*	*175*	*185*	*185*	*185*
	Average Adult CC beds available	181	184	185	184	179	182	183	182	185	181	185	184
	Occupancy %	69%	78%	78%	79%	79%	77%	81%	77%	77%	73%	74%	74%

Appendix 4 – Glossary

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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
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.

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North Central London ICB
Board of Members Meeting
27 September 2022

Report Title	Month 5 Finance Board Report	**Date of report**	16 September 2022	**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 £47.4m deficit at Month 5 representing an adverse variance of £22.3m against the year to date (YTD) plan at Month 5. The ICB reports year to date YTD surplus of £15.9m, £4.1m adverse to plan and forecast outturn (FOT) adverse variance of £9.4m.			
Report Summary	In accordance with national guidance NCL CCG submitted the annual 2022/23 financial plan to NHSE on 20 June 2022. This plan was approved by the outgoing CCG Governing Body in June 2022. The ICB formed on 1 July 2022 resulting in a nine month reporting period in 2022/23 being 1 July 2022 to 31 March 2023. To meet the statutory requirements of delivering the 2022/23 financial plan the ICB is required to deliver a surplus of £25.6m which would be £9.4m adverse to plan. This adverse variance offsets the favourable variance in M1 -3 and delivers on plan for the year as a whole. At Month 5 the ICB is reporting a year to date YTD surplus of £15.9m, £4.1m adverse to plan and FOT adverse variance of £9.4m. The ICB reports a balanced risk position at Month 5, with £42.6m of risks (circa 1.8% of the ICB total budget).				
Recommendation	The Board of Members is asked to **NOTE** the contents of this report and **DISCUSS** at the Board meeting.				

Identified Risks and Risk Management Actions	The ICB reports a balanced risk position at Month 5, with £42.6m of risks (circa 1.8% of the ICB total budget). Mitigations to these risks are in place including the use of non-recurrent support if ultimately required. System risks are currently being accessed and will be reported to the Finance Committee.
Conflicts of Interest	This paper was written in accordance with the Conflicts of Interest Policy.
Resource Implications	The ICB has identified mitigations to offset potential risks. These mitigations are non-recurrent, if non-recurrent measures are used to mitigate recurrent spend, this will impact the ICB's underlying position and the opening plan for 2023/24.
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

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Month 5 Finance Board Report

August 2022

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NCL ICS Financial Position 22/23 – Month 5 (Aug'22)

NCL ICS M5 Financial Position

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NCL ICS is reporting a £47.4m deficit at M5 representing an adverse variance of £22.3m against the YTD plan at M5.

M5 Financial Position Overview

Year to date

- Providers - The M5 YTD plan for providers from the June submission is a £35.8m deficit. The YTD reported bottom-line for providers is a £63.5m deficit representing an adverse variance of £27.6m against the YTD plan at M5.
- The YTD plan for the ICB was to deliver a £10.7m surplus at M5. This consists of YTD plans for the CCG between M1 to M3 of £6.4m surplus and a £4.3m surplus for the ICB for M4 and M5.
- The CCG ended M3 with a favourable variance to plan of £9.4m and the ICB reported an adverse variance to plan of £4.1m for M4 and M5. The combined CCG and ICB YTD position (excluding the favourable variance of £5.3m for Elective Recovery Fund) is £0.44m adverse to the M5 YTD plan.
- The ICB position is explored in further detail in the next section.

Forecast outturn

- All organisations within NCL will be reporting a forecast outturn in line with June submitted 22/23 plans.

In Month 5

- £8.1m of the YTD adverse variance of £22.3m relates to M5. This is mainly driven by adverse movements in provider positions in M5. This is mostly due to slippage on efficiency programmes and items such as Covid-19 spend, underperformance in non-NHS income and IFRS-16.

	M5 Year to date				M5 Forecast Outturn		
	YTD Plan (20th June submission)	YTD Actual	YTD Variance	YTD Variance (Excluding ERF for providers reporting clawback)	Annual Plan (20th June submission)	Forecast Outturn	FOT Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NCL Providers	(35,753)	(63,362)	(27,609)	(17,836)	(25,581)	(25,347)	234
NCL CCG/ICB	10,660	15,932	5,272	(444)	25,583	25,583	(0)
ICS Total	**(25,093)**	**(47,429)**	**(22,336)**	**(18,281)**	**2**	**236**	**234**

	M4 Year to date			M5 Year to date			In month M5 Position		
	YTD Plan (20th June submission)	YTD Actual	YTD Variance	YTD Plan (20th June submission)	YTD Actual	YTD Variance	M4 Plan	M4 Actual	M4 Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NCL Providers	(32,144)	(51,423)	(19,279)	(35,753)	(63,445)	(27,692)	(3,609)	(12,022)	(8,413)
NCL CCG/ICB	8,528	13,632	5,104	10,660	15,932	5,272	2,132	2,300	168
ICS Total	**(23,616)**	**(37,791)**	**(14,175)**	**(25,093)**	**(47,429)**	**(22,336)**	**(1,477)**	**(9,638)**	**(8,161)**

NCL ICS M5 Financial Position (cont.)

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M5 Financial Position Overview (cont.)

ERF Income

- As of M5, ERF income earned by NCL providers totalled £40m. This is worse than plan by £5.3m as of M5. Gross under-performance was £9.3m, mostly in North Middlesex University Hospital NHS Trust and Royal Free London NHS Foundation Trust, offset by £4m of over-performance at University College London NHS Foundation Trust.
- The ICB is reporting a corresponding underspend of £5.3m on ERF. This reflects the national policy not to clawback ERF from systems in H1, and the agreement with NHS London on how this should be presented in system financial statements at this point.

Efficiency savings

- The 22/23 plan for the NCL system assumes delivery of £74.9m of efficiency savings by M5. This consists of savings totalling £61.2m at providers and £13.7m at the ICB.
- As of M5, the system is reporting year to date efficiency savings delivery of £55.9m which is behind plan by £19m. £14.2 of the variance relate to providers while the remaining £4.7m relate to the ICB. Broadly half of the providers have phased their efficiency plans in equal twelfths each month and half have back-loaded the plan. Overall a sixth of the total efficiency requirement is planned to be achieved in Q1, a quarter in Q2 and Q3 and a third in Q4.
- All organisations in NCL are forecasting full delivery of savings for 22/23 which will include a material level of non-recurrent savings.

Provider Capital Position

- Providers are reporting YTD underspends of £60m across NCL and National capital programmes at M5. All providers are forecasting capital expenditure in line with plan for 22/23.
- We are undertaking a capital deep dive exercise at M6 to refine the forecast outturn and re-prioritise any in-year slippages where possible.

Note on the M5 NCL Providers financial position

- At the time of producing this report, NCL providers had not yet finalised the financial reporting of M5.
- A more comprehensive ICS financial report for M5 will be presented at the finance committee.
- BEH, RFL and GOSH were affected by an outage from a nationwide supplier of financial systems during August which would have impacted their ability to report M5.

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NCL ICB Financial Position 22/23 – Month 5 (Aug'22)

Month 5 Summary Position

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Month 5 Summary Position

Background

In accordance with national guidance NCL CCG submitted the annual 2022/23 financial plan to NHSE on 20th June 2022. This plan was approved by the outgoing CCG Governing Body in June 2022.

The ICB formed on 1 July 2022 resulting in a nine month reporting period in 2022/23 being 1 July 2022 to 31 March 2023.

To meet the statutory requirements of delivering the 2022/23 financial plan the ICB is required to deliver a surplus of £25.6m which would be £9.4m adverse to plan. This adverse variance offsets the favourable variance in M1 -3 and delivers on plan for the year as a whole.

Month 5 (August 2022)

At Month 5 the ICB is reporting a year to date (YTD) surplus of £15.9m, £4.1m adverse to plan and forecast outturn (FOT) adverse variance of £9.4m. The table to the right summarises the ICB Month 5 reported position.

Summary financial position (£m)

	YTD			Full Year		
	Bud	Actual	Var	Bud	FOT	Var
	£m	£m	£m	£m	£m	£m
Revenue Resource Limit	**543.0**	**543.0**	**0.0**	**2,389.9**	**2,389.9**	**0.0**
Acute	269.4	264.1	5.4	1,203.4	1,202.9	0.5
Non-Acute	224.5	226.1	(1.7)	1,019.8	1,021.9	(2.1)
Other Programme Services	2.9	10.6	(7.7)	19.5	27.3	(7.8)
Running Costs	6.2	6.2	0.0	22.3	22.3	0.0
COVID-19 Costs	20.0	20.1	(0.1)	89.8	89.8	0.0
Total Operational	**522.9**	**527.0**	**(4.1)**	**2,354.9**	**2,364.3**	**(9.4)**
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	**522.9**	**527.0**	**(4.1)**	**2,354.9**	**2,364.3**	**(9.4)**
Surplus / (Deficit)	**20.0**	**15.9**	**(4.1)**	**35.0**	**25.6**	**(9.4)**

Month 5 Summary Position (cont.)

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Month 5 Summary Position

Key points to note:
The YTD position is adverse to plan by c£4.1m. This is mainly driven by profiling of expenditure as a result of revised programme scheduling, including the Community Services Review and Aging Well (**£7.7m**). This is offset by the favourable variance reported in Months 1-3. In addition there is an adverse variance of **£1.1m** due to the Additional Roles Reimbursement Scheme (ARRS), which is due to be reimbursed by NHSE. Adverse variances are offset, in part, by a favourable variance for Elective Recovery Fund (ERF), **£5.3m**.

The ERF favourable variance of £5.3m has been reported for ERF performance against the M1-5 ERF allocation. This represents £9.3m of clawback, mostly in North Middlesex University Hospital NHS Trust and Royal Free London NHS Foundation Trust, offset by £4m of over-performance at University College London NHS Foundation Trust.

National ERF targets are expected to be achieved by the end of the year and therefore reported as breakeven in the forecast for the ICB.

Actual ERF payments will be based on the NHSE assessment of performance.

The FOT position reports a £9.4m adverse variance which is the required position to achieve a breakeven 2022/23 financial plan.

Key points to note with the FOT adverse variance of £9.4m: Similar to the YTD position above, this is due to profiling of expenditure as a result of revised programme scheduling, including the Community Services Review and Aging Well. This is offset by the favourable variance reported in Months 1-3. The ICB will therefore report an overall balanced position for the full financial year.

A detailed variance analysis is available on slide 11 for YTD and slide 12 for FOT.

Month 5 Summary Position (cont.)

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Month 5 Summary Position

System Reserve Funding

Included within the ICB position is the system reserve funding of £21.1m, which is earmarked for systems costs

Pay

The below tables summarises the Month 5 pay position, noting that pay costs exclude the allocation of vacancies; transferred from London Shared Services.

	Budgeted WTE	M4-M12 Budget (inc. CIP)	YTD Budget	Total YTD Actual	YTD Variance	FOT	(Favourable) / Adverse variance	Income & non-pay budgets	Position incl. Income (Favourable) / Adverse variance
	WTE	£000	£000	£000	£000	£000	£000	£000	£000
TOTAL	755	39,626	10,732	10,420	(311)	45,362	5,736	(5,423)	313

Efficiencies

To deliver the 2022/23 financial plan the ICB is required to deliver £19.6m of recurrent efficiencies. YTD achievement is c£1.9m (c10%). This leaves £17.7m yet to be delivered, with £6.3m identified and £11.4m yet to be identified. This represents a significant risk to the ICB financial position.

At Month 5 the ICB is reporting that full year efficiencies will be achieved in full including non-recurrent savings. Further detail of the efficiency programme and the mitigations against delivery, including non-recurrent support, will be provided for the Finance Committee.

Month 5 Summary Position (cont.)

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Month 5 Summary Position

Use of Non-Recurrent Funds

Included within the CCG/ICB 2022/23 financial plan is £23.7m non-recurrent funding. This reflects the planned non-recurrent funding required in year to enable the CCG/ICB to deliver a balanced financial plan.

As at Month 5 the ICB is on track to fully deliver these actions through use of non-recurrent support, but this serves to highlight the improvement required to the underlying position of the ICB.

Risks & Mitigations

The ICB reports a balanced risk position at Month 5, with £42.6m of risks (circa 1.8% of the ICB total budget). Mitigations to these risks are in place including the use of non-recurrent support if ultimately required.

The top three risks identified at month five are:

- Unachieved efficiencies **£9m**
- Continuing Healthcare/Discharge Services **£9m**
- Planned non-recurrent funding **£8.3m**

Recurrent risks that emerge in year will impact on the ICB's underlying financial position.

ICB Month 5 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 Budget £m	Year to Date Actual £m	Year to Date Variance £m	Key Variances
Allocations				
In year allocations	543.0	543.0	0.0	
Total Allocations	**543.0**	**543.0**	**0.0**	
Expenditure				
Acute	287.0	281.7	5.4	**Favourable Variance:** Mainly due to an adjustment to offset the ERF clawback in NCL providers in-line with NHSE policy
Non-Acute				
Mental Health & LD	66.7	66.2	0.5	**Favourable Variance:** Mental Health S117 & Complex Care costs
Delegated Commissioning	43.4	44.5	(1.1)	**Adverse Variance:** Due to costs incurred against the Additional Roles Reimbursement Scheme (ARRS), which is expected to be reimbursed by NHSE. The ARRS entitles PCNs to access funding to support recruitment across five reimbursable roles
Community Services	51.8	52.0	(0.1)	**Adverse Variance:** During M1-3 the CCG reported an underspend against Community due to the start of the Community Services Review being phased later on in the year. The expenditure is now reported within the ICB resulting an offsetting adverse variance.
Primary Care	8.7	9.6	(0.9)	**Adverse Variance**: Mainly driven by unfunded costs for locally commissioned Long Term Conditions (LTC) services
Primary Care - Prescribing	31.6	31.6	0.0	
Continuing Care	22.9	23.1	(0.2)	**Adverse Variance:** Predominately due to staffing pressures required to deliver additional efficiencies
Total	**225.2**	**227.0**	**(1.8)**	
Other Programme Services & Running Costs				
Other Programme Services	4.5	12.2	(7.7)	**Adverse Variance:** Mainly driven by profiling of expenditure as a result of a delayed start to Programme expenditure, which is expected to start later in the financial year. The underspend was reported in M1-3 under the CCG. This will result in an overall breakeven position
Running Costs	6.2	6.2	0.0	
Total	**10.7**	**18.4**	**(7.7)**	
Total Expenditure	**522.9**	**527.0**	**(4.1)**	
(Surplus) / Deficit	**20.0**	**15.9**	**4.1**	

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	2,389.9	2,389.9	0.0	
Total Allocations	**2,389.9**	**2,389.9**	**0.0**	
Expenditure				
Acute	1,282.7	1,282.2	0.5	**Favourable Variance:** Predominately driven by agreed system recovery contribution from NHS Providers
Non-Acute				
Mental Health & LD	306.7	305.4	1.3	**Favourable Variance:** Mental Health S117 & Complex Care costs
Delegated Commissioning	200.5	204.9	(4.4)	**Adverse Variance:** Costs for the continuation of Sunday bank holiday and NHS111 services. The adverse variance is offset by the favourable variance within Primary Care, where the budget is reported
Community Services	231.3	231.9	(0.7)	**Adverse Variance:** Due to profiling, offsetting underspends were reported in M1-3
Primary Care	39.3	36.6	2.7	**Favourable Variance:** Relating to costs for the continuation of Sunday bank holiday and 111 serves being recognised within Delegated Commissioning. The budget is reported within Primary Care (see above). This is offset in part by unfunded cost for locally commissioned Long Term Conditions (LTC) services
Primary Care - Prescribing	142.2	142.2	0.0	
Continuing Care	103.2	104.2	(1.0)	**Adverse Variance:** Predominately due to staffing pressures required to deliver additional efficiencies
Total	**1,023.2**	**1,025.2**	**(2.1)**	
Other Programme Services & Running Costs				
Other Programme Services	26.8	34.6	(7.8)	**Adverse Variance:** Mainly driven by profiling of expenditure as a result of a delayed start to Programme expenditure, which is expected to start later in the financial year. The underspend was reported in M1-3 under the CCG. This will result in an overall breakeven position
Running Costs	22.3	22.3	0.0	
Total	**49.1**	**56.9**	**(7.8)**	
Total Expenditure	**2,354.9**	**2,364.3**	**(9.4)**	
(Surplus) / Deficit	**35.0**	**25.6**	**9.4**	**Deficit offset by Q1 reported surplus**

North Central London
Integrated Care Board

Financial Accounts

Appendices

Appendix 1 - Income & Expenditure
Appendix 2 - Cash Flow Statement

Appendix 1 - Income & Expenditure

	2022/23 In-Month AP5 - AUG 22			2022/23 Year to Date AP5 - AUG 22			2022/23 Annual Forecast			2021/22 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												
Education, training and research	0	0	0	0	0	0	0	0	0	0	(1,033)	(1,033)
Non-patient care services to other bodies	0	(1,690)	(1,690)	0	(3,250)	(3,250)	0	(15,414)	(15,414)	(28)	(19,383)	(20,012)
Other Contract income	0	(517)	(517)	0	(368)	(368)	0	(916)	(916)	(1,062)	(2,037)	(3,100)
Other non contract revenue	0	0	0	0	0	0	0	0	0	(25)	0	(25)
Total Operating revenue	**0**	**(2,207)**	**(2,207)**	**0**	**(3,618)**	**(3,618)**	**0**	**(16,329)**	**(16,329)**	**(1,116)**	**(23,053)**	**(24,169)**
Operating Expenses	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Expenses												
Perm E/ees - Salaries and Wages	1,099	1,974	3,073	2,265	4,304	6,569	9,150	18,287	27,437	9,675	16,588	26,263
Perm E/ees - Social Security Costs	140	263	402	283	523	806	1,758	3,383	5,141	1,235	1,905	3,140
Perm E/ees - Em/er Contribs to NHS Pension	9	282	291	290	558	848	1,832	3,525	5,357	2,755	2,171	4,927
Perm E/ees - Apprenticeship Levy	16	0	16	32	0	32	101	0	101	138	0	138
Other E/ees - Salaries and Wages	222	805	1,028	433	1,281	1,714	1,761	3,318	5,079	1,968	7,074	9,043
Total Gross employee expenses	**1,487**	**3,324**	**4,811**	**3,303**	**6,667**	**9,969**	**14,601**	**28,513**	**43,114**	**15,772**	**27,738**	**43,510**
Other Operating Expenses												
Services from other CCGs and NHS England	(77)	577	500	416	(1,067)	(651)	1,873	2,014	3,888	11,076	8,644	19,720
Services from foundation trusts	0	37,393	37,393	0	138,593	138,593	0	302,377	302,377	0	1,365,023	1,365,023
Services from other NHS trusts	0	83,273	83,273	0	170,641	170,641	0	776,125	776,125	0	1,034,366	1,034,366
Services from Other WGA bodies	0	0	0	0	0	0	0	0	0	0	0	0
Purchase of healthcare from non-NHS bodies	0	31,152	31,152	0	61,741	61,741	0	276,758	276,758	0	412,394	412,394
Purchase of social care	0	537	537	0	1,073	1,073	0	4,829	4,829	0	1,643	1,643
Chair and Non Executive Members	14	1	15	28	1	29	160	0	160	884	6	890
Supplies and services - clinical	0	120	120	0	213	213	0	356	356	0	1,302	1,302
Supplies and services - general	1,396	7,301	8,697	1,396	6,491	8,486	2,801	513	3,314	106	17,370	17,476
Consultancy services	0	0	0	0	(0)	(0)	225	150	375	0	1,711	1,711
Establishment	7	464	471	51	568	619	480	2,373	2,853	782	2,760	3,542
Transport	2	0	2	2	0	2	0	0	0	22	0	22
Premises	(0)	26	26	40	652	693	1,115	2,986	4,102	1,810	3,839	5,650
Depreciation	80	0	80	160	0	160	101	0	101	122	12	134
Audit fees	78	0	78	95	0	95	429	0	429	204	0	204
· Internal audit services	7	0	7	21	0	21	134	0	134	180	0	180
· Other services	(2)	0	(2)	0	0	0	18	0	18	24	0	24
Prescribing costs	0	15,827	15,827	0	31,548	31,548	0	141,967	141,967	0	186,987	186,987
Pharmaceutical services	0	1	1	0	2	2	0	7	7	0	21	21
GPMS/APMS and PCTMS	0	22,788	22,788	0	46,674	46,674	0	215,395	215,395	0	263,228	263,228
Other professional fees excl. audit	24	358	382	38	595	633	60	2,849	2,909	76	3,869	3,945
Legal Fees	(48)	1	(47)	10	(34)	(24)	210	0	210	405	96	501
Grants to Other bodies	0	0	0	0	0	0	0	0	0	0	3	3
Education and training	1	70	71	1	110	111	115	491	606	263	357	620
Other expenditure	3	1	4	6	1	7	0	0	0	0	(134)	(134)
Total other costs	**2,083**	**260,490**	**262,573**	**2,866**	**517,801**	**520,667**	**7,721**	**2,329,792**	**2,337,512**	**15,953**	**3,303,498**	**3,319,451**
Net Operating Expenditure	**3,570**	**263,814**	**267,384**	**6,169**	**524,468**	**530,637**	**22,322**	**2,358,305**	**2,380,627**	**31,725**	**3,331,236**	**3,362,961**
Net Expenditure	**3,570**	**261,607**	**265,177**	**6,169**	**520,850**	**527,019**	**22,322**	**2,341,975**	**2,364,297**	**30,609**	**3,308,183**	**3,338,792**
Revenue Resource Limit	**3,608**	**257,463**	**261,070**	**6,169**	**516,743**	**522,912**	**22,322**	**2,332,596**	**2,354,918**	**30,629**	**3,311,758**	**3,342,387**
Surplus / (Deficit) from Operations	**38**	**(4,144)**	**(4,107)**	**0**	**(4,107)**	**(4,107)**	**0**	**(9,379)**	**(9,379)**	**20**	**3,575**	**3,595**

Appendix 2 - Cash Flow Statement

	AP1 - APR 22	AP2 - MAY 22	AP3 - JUN 22	AP4 - JUL 22	AP5 - AUG 22	AP6 - SEP 22	AP7 - OCT 22	AP8 - NOV 22	AP9 - DEC 22	AP10 - JAN 23	AP11 - FEB 23	AP12 - MAR 23	Total
	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance bfwd	218	924	2,024	2,476	2,010	629	1,962	959	682	853	289	1,160	218
RECEIPTS													
Main Cash Drawdown	250,000	243,000	250,000	251,800	245,200	285,000	246,000	236,700	234,500	236,000	238,000	236,635	2,952,835
Supplementary Drawdown	11,000	0	4,500	0	0	0	0	0	0	0	0	0	15,500
Other	1,702	6,072	2,378	8,195	553	0	0	0	0	0	0	0	18,899
VAT	1,118	1,086	1,455	1,073	630	0	0	0	0	0	0	0	5,361
Total Receipts	263,819	250,158	258,333	261,068	246,383	285,000	246,000	236,700	234,500	236,000	238,000	236,635	2,992,596
PAYMENTS													
NHS Payables	204,266	179,978	188,290	201,688	186,473	221,864	195,345	185,558	185,527	185,505	185,500	185,509	2,305,504
Non NHS Payables	55,525	65,684	66,137	55,950	57,031	57,401	47,258	47,019	44,403	46,658	47,229	47,378	637,671
Salaries & Wages (inc Tax, NI & Pension)	3,323	3,396	3,454	3,896	4,260	4,402	4,400	4,400	4,400	4,400	4,400	4,400	49,131
Total Payments	263,113	249,058	257,880	261,534	247,764	283,667	247,003	236,977	234,329	236,564	237,129	237,287	2,992,306
BALANCE CFWD	924	2,024	2,476	2,010	629	1,962	959	682	853	289	1,160	507	507

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
27 September 2022

Report Title	Board Assurance Framework ('BAF') Report	**Date of report**	11 September 2022	**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	Chris Hanson, Governance and Risk Lead	**Email / Tel**		christopher.hanson1@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 Board of Members Board Assurance Framework ('BAF') for North Central London ICB. It captures the most serious risks that have been identified as threatening the achievement of the ICB's strategic objectives. This is the first BAF report for the ICB.

Risk transfer and review

All of the risks of North Central London Clinical Commissioning Group ('CCG') were transferred to the ICB on 1st July 2022. The risks were all subsequently reviewed by the appropriate Executive Directors with each risk either being:

- Amended to reflect the ICB;
- Closed as:
  - No longer applicable;
  - Having been sufficiently mitigated or avoided;
  - Amalgamated into another risk;
  - Incorporated into a new risk.

Risks will continue to be overseen in line with the ICB's Risk Management Policy. This includes all key risks with a current risk score of 12 or higher being escalated for oversight by the appropriate committee or sub-committee.

Board Assurance Framework ('BAF')

There are 12 risks on the BAF. The threshold for inclusion on the BAF is a risk score of 15 or higher.

Since the final meeting of the CCG's Governing Body in June 2022, 3 risks have closed and 2 risks have been added. 1 risk's rating has reduced but remains above the BAF threshold with the remaining 9 risks' ratings remaining the same.

	The full version of the BAF can be found here. **Key Highlights:** **PERF18:** *Primary care workforce development (Threat).* **Oversight Committee:** Primary Care Contracting Committee. **Current Risk Rating:** 16. 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'). We are currently in year 4 of the 5 year scheme which enables PCNs to access national funding to recruit into a range of 15 different roles. There is an expectation that ICBs and systems will explore different ways of supporting PCNs to recruit. PCNs continue to recruit to these roles and are supported by Training Hubs with induction and professional development. Other recent key measures include: • Measures to support GP training, recruitment and retention to help deliver 6,000 more doctors in primary care. This includes £94m to address recruitment and retention issues, including a Partnership Premium of £20,000 and greater proportion of GP training time spent in general practice; • NCL Training Hub developed Primary Care Nursing Strategy and NCL Primary Care Nursing Programme Priorities 22-23. Discussed at the CCG's Primary Care Commissioning Committee in February to identify further opportunities to strengthen this work within the ICS; • Expansion and promotion of Clinical Placements in NCL to attract, support and embed more new to practice workforce; • Winter Access funding and additional GP Nursing funding received to enable workforce development schemes focusing on Reception & Admin staff, Healthcare Assistants (HCA), GP Nurses (GPN), Nursing Associates (NAs), Trainee Nursing Associates (TNAs), retention of volunteers; • Primary Care Flexible Staff Pool procurement completed and new offer to strengthen links between practices and GPs and GPNs wishing to work flexibly live from late March 2022; • Mentoring scheme first developed under the GP and GPN Fellowship and Mentoring scheme to be expanded out to wider workforce in 2022/23; • 12 GP Retention Schemes live in NCL at a borough level supporting development and retention of GPs. Given the high demand on the Primary Care workforce during the pandemic, the ICB will have to monitor the impact on wellbeing and fatigue. The ICB and NCL training hub have been implementing a wellbeing programme targeting Primary Care staff. This programme will continue into 22/23 with a Primary Care Wellbeing Lead recruited. Recent media coverage has highlighted the need for further scrutiny in relation the support and supervision offered to the newly diversified roles in General Practice which has been picked up as a key priority by the newly appointed Chief Medical Officer and Chief Nursing Officer.

	COMM14: *Failure To Achieve NHS Constitutional Targets - Urgent and Emergency Care (Threat).* **Oversight Committee:** Strategy and Development Committee. **Current Risk Rating:** 16. New Governance arrangements are in place that bring together Urgent Emergency Care ('UEC') and Community Silver meetings into a single weekly Flow Operational Group ('FOG') with the aim of improving matrix working to rapidly resolve system pathway issues that can't be answered at place level. The group is jointly chaired by the ICS CEO lead for Urgent Care and ICS lead for Community Care and includes representation from Acute, Mental Health ('MH') and Community providers, London Ambulance Service ('LAS') and NHS111 as well as Local Authorities A Flow Board has also been recently established to oversee the work of the FOG, defining the NCL strategic approach to improving the urgent care and community pathways from NHS111/LAS, A&E front door to internal flow and post-discharge recovery. The Flow Board will inform and be informed by both the UEC London Board's strategic approach to urgent and emergency care transformation and the NCL System Management Board. The Flow Board met 22 July 2022. The work of the Flow Groups will also interface with the NCL Clinical Advisory Group ('CAG') to provide clinical leadership and support the sharing and embedding of best practice learning The Terms of Reference for the UEC London Board have yet to be finalised but are likely to include a focus on providing strategic oversight of the complete UEC pathway and will include decision making on programme priorities, and the delivery of new or existing transformation projects/programmes. A UEC system pathway action plan focussed on improving hospital handover has been developed. The plan is reviewed fortnightly with monthly submission to NHSE. The remit of the group is under review to consider further key areas of focus and associated actions to mitigate in-year and winter pressures, such as: Workforce issues; MH capacity and flow; increasing Emergency Department activity including paediatrics; discharge capacity and COVID/flu planning. NHS111 re-procurement process remains on track. The business case is developed and approved through Governing Body June 2022. A Service Specification and Invitation to Tender documentation have been developed for approval through committee in September 2022. **COMM21:** *Variation in Community and Mental Health Services across NCL (Threat).* **Oversight Committee:** Strategy and Development Committee. **Current Risk Rating:** 16. Due to historical funding differences across the 5 legacy CCGs there are variations to Community and Mental Health ('MH') services within NCL ICB with possible consequences for service access and effectiveness, health inequalities, and resource management. The ICB completed two baseline reviews, one for Community Services and one for Mental health, and are available on the ICB website. These set out a clear case for change for both service areas. As part of the process a series of design workshops have been held. These have been attended by a wide range of colleagues from Provider Trusts, both clinical and operational staff, as well as colleagues from Local Authorities, experts by experience and some voluntary sector representatives.

	The ICB and programme board approved core service offers and a gap analysis between the existing and proposed services. These reports were agreed at September 2021 programme boards. To support the core service offers and gap analysis an impact assessment was finalised and work took place during Q1 2022-23 to agree an approach for funding the community service review. Providers are collaborating to deliver improvements to an agreed range of services e.g. P2 beds, Virtual Ward, Children and Young People's community services and coordinating functions, which are designed to deliver productivity and transformed services. Within MH care, providers are working collaboratively together on issues including Out of Area placements and community based teams. Providers completed project documentation for collaboration projects during July and August 2022. For community, which does not have dedicated investment (i.e. through an equivalent of the Mental Health Investment Standard) the programme board has used financial principles for investment, alongside programme principles to review which of the 'gaps' within the gap analysis should be addressed through ICS investment in year 1. A list of prioritised investment areas has been agreed via ICS and ICB governance and providers are drafting delivery plans, to be agreed with place based partners and the Implementation Steering Group. High level requirements from Reviews have been included in contractual documents e.g. a Service Development and Improvement Plan for 2022/23. Implementation workshops are taking place Borough partners and Local Authority Chief Executives have been engaged in terms of mental health and how to navigate an approach that recognises the importance of Place for most Mental Health service delivery, whilst still working at a NCL level to address key challenges such as inequitable service provision and workforce etc. The ICS is establishing an on-going monitoring programme for the outcomes of the review with the key governance forum being implementation steering groups, chaired by the ICS CEO lead for the area which report into the relevant programme board. **COMM22:** *Failure of the Integrated Care Board in effectively managing the transition of the budgets for Specialist Commissioning from April 23 onwards (Threat)*. **Oversight Committee:** Strategy and Development Committee. **Current Risk Rating:** 16. We have been working with NHSE and ICS Partners since February on a Due Diligence Process that has been merged with the Pre-Delegation Assurance Framework ('PDAF'). We undertook initial analysis of Specialist Commissioning ('Spec Comm') data in March 2022 which showed the extent of income that comes into NCL from other ICSs and this has influenced our approach to working with the East of England Region where we now have monthly meetings and also led to the development of the North London Programme Board. Our work on Pillar 5 (Data) has led to ICSs now having access to Spec Comm Data from 1st July and our work on Pillar 2 (Commissioning) has broadly agreed the form of contract that will exist from 2023/24 onwards (i.e. a single contract incorporating ICS Services, Delegated Spec Comm and Retained Spec Comm). The PDAF is produced in draft and will go through a process of refinement prior to submission to NHS London in early October. We have also identified some draft Clinical Priorities, discussed by Clinical Advisory Group in August 2022. **COMM26:** *Failure to make changes to support the shift of resources / investment into prevention & proactive care from crisis & acute management of care (Threat).* **Oversight Committee:** Strategy and Development Committee. **Current Risk Rating:** 16.

	One of the core purposes of the ICS is to improve the outcomes for its population. To achieve this, NCL is developing its population health improvement approach. As part of this we need to consider how we do things differently, in partnership with residents, communities, the voluntary sector and our partners, and including how we deploy our resources differently, with the emphasis on prevention, self-care and early intervention. We know that this is going to be a journey for the ICS and its partners, during a time when there are significant pressures on all to support elective recovery, respond to the financial challenges and look after our workforce. However, if we don't start to plan for and make these changes, we won't see the step-change in outcomes for our residents. Progress on the Population Health Improvement (PHI) portfolio was shared with the CCG's Strategy & Commissioning Committee during autumn 21 / winter 22, including updates on: • Establishment of PHI Committee; • NCL Population Health Needs Analysis; • Deep Dive Needs analysis - deprivation, age and ethnicity; • Draft Outcomes Framework; • Outline proposals for initial Population Health Improvement Strategy. The first iteration of the draft NCL Population Health Improvement Strategy has been completed and shared with the PHI Committee. It is now being socialised more widely and we are building a "response" which will come from 5x Places, transformation programmes and enabler workstreams to demonstrate what is already underway to address the gaps / inequalities in outcomes - with a focus on the principles and the core themes of delivery from the strategy permeating all the different areas of work, including how resources will be allocated to achieve our ambition of increased prevention and early intervention. A baseline of the indicators that constitute the Outcomes Framework was completed and shared with Population Health & Inequalities ('PHI') Committee on 5 July 2022. These have been socialised with borough partnerships and other stakeholders. Discussions are ongoing to consider how this supports the identification of NCL and local outcome priorities. **STR8:** *Failure to Deliver the 2022/23 System Efficiency Plans (SEP) and Transformation Programme (Threat)*. **Oversight Committee:** Finance Committee **Current Risk Rating:** 20 The ICS System Efficiency plan will introduce a new approach that will be built with input from all system partners to support the financial recovery plan. The programme will include key efficiencies set out in the recent planning guidance. This will include clinical transformation, reduction in agency spend, medicine management, workforce, procurement and corporate services. This process includes developing and embedding a system wide culture change, reinforcing mechanisms within processes and enabling change through continuous improvement. The CCG/ICB Cost Improvement Programme (CIP) plan for 2022/23 includes efficiencies with primary care prescribing, CHC/CIC, pay budget reviews and small contract reviews. **FIN3:** *Long Term Financial Sustainability (Threat)*. **Oversight Committee:** Finance Committee. **Current Risk Rating:** 20.

	From 2022/23, the financial regime has not reverted to a pre-COVID-19 financial regime, the start point for 22/23 funding was 2 x the funding received for the second six months of 2021/22. The 22/23 system envelope for NCL contains a real terms reduction of c5% mostly due to a 57% reduction to the COVID fund, no non-NHS income support and a convergence adjustment (based upon comparative distance from target) of 1.55%, the largest in London. There is a greater emphasis on contracts and a cost and volume element for elective to drive elective recovery. There is an elective recovery fund to enable systems to achieve 104% of 19/20 elective activity baseline. Funding then can be reduced or increased at a marginal rate of 75% tariff depending whether the 104% target is achieved – we are awaiting final ERF guidance. We know that the financial full year effects of capacity increases (e.g. ITU, Endoscopy) in response to COVID-19 pressures, and productivity losses (due to infection prevention control measures) will extend the underlying cost base further and the additional costs do not currently have a financial mitigation. The aim will be to make best use of capacity across the sector and to prepare a sector-wide efficiency programme to focus on 2022/23 in order to smooth the transition and avoid a financial cliff-edge. The draft 22/23 operating plan submitted on the 17th March 2022 identified a gross system deficit of £283m. The net position after a technical baselines issue for Royal Free, inflation in excess of 2.7% planning levels and the revenue impact of IFRS 16 was a deficit of £165m. For the April 22/23 operating plan submission the aggregate deficit reduced to £221m and the net position £123m. On 19th May the national team announced additional 22/23 allocations covering excess inflation, ambulance services, CHC and BCF pressure. The final 22/23 plan submission (20th June), following a peer review process with North West London ICS and a final apportionment of the remaining £23m, was for a system financial break-even position (with significant risk). The task is now to monitor and manage the system position to achieve, or get as close as possible to achieving, the break-even plan for 22/23 whilst developing plans to address the recurrent position for 23/24 and beyond. **FIN11:** *Failure to Deliver 2022/23 Statutory and Other Financial Requirements Set By NHS England (Threat)*. **Oversight Committee:** Finance Committee. **Current Risk Rating:** 20. This risk has been developed to address the in-year financial risk for 2022/23. The 2022/23 annual financial plan was signed off by the NCL Governing Body in June 2022. This was the final submission in accordance with the national timetable. The ICB Finance Committee and Board will monitor progress against this plan. At month 4, (month 1 of the ICB) July 2022, the ICB submitted a balanced plan excluding the system surplus which the ICB is holding on behalf of the ICS. **QUAL24:** *Failure to base CHC Commissioning cycle and service on reliable data (Threat)*. **Oversight Committee:** Strategy and Development Committee. **Current Risk Rating:** 16. As part of strengthening our approach to CHC/CIC a review of CHC/CIC data was conducted. Following the review an increased focus on data quality has been developed within this area of operation and further informed with feedback from NCL CHC/CIC Staff workshops on the steps to take forward to improve.

	Standardisation and training in new procedures will effectively manage this risk, once controls are fully embedded. CHC Caretrack platforms have now been merged and the legacy records have been archived - with new records more complete given the increase in mandatory fields and standardisation of recording. Ongoing data cleansing continues, including the harmonisation of the rate cards. Additionally, a non-CHC (Mental Health, Learning Disability ('LD') and Children and Young People ('CYP')) clear line of sight patient data Caretrack upload has been completed for Mental Health and CYP with LD. Furthermore, historical practices are being managed, namely, timeliness in updating data on Caretrack, however, the introduction of Digital Referral Assessment ('D-RAR') and Spine will support this. A Caretrack training programme has been established for new and existing Caretrack Users to support the ongoing standardisation of data entry. CHC are also having discussions on the development of an NCL system-wide training strategy. The CHC Performance reports, via Caretrack Business Intelligence Tool, are reviewed weekly at the CHC Operational Performance Meeting and circulated to borough teams to review and validate data. This is driving up the quality and accuracy of the data. This will also be expanded to complex care patients once on Caretrack. NCL CCG signed the contract for NHS Spine. Phase 1 of this, delivering automated RIP recording and commissioned care closedown, was implemented in July 2022 reducing the risk of paying for RIP patients. Regarding NCL CCG/ICB D-RAR via Caretrack, which will enable digital referrals, Phase 1 – internal was launched on 7 March 2022. Further training and extension to external referrers to be developed. The NCL CHC Policy and Standard Operating Procedures, which will support all these areas, was launched at the NCL CHC/CIC Wider Team Meeting on 8 June 2022. <u>Decreasing risk</u> Since the last meeting of the CCG's Quality and Safety Committee, the following risk's rating has reduced but remains above the Committee threshold: **PERF7:** *Failure to manage surges during heightened periods of pressure (including winter, Easter and other Bank Holidays) and impact on waiting time standards and capacity for elective pathways (Threat)*. **Oversight Committee:** Primary Care Contracting Committee. **Current Risk Rating:** 16. Front of House (FoH) models comprising Streaming, Redirection and Treat & Transfer schemes are now in place across hospital sites to support A&E departments during periods of significant demand. In addition, direct referral pathways that bypass Emergency Departments ('ED') where appropriate and take patients straight to Same Day Emergency Care services (SDEC) have been strengthened. The London Ambulance Service (LAS) and the NCL system have implemented the straight to SDEC for three clinical pathways. Review of impact on alleviating pressures in ED will be assessed through the NCL Urgent & Emergency Care Operations Group. A strategic review of same day access was being undertaken during April 2022 in order to determine the longer term approach to managing A&E demand. Oversight

	of this work will be maintained by the NCL Urgent and Emergency Care (UEC) Operations Group. A review of winter was undertaken across NCL with key issues for winter identified: Mental Health inpatient capacity; crowding in EDs leading to high number of 12 hour breaches and high number of ambulance handover delays; increasing paediatric activity; increasing low acuity ED attendances; limited discharge capacity; and increasing rates of COVID-19 infection and flu. Actions identified are being developed to address these issues. Progress against these will be monitored through the NCL Flow Board and NCL Flow Operations Group. The ICB anticipates that these actions should impact directly on the improving of the issues we have raised for winter. As such the risk rating has been reduced to 16 from 20. <u>New risks</u> Since the final meeting of the CCG's Governing Body, the following risks have been added to the BAF: **PERF24:** *Failure of the Integrated Care Board in effectively managing the risks of devolution for Dental, Optometry, and Community Pharmacy Services from April 23 onwards (Threat)*. **Oversight Committee:** Strategy and Development Committee. **Current Risk Rating:** 16. This is a new risk. The ICB has been working closely with NHS England ('NHSE') since July 2022 to facilitate the delegation of Dental, Optometry, and Community Pharmacy ('DOP') Services in April 2023. The Pre-Delegation Assurance Framework ('PDAF') is prepared in draft form and will be finalised in advance of the final submission deadline in October 2022. Executive Management Team have been kept updated on the issues relating to the DOP delegation. Progress towards meeting the delegation deadline is dependent upon the ICB receiving further guidance and service data from NHSE. This will support the ICB's intended deepdive in to the delegation's clinical and financial consequences and impact. All evidence received to date indicate the delegation will progress as planned. The Board will be kept updated with regards to DOP delegation. **PERF25:** *Failure to ensure adequate integration along urgent care pathway resulting in lengthy ambulance handover delays and slower response times in the community (Threat).* **Oversight Committee:** Quality and Safety Committee. **Current Risk Rating:** 16. This is a new risk, and therefore will continue to develop over the following few weeks. It has been identified within the context of the high volume of ambulance delayed handovers, arising due to slow flow rates through hospitals. Site based root cause analysis is underway, but the cause is expected to be related winter-level attendance at A&E sustained throughout the summer months. A Quality Improvement (QI) toolkit is being developed to support system wide recovery. This is expected to be implemented in advance of the winter 2022/23

months. This will be one of the matrices that system performance will be measured against by NHS England.

Closed risks

Since the last meeting of the CCG's Governing Body, the following three risks have been closed:

PERF21: *Failure of Primary Care patient access (Threat)*: This risk was identified as part of the system recovery further to the COVID-19 pandemic where practices had been asked to revert to a Total Triage model. Controls and actions have now been completed and risk no longer remains live.

A new risk is under development to capture the broader challenges of Patient GP access and experience. This will be ready in advance of the next Primary Contracting Committee meeting.

FIN13: *Failure to manage the in-housing of the CSU services within available timeframe and manage financial implications (Threat):* The in-housing of the Commissioning Support Unit ('CSU') has been completed.

As such the risk has been closed, however, a new risk is under development to address the ongoing financial risk to the ICB further to the in-housing of services.

AO1: *Failure to Establish Appropriate and Effective Arrangements for the New ICS Organisation at pace (Threat)*: The new ICB has been established and the CCG successfully closed down. The ICB's Board of Members met for the first time on 4th July 2022 and approved the governance framework. All ICB Board members have been recruited.

This risk has been successfully avoided and therefore is closed.

System risk management- emerging approach

The Governance and Risk Team has agreed an approach with the governance teams of NCL provider Trusts and Foundation Trusts to help ensure there is system collaboration to identify and address key system risks. The approach is as follows:

- The key to effective risk management is to have improved communications and collaboration between system partners rather than having to fundamentally alter each organisation's Board Assurance Frameworks;
- ICB Executive Directors will continue to own key risks and support the management of key system risks that they are aware of through the various system boards, forums and groups that are within their portfolios. This includes emerging risks as well as current ones;
- An NCL Governance Leads Group has been established which includes the Directors of Governance/Trust Secretaries of each of the NCL provider Trusts/Foundation Trusts and the ICB's Governance and Risk Team. The NCL Governance Leads Group has agreed to act as an additional mechanism whereby significant risks can be raised with each other and information passed onto the relevant Executive Directors of each organisation where a system approach to managing each risk is appropriate. This includes:
    - Discussing risk at each of the monthly NCL Governance Leads Group meetings;
    - Extending the NCL Governance Leads meeting once per quarter to dedicate the meeting to risk;
    - In the weeks in between meetings e-mailing colleagues with risk alerts as follows:

	▪ Horizontal collaboration (for those key provider risks which impact other providers in NCL): A Governance Lead with a key risk will e-mail the Governance Leads in the other impacted organisations so they can understand the wider picture and facilitate cross organisation collaboration; ▪ Linear collaboration (for those key commissioner or provider risks which impact on the system or would benefit from the ICB being involved as the commissioner): A Governance Lead with a key risk will e-mail the Governance Leads in the other impacted organisations so they can understand the wider picture and facilitate cross organisation collaboration. **System-wide risks** The Governance and Risk Team met with each of the Executive Directors to identify system wide risks where oversight and leadership by the ICB would be beneficial. These risks are: • Recruitment shared services, as well as a broader risk to the credibility of North London Shared Services model if the immediate recruitment challenges are not resolved; • The ICS meeting the system control total; • Backlog of Continuing Health Care ('CHC') assessments due to System workforce challenges. In addition to the above the NCL Governance Leads Group identified the following risk: • Impact on staffing due to rising cost of living/energy prices. These risks are in the process of being developed for inclusion on the ICB's Corporate Risk Register. The Governance and Risk Team is seeking to commence discussions with Local Authority colleagues to similarly considered shared communication of key system risks.
Recommendation	The Board of Members is asked to **NOTE** the report and provide feedback on the risks.
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. The Board of Members includes clinicians, Non-Executive Members, Partner Members and other key stakeholders.
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	To continue to manage risk across the organisation in a robust way.
Appendices	The following documents are included: • BAF Risks Highlight Report; and, • Risk Scoring Key.

North Central London ICB BAF Risks - Highlight Report

Risk ID	Risk Title	Risk Owner	Key Updates	2022/23 Current Risk Score DEC	MAR	JUN	SEPT	Movement From Last Report	Target Risk Score
PERF7	Failure to manage surges during heightened periods of pressure (including winter, Easter and other Bank Holidays) and impact on waiting time standards and capacity for elective pathways (Threat)	Richard Dale - Executive Director of Performance and Transformation	Front of House (FoH) models comprising Streaming, Redirection and Treat & Transfer schemes are now in place across hospital sites to support A&E departments during periods of significant demand. In addition, direct referral pathways that bypass Emergency Departments ('ED') where appropriate and take patients straight to Same Day Emergency Care services (SDEC) have been strengthened. The London Ambulance Service (LAS) and the NCL system have implemented the straight to SDEC for three clinical pathways. Review of impact on alleviating pressures in ED will be assessed through the NCL Urgent & Emergency Care Operations Group. A strategic review of same day access was being undertaken during April 2022 in order to determine the longer term approach to managing A&E demand. Oversight of this work will be maintained by the NCL Urgent and Emergency Care (UEC) Operations Group. A review of winter was undertaken across NCL with key issues for winter identified: Mental Health inpatient capacity; crowding in EDs leading to high number of 12 hour breaches and high number of ambulance handover delays; increasing paediatric activity; increasing low acuity ED attendances; limited discharge capacity; and increasing rates of Covid-19 infection and flu. Actions identified are being developed to address these issues. Progress against these will be monitored through the NCL Flow Board and NCL Flow Operations Group. The ICB anticipates that these actions should impact directly on the improving of the issues we have raised for winter. As such the risk rating has been reduced to 16 from 20.	20	20	20	16	↓	12
PERF18	Failure to effectively develop the primary care workforce (Threat)	Sarah McDonnell-Davies - Executive Director of Places	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'). We are currently in year 4 of the 5 year scheme which enables PCNs to access national funding to recruit into a range of 15 different roles. There is an expectation that ICBs and systems will explore different ways of supporting PCNs to recruit. PCNs continue to recruit to these roles and are supported by Training Hubs with induction and professional development. Other recent key measures include: • Measures to support GP training, recruitment and retention to help deliver 6,000 more doctors in primary care. This includes £94m to address recruitment and retention issues, including a Partnership Premium of £20,000 and greater proportion of GP training time spent in general practice; • NCL Training Hub developed Primary Care Nursing Strategy and NCL Primary Care Nursing Programme Priorities 22-23. Discussed at the CCG's Primary Care Commissioning Committee in February to identify further opportunities to strengthen this work within the ICS; • Expansion and promotion of Clinical Placements in NCL to attract, support and embed more new to practice workforce; • Winter Access funding and additional GP Nursing funding received to enable workforce development schemes focusing on Reception & Admin staff, Healthcare Assistants (HCA), GP Nurses (GPN), Nursing Associates (NAs), Trainee Nursing Associates (TNAs), retention of volunteers; • Primary Care Flexible Staff Pool procurement completed and new offer to strengthen links between practices and GPs and GPNs wishing to work flexibly live from late March 2022; • Mentoring scheme first developed under the GP and GPN Fellowship and Mentoring scheme to be expanded out to wider workforce in 2022/23; • 12 GP Retention Schemes live in NCL at a borough level supporting development and retention of GPs. Given the high demand on the Primary Care workforce during the pandemic, the ICB will have to monitor the impact on wellbeing and fatigue. The ICB and NCL training hub have been implementing a wellbeing programme targeting Primary Care staff. This programme will continue into 22/23 with a Primary Care Wellbeing Lead recruited. Recent media coverage has highlighted the need for further scrutiny in relation the support and supervision offered to the newly diversified roles in General Practice which has been picked up as a key priority by the newly appointed Chief Medical Officer and Chief Nursing Officer.	16	16	16	16	→	9
PERF24	Failure of the Integrated Care Board in effectively managing the risks of devolution for Dental, Optometry, and Community Pharmacy Services from April 23 onwards (Threat)	Sarah McDonnell-Davies - Executive Director of Places	This is a new risk. The ICB has been working closely with NHS England ('NHSE') since July 2022 to facilitate the delegation of Dental, Optometry, and Community Pharmacy ('DOP') Services in April 2023. The Pre-Delegation Assurance Framework ('PDAF') is prepared in draft form and will be finalised in advance of the final submission deadline in October 2022. Executive Management Team have been kept updated on the issues relating to the DOP delegation. Progress towards meeting the delegation deadline is dependent upon the ICB receiving further guidance and service data from NHSE. This will support the ICB's intended deepdive in to the delegation's clinical and financial consequences and impact. All evidence received to date indicate the delegation will progress as planned. The Board will be kept updated with regards to DOP delegation.				16	→	12

PERF25	Failure to ensure adequate integration along urgent care pathway resulting in lengthy ambulance handover delays and slower response times in the community (Threat).	Richard Dale - Executive Director of Performance and Transformation	This is a new risk, and therefore will continue to develop over the following few weeks. It has been identified within the context of the high volume of ambulance delayed handovers, arising due to slow flow rates through hospitals. Site based root cause analysis is underway, but the cause is expected to be related winter-level attendance at A&E sustained throughout the summer months. A Quality Improvement (QI) toolkit is being developed to support system wide recovery. This is expected to be implemented in advance of the winter 2022/23 months. This will be one of the matrices that system performance will be measured against by NHS England.				16		→	9
COMM14	Failure To Achieve NHS Constitutional Targets - Urgent and Emergency Care (Threat)	Sarah Mansuralli - Chief Development and Population Health Officer	New Governance arrangements are in place that bring together Urgent Emergency Care ('UEC') and Community Silver meetings into a single weekly Flow Operational Group ('FOG') with the aim of improving matrix working to rapidly resolve system pathway issues that can't be answered at place level. The group is jointly chaired by the ICS CEO lead for Urgent Care and ICS lead for Community Care and includes representation from Acute, Mental Health ('MH') and Community providers, London Ambulance Service ('LAS') and NHS111 as well as Local Authorities A Flow Board has also been recently established to oversee the work of the FOG, defining the NCL strategic approach to improving the urgent care and community pathways from NHS111/LAS, A&E front door to internal flow and post-discharge recovery. The Flow Board will inform and be informed by both the UEC London Board's strategic approach to urgent and emergency care transformation and the NCL System Management Board. The Flow Board met 22 July 2022. The work of the Flow Groups will also interface with the NCL Clinical Advisory Group ('CAG') to provide clinical leadership and support the sharing and embedding of best practice learning The Terms of Reference for the UEC London Board have yet to be finalised but are likely to include a focus on providing strategic oversight of the complete UEC pathway and will include decision making on programme priorities, and the delivery of new or existing transformation projects/programmes. A UEC system pathway action plan focussed on improving hospital handover has been developed. The plan is reviewed fortnightly with monthly submission to NHSE. The remit of the group is under review to consider further key areas of focus and associated actions to mitigate in-year and winter pressures, such as: Workforce issues; MH capacity and flow; increasing Emergency Department activity including paediatrics; discharge capacity and Covid/flu planning. NHS111 re-procurement process remains on track. The business case is developed and approved through Governing Body June 2022. A Service Specification and Invitation to Tender documentation have been developed for approval through committee in September 2022.	16	16	16	16		→	9
COMM21	Variation in Community and Mental Health Services across NCL (Threat)	Sarah Mansuralli - Chief Development and Population Health Officer	Due to historical funding differences across the 5 legacy CCGs there are variations to Community and Mental Health ('MH') services within NCL ICB with possible consequences for service access and effectiveness, health inequalities, and resource management. The ICB completed two baseline reviews, one for Community Services and one for Mental health, and are available on the ICB website. These set out a clear case for change for both service areas. As part of the process a series of design workshops have been held. These have been attended by a wide range of colleagues from Provider Trusts, both clinical and operational staff, as well as colleagues from Local Authorities, experts by experience and some voluntary sector representatives. The ICB and programme board approved core service offers and a gap analysis between the existing and proposed services. These reports were agreed at September 2021 programme boards. To support the core service offers and gap analysis an impact assessment was finalised and work took place during Q1 2022-23 to agree an approach for funding the community service review. Providers are collaborating to deliver improvements to an agreed range of services e.g. P2 beds, Virtual Ward, Children and Young People's community services and coordinating functions, which are designed to deliver productivity and transformed services. Within MH care, providers are working collaboratively together on issues including Out of Area placements and community based teams. Providers completed project documentation for collaboration projects during July and August 2022. For community, which does not have dedicated investment (i.e. through an equivalent of the Mental Health Investment Standard) the programme board has used financial principles for investment, alongside programme principles to review which of the 'gaps' within the gap analysis should be addressed through ICS investment in year 1. A list of prioritised investment areas has been agreed via ICS and ICB governance and providers are drafting delivery plans, to be agreed with place based partners and the Implementation Steering Group. High level requirements from Reviews have been included in contractual documents e.g. a Service Development and Improvement Plan for 2022/23. Implementation workshops are taking place Borough partners and Local Authority Chief Executives have been engaged in terms of mental health and how to navigate an approach that recognises the importance of Place for most Mental Health service delivery, whilst still working at a NCL level to address key challenges such as inequitable service provision and workforce etc. The ICS is establishing an on-going monitoring programme for the outcomes of the review with the key governance forum being implementation steering groups, chaired by the ICS CEO lead for the area which report into the relevant programme board.	16	16	16	16		→	6
COMM22	Failure of the Integrated Care Board in effectively managing the transition of the budgets for Specialist Commissioning from April 23 onwards (Threat)	Sarah Mansuralli - Chief Development and Population Health Officer	We have been working with NHSE and ICS Partners since February on a Due Diligence Process that has been merged with the PDAF. We undertook initial analysis of Specialist Commissioning ('Spec Comm') data in March 2022 which showed the extent of income that comes into NCL from other ICSs and this has influenced our approach to working with the East of England Region where we now have monthly meetings and also led to the development of the North London Programme Board. Our work on Pillar 5 (Data) has led to ICSs now having access to Spec Comm Data from 1st July and our work on Pillar 2 (Commissioning) has broadly agreed the form of contract that will exist from 2023/24 onwards (i.e. a single contract incorporating ICS Services, Delegated Spec Comm and Retained Spec Comm). The Pre-Delegation Assurance Framework is produced in draft and will go through a process of refinement prior to submission to NHS London in early October. We have also identified some draft Clinical Priorities, discussed by Clinical Advisory Group in August 2022.			16	16		→	12

COMM26	Failure to making changes to support the shift of resources / investment into prevention & proactive care from crisis & acute management of care (Threat)	Sarah Mansuralli - Chief Development and Population Health Officer	One of the core purposes of the ICS is to improve the outcomes for its population. To achieve this, NCL is developing its population health improvement approach. As part of this we need to consider how we do things differently, in partnership with residents, communities, the voluntary sector and our partners, and including how we deploy our resources differently, with the emphasis on prevention, self-care and early intervention. We know that this is going to be a journey for the ICS and its partners, during a time when there are significant pressures on all to support elective recovery, respond to the financial challenges and look after our workforce. However, if we don't start to plan for and make these changes, we won't see the step-change in outcomes for our residents. Progress on the Population Health Improvement (PHI) portfolio was shared with the CCG's Strategy & Commissioning Committee during autumn 21 / winter 22, including updates on: • Establishment of PHI Committee; • NCL Population Health Needs Analysis; • Deep Dive Needs analysis - deprivation, age and ethnicity; • Draft Outcomes Framework; • Outline proposals for initial Population Health Improvement Strategy. The first iteration of the draft NCL Population Health Improvement Strategy has been completed and shared with the PHI Committee. It is now being socialised more widely and we are building a "response" which will come from 5x Places, transformation programmes and enabler workstreams to demonstrate what is already underway to address the gaps / inequalities in outcomes - with a focus on the principles and the core themes of delivery from the strategy permeating all the different areas of work, including how resources will be allocated to achieve our ambition of increased prevention and early intervention. A baseline of the indicators that constitute the Outcomes Framework was completed and shared with Population Health & Inequalities ('PHI') Committee on 5 July 2022. These have been socialised with borough partnerships and other stakeholders. Discussions are ongoing to consider how this supports the identification of NCL and local outcome priorities.			16	16		→	9
STR8	Failure to Deliver the 2022/23 System Efficiency Plans (SEP) and Transformation Programme (Threat)	Richard Dale - Executive Director of Performance and Transformation	The ICS System Efficiency plan will introduce a new approach that will be built with input from all system partners to support the financial recovery plan. The programme will include key efficiencies set out in the recent planning guidance. This will include clinical transformation, reduction in agency spend, medicine management, workforce, procurement and corporate services. This process includes developing and embedding a system wide culture change, reinforcing mechanisms within processes and enabling change through continuous improvement. The CCG/ICB Cost Improvement Programme (CIP) plan for 2022/23 includes efficiencies with primary care prescribing, CHC/CIC, pay budget reviews and small contract reviews.	20	20	20	20		→	16
FIN3	Long Term Financial Sustainability (Threat)	Phill Wells - Chief Finance Officer	From 2022/23, the financial regime has not reverted to a pre-COVID-19 financial regime, the start point for 22/23 funding was 2 x the funding received for the second six months of 2021/22. The 22/23 system envelope for NCL contains a real terms reduction of c5% mostly due to a 57% reduction to the COVID fund, no non-NHS income support and a convergence adjustment (based upon comparative distance from target) of 1.55%, the largest in London. There is a greater emphasis on contracts and a cost and volume element for elective to drive elective recovery. There is an elective recovery fund to enable systems to achieve 104% of 19/20 elective activity baseline. Funding then can be reduced or increased at a marginal rate of 75% tariff depending whether the 104% target is achieved – we are awaiting final ERF guidance. We know that the financial full year effects of capacity increases (e.g. ITU, Endoscopy) in response to COVID-19 pressures, and productivity losses (due to infection prevention control measures) will extend the underlying cost base further and the additional costs do not currently have a financial mitigation. The aim will be to make best use of capacity across the sector and to prepare a sector-wide efficiency programme to focus on 2022/23 in order to smooth the transition and avoid a financial cliff-edge. The draft 22/23 operating plan submitted on the 17th March 2022 identified a gross system deficit of £283m. The net position after a technical baselines issue for Royal Free, inflation in excess of 2.7% planning levels and the revenue impact of IFRS 16 was a deficit of £165m. For the April 22/23 operating plan submission the aggregate deficit reduced to £221m and the net position £123m. On 19th May the national team announced additional 22/23 allocations covering excess inflation, ambulance services, CHC and BCF pressure. The final 22/23 plan submission (20th June), following a peer review process with North West London ICS and a final apportionment of the remaining £23m, was for a system financial break-even position (with significant risk). The task is now to monitor and manage the system position to achieve, or get as close as possible to achieving, the break-even plan for 22/23 whilst developing plans to address the recurrent position for 23/24 and beyond.	20	20	20	20		→	16

FIN11	Failure to Deliver 2022/23 Statutory and Other Financial Requirements Set By NHS England (Threat)	Phill Wells - Chief Finance Officer	This risk has been developed to address the in-year financial risk for 2022/23. The 2022/23 annual financial plan was signed off by the NCL Governing Body in June 2022. This was the final submission in accordance with the national timetable. The ICB Finance Committee and Board will monitor progress against this plan. At month 4 (month 1 of the ICB) July 2022 the ICB submitted a balanced plan excluding the system surplus which the ICB is holding on behalf of the ICS.	20	20	20	20		→	16
QUAL24	Failure to base CHC and CIC Commissioning cycle and service on reliable data (Threat)	Chis Caldwell -Chief Nurse Officer	As part of strengthening our approach to CHC/CIC a review of CHC/CIC data was conducted. Following the review an increased focus on data quality has been developed within this area of operation and further informed with feedback from NCL CHC/CIC Staff workshops on the steps to take forward to improve. Standardisation and training in new procedures will effectively manage this risk, once controls are fully embedded. CHC Caretrack platforms have now been merged and the legacy records have been archived - with new records more complete given the increase in mandatory fields and standardisation of recording. Ongoing data cleansing continues, including the harmonisation of the rate cards. Additionally, a non-CHC (Mental Health, Learning Disability ('LD') and Children and Young People ('CYP')) clear line of sight patient data Caretrack upload has been completed for Mental Health and CYP with LD. Furthermore, historical practices are being managed, namely, timeliness in updating data on Caretrack, however, the introduction of Digital Referral Assessment ('D-RAR') and Spine will support this. A Caretrack training programme has been established for new and existing Caretrack Users to support the ongoing standardisation of data entry. CHC are also having discussions on the development of an NCL system-wide training strategy. The CHC Performance reports, via Caretrack Business Intelligence Tool, are reviewed weekly at the CHC Operational Performance Meeting and circulated to borough teams to review and validate data. This is driving up the quality and accuracy of the data. This will also be expanded to complex care patients once on Caretrack. NCL CCG signed the contract for NHS Spine. Phase 1 of this, delivering automated RIP recording and commissioned care closedown, was implemented in July 2022 reducing the risk of paying for RIP patients. Regarding NCL CCG/ICB D-RAR via Caretrack, which will enable digital referrals, Phase 1 – internal was launched on 7 March 2022. Further training and extension to external referrers to be developed. The NCL CHC Policy and Standard Operating Procedures, which will support all these areas, was launched at the NCL CHC/CIC Wider Team Meeting on 8 June 2022.	16	16	16	16		→	9

Risk Key

Risk Improving ↓

Risk Worsening ↑

Risk neither improving nor worsening but working towards target →

NHS
North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
27 September 2022

Report Title	Committee Terms of Reference, Standing Financial Instructions and Chair's Action Report	**Date of report**	16 September 2022	**Agenda Item**	4.1
Lead Director / Manager	Ian Porter, Executive Director of Corporate Affairs	**Email / Tel**		Ian.porter3@nhs.net	
Board Member Sponsor	Not applicable.				
Report Author	Andrew Spicer, Head of Governance and Risk	**Email / Tel**		Andrew.spicer1@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** The Terms of Reference set out each committee's purpose and role including the ability to commit organisational spend.			
Report Summary	The Board of Members approved the Terms of Reference for each of its committee and sub-committees at its meeting on 4 July 2022. Subsequently, the Terms of Reference and the Standing Financial Instructions were reviewed and some amendments are recommended for approval. These are as follows: <u>Strategy and Development Committee</u> • A change in the frequency of committee meetings from bi-monthly to four times per year. It is expected that committee meetings will be held quarterly and the Terms of Reference retain the ability for the committee to hold additional meetings as required; • The inclusion of an additional Partner Member to the committee's membership; • The inclusion of the ICB's Chief People Officer as a Standing Participant at committee meetings. <u>Integrated Medicines Optimisation Committee</u> • A change in the Chair and deputy Chair requirements so that a Partner Member will Chair the committee and a Non-Executive Member ('NEM') shall be the Deputy Chair. This is to ensure the robust management of conflicts of interest in the event that the Chair has a conflict of interest. <u>Finance Committee</u> • A reduction in the frequency of committee meetings from monthly to ten times per year. This, in addition to the Board of Members meeting, will continue to provide robust oversight of the committee's key functions for finance.				

Primary Care Contracting Committee

- An amendment to section 21 which corrects a typographical error and so makes it clear that the committee may not delegate any of its functions, powers or decision making authority to a working group.

Standing Financial Instructions- Annex 1 (Delegated Financial Limits)

- An amendment to line 5.13 entitled *'Compromise Agreements, COT3 Agreements and other types of agreements for termination or loss of office or employment (NHS England agreement must also be sought)- outside of contract'* which corrects a typographical error in the Chief People Officer column (changing the word 'or' to 'and') so that the Chief Executive, Chief Finance Officer ('CFO') and the Chief People Officer must act together when approving these types of payments up to £20k. This is consistent with the requirements in the Chief Executive and the CFO columns.

Functions and Decisions Map

- An amendment to include the VCSE Alliance in the Functions and Decisions Map.

The Board of Members is asked to approve the above amendments to the Terms of Reference for the Strategy and Development Committee, the Integrated Medicines Optimisation Committee, the Finance Committee and the amendments to the Functions and Decisions Map and the Standing Financial Instructions- Annex 1.

Chair's Action

A review of the membership of the Procurement Oversight Group ('POG') was undertaken and a decision made to seek the Board of Members' approval to revise the POG's membership. However, an urgent meeting of the POG needed to take place to ensure the timely procurement and mobilisation of the NHS 111 service and the revisions could not wait until the following Board of Members meeting on 27 September 2022.

Therefore, a request to revise the POG's membership was approved by Chair's Action on 10 August 2022.

Chair's Action

Under section 13 of the ICB's Standing Orders the Chair and Chief Executive acting together may exercise any of the decision making powers reserved to the Board of Members under the Scheme of Reservation and Delegation where a decision is of such importance or urgency that it cannot wait until the next ICB Board meeting or appropriate ICB Board committee or Sub-Committee meeting.

The power can only be exercised by the Chair and Chief Executive after having consulted at least two other members of the Board of Members, including at least one Non-Executive Member. All decisions made by Chair's Action must be reported at the following Board of Members meeting.

The approved revisions were as follows:

- Amendments to the membership of the POG so that it becomes an executive led committee as follows:
    - Removal of the Non-Executive Members;
    - The CFO to Chair the POG;
    - The Head of Governance and Risk to be a Standing Participant;
- Amendments to the POG's quorum requirements so that quoracy is the Chair, an additional Executive Director and a clinician;

	• The Independent Clinician remains a member of the POG; • The removal of the ability for the POG to approve Single Tender Waivers over the limit of the Chief Executive and CFO acting together (currently £1m), on behalf of the Board of Members given the POG's revised membership; • The addition of the ability for the Finance Committee to approve Single Tender Waivers on behalf of the Board of Members; • Amendments to line 2.5 of Annex 1 of the Standing Financial Instructions which: a) removes the requirement for Single Tender Waivers to be reported to the POG, and b) provides the Finance Committee with the ability to approve all Single Tender Waivers on behalf of the Board of Members that are over the limit of the Chief Executive and CFO acting together (currently £1m). Single Tender Waivers would continue to be reported to the Audit Committee and included on the ICB's Register of Procurement Decisions, which is overseen by the POG. The Board of Members is asked to note the Chair's Action. The amended Terms of Reference and Standing Financial Instructions will be published on the staff intranet and in the Governance Handbook on the ICB's website.
Recommendation	The Board of Members is asked to: • **APPROVE** the amendments to: o The Terms of Reference for the Strategy and Development Committee, the Integrated Medicines Optimisation Committee, and the Finance Committee; o The Functions and Decisions Map; o The Standing Financial Instructions- Annex 1. • **NOTE** the Chair's Action.
Identified Risks and Risk Management Actions	The amendments contained in this paper assist the ICB in the effective oversight and exercise of its functions.
Conflicts of Interest	All conflicts of interest will be managed robustly in line with NHS England statutory guidance, the principles contained in the ICB's Constitution, the organisation's Conflicts of Interest Policy and English law.
Resource Implications	The Terms of Reference and the Standing Financial Instructions support the organisation's oversight of its resources.
Engagement	This report is being presented to the Board of Members which includes independent members and Partner Members.
Equality Impact Analysis	This report has been drafted in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	The committee Terms of Reference and the Standing Financial Instructions were last presented to the Board of Members on 4 July 2022.
Next Steps	If the Board of Members approve the amendments contained in this paper the next steps will be to implement the revisions.

Appendices	None.