NHS North Central London ICB
Board of Members Meeting

Tuesday, 9 May 2023
2pm – 3.30pm
Clerkenwell Room
2nd Floor, Laycock Professional Development Centre
Laycock Street
N1 1TH

AGENDA
Part 1

Item	Title	Lead	Action	Page	Time
1.	**INTRODUCTION**				
1.1	Welcome and Apologies	Chair	Note	Oral	2pm
1.2	Declarations of Interest (not otherwise stated)	Chair	Note	3	
1.3	Draft Minutes of the NCL ICB Board of Members Meetings on 7 February and 28 March 2023	Chair	Approve	8 18	
1.4	Matters Arising	Chair	Note	26	
1.5	Update from the Chair	Chair	Note	Oral	2.10pm
1.6	Report from the Chief Executive Officer	Frances O'Callaghan	Note	28	2.15pm
2.	**STRATEGY AND BUSINESS**				
2.1	ICS People Strategy	Sarah Morgan	Approve	34	2.30pm
2.2	ICB Priorities 2023/24	Sarah Mansuralli and Ian Porter	Approve	55	2.40pm
3.	**OVERVIEW REPORTS**				
3.1	Integrated Performance and Quality Escalation Report	Richard Dale and Dr Chris Caldwell	Note	62	2.50pm
3.2	2023/24 Financial Planning Update	Phill Wells	Note	82	3.05pm
3.3	Board Assurance Framework	Ian Porter	Note	88	3.15pm

4.	ITEMS FOR INFORMATION AND ASSURANCE				
4.1	Minutes of the Audit Committee Meeting on 24 January 2023	Kay Boycott	Note		3.25pm
4.2	Minutes of the Finance Committee Meeting on 31 January 2023	Usman Khan	Note		
4.3	Minutes of the Quality and Safety Committee Meeting on 10 January 2023	Liz Sayce	Note		
4.4	Minutes of the Strategy and Development Committee Meeting on 2 November 2022	Chair	Note		
5.	ANY OTHER BUSINESS				
5.1	Any Other Business				
6.	DATE OF NEXT MEETING				
6.1	25 July 2023 (2pm – 4pm)				
7.	PART 2 MEETINGS				
7.1	To resolve that as publicity on items contained in Part 2 of the agenda would be prejudicial to public interest by reason of their confidential nature, representatives of the press and members of the public should be excluded from the remainder of the meeting. Section 1 (2) Public Bodies (Admission to meetings) Act 1960.				

North Central London ICB
Board of Members Meeting
9 May 2023

Report Title	Declaration of Interests Register – NCL ICB Board of Members	**Date of report**	2 May 2023	**Agenda Item**	1.2
Integrated Care Board Sponsor	Mike Cooke Chair, NCL ICB	**Email / Tel**		mike.cooke4@nhs.net	
Lead Director / Manager	Frances O'Callaghan, Chief Executive, NCL ICB	**Email / Tel**			
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 - May 2023

Name	Current Position (s) held- i.e. ICB Board, Trust, Member practice, Employee or other	Declared Interest - (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or Indirect?	Nature of Interest	Date of Interest				Actions to be taken to mitigate risk (to be agreed with line a manager of a senior CCG manager)
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	Date declared	Updated	
Members												
Mr Mike **Cooke**	Chair North London Integrated Care System		Yes			direct						
	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	BEAT is commissioned by some commissioning organisations to provide services. This declaration is for transparency. There is no conflict of interest between the roles flagged in this declaration. In any future scenario where NCL based commissioners enter any discussions with BEAT I would step out of and would not be involved in any discussions or decision making
Ms Frances **O'Callaghan**	Chief Executive of North London Integrated Care System	n/a	no	no	no	no				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	Where decisions to be taken by the ICB contain a potential or perceived conflict, I will excuse myself from the decision making process and a suitable deputy will act in my place
		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		
	Member of Primary Care Contracting Committee	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		Appropriate mitigations to be taken as directed by ICB, to avoid my involvement in any decision making pertaining to financial transactions /or other.
		City Road Medical Centre	yes	yes	yes	direct	GP Partner	11/07/2019	current	10/07/2022		contrcat to novate to salaried GP - Federation
		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											
	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		These are infrequent and under NDA - In previous NHS roles I have agreed I would declare if relevant to a specific agenda item
		IBM	no	no	no	Indirect				11/07/2022		
Ms Liz **Sayce OBE**	Non Executive Member, Member of the ICB Board											
	Chair of ICB Remuneration Committee											
	Chair of ICB Quality and Safety Committee	Action on Disability and Development International	yes	yes		direct	Trustee	26/01/2021	current	26/08/2022		
	Member of ICB Audit Committee	London School of Economics	yes	yes		direct	Visiting Professor in Practice		current	26/08/2022	22/01/2023	
	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		
	Chair NCL People Board	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		
		Furzedown Project, Wandsworth, Charity no 1076087	no			direct	Trustee	24/11/2022	current	24/11/2022		

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

		Consultancy roles	no	no	no	indirect	My partner offers consultancy across the UK to mental health services, sometimes working with NHS Trusts, local authorities or voluntary sector organisations		current	26/08/2022		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 Executive Management Team	none	N/A	N/A	N/A	N/A	N/A			04/07/2022		
	Member of ICB Board											
	Member of Quality and Safety Committee											
	Member of Strategy and Development Committee											
	Member of Primary Care Contracting Committee											
		Middlesex University	N/A	YES	N/A	Direct	visiting honorary Professor	30/03/2023	current	30/03/2023		
Mr Mark **Lam**	Board Member ICB		no	yes	no	Direct	Member	01/03/2023	current	12/04/2023		
		Royal Free Hospitals	yes	yes	no	Direct	Chair	01/04/2021	current	12/04/2023		
		North Middlesex University Hospital	yes	yes	no	Direct	Chair	01/10/2021	current	12/04/2023		
		UCL Partners	yes	yes	no	Direct	Director	12/04/2021	current	12/04/2023		
		UCL Health Alliance	yes	yes	no	Direct	Vice Chair	12/12/2022	current	12/04/2023		
		Social Work England	yes	yes	no	Direct	Non Executive Director	11/01/2019	current	12/04/2023		
		Broadway Partners	yes	yes	no	Direct	Vice Chair	01/02/2022	current	12/04/2023		
		JT Group	yes	yes	no	Direct	Non Executive Director	01/04/2023	current	12/04/2023		
		Games Workshop Group PLC	yes	yes	no	Direct	Non Executive Director	12/04/2023	current	12/04/2023		
		Hastings International Piano	no	no	yes	direct	Trustee	27/05/2011	current	12/04/2023		
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	Vice Chair of Governors	01/08/2022	current	07/09/2022	09/01/2023	
	Member of ICB Remuneration Committee	Motor Neurone Disease Association	yes	yes	yes	Direct	Chair of Trustees / director	01/07/2021	current	07/09/2022		
		FIPRA, a European public affairs consultancy	yes	yes	yes	Direct	Senior Advisor for EU Health Policy	01/50/2020	current	07/09/2022		
		KU Leuven University, Belgium	yes	yes	yes	Direct	Visiting Professor in Health Management and Policy		current	07/09/2022		
		Good Governance Institute	no	yes	No	Direct	Senior Advisor / Associate	01/02/2022	current	07/09/2022	09/01/2023	
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		01/07/2022	current	01/07/2022		
	Audit Committee, attendee											
	Procurement Oversight Group, voting member											
	Remuneration Committee, attendee											
	Member of ICB 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	James Wigg and Queens Crescent Practices	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 Member 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		
Dr Alpesh **Patel**	Board Member Attendee and Chair of GPPA	White Lodge Medical Practice	Y	y	n	direct	GP Partner	1998	current	27/01/2016	12/12/2022	
		Gemini Health	y	y	n	indirect	Director	Aug-17	current	27/01/2016	12/12/2022	
		Enfield Healthcare Cooperative	y	y	n	indirect	Director	Sep-17	current	27/01/2016	12/12/2022	
		Enfield One Ltd	y	y	n	indirect	Director			27/01/2016	12/12/2022	
		White Lodge Medical Practice Ltd	y	y	n	indirect	Director	2009	current	27/01/2016	12/12/2022	
			y	y	n	indirect	Director	2009	current	27/01/2016	12/12/2022	
		Equity Health LLP	y	y	n	indirect	Director	Nov-08	current	27/01/2016	12/12/2022	
		Enfield Health Partnership Limited, Provider of community gynaecology service	y	y	n	indirect	Shareholder 5%	Mar-13	current	27/01/2016	12/12/2022	
		Enfield Healthcare Alliance	Y	Y	N	indirect	Shareholder less than 5% (as White Lodge	2015	curremt	27/01/2016	12/12/2022	
		Local Medical Committee	N	Y	N	indirect	member	11/09/2014	current	27/01/2016	12/12/2022	
		BEH MHT	N	Y	N	indirect	spouse is a Pyschiatrist at Trust	27/01/2016	currrent	27/01/2016	12/12/2022	
		Evergreen Surgery	y	y	y	direct	Director	2007	current	27/01/2016	12/12/2022	
		NCL training Hub	y	y	y	direct	Clinical Lead	01/04/2022	current	12/12/2022		
		NHSE	y	y	y	direct	GP Appraiser	2016	current	12/12/2022		
		Enfield Health Partnership Limited (Federation)	y	y	y	direct	co-chair	mid 2020	current	12/12/2022		
		Enfield Care Network	y	y	y	direct	Practice is a member of PCN	01/07/2019	current	08/05/2020	12/12/2022	
Kaya **Comer-Schartz**	Board Member attendee and Leader of Islington Borough Council	Islington Borough Council	y	y	y	direct	Leader of the Council		current	14/12/2022		
		Junction Ward - Islington Borough					Councillor Representative, Labour		current	14/12/2022		
Richard **Dale**	Executive Director of Transtion and Performance Member of Executive Management Team Attend ICB Board of Members Finance Committee Audit Committee Strategy and Development Committee Member of Quality and Safety Commitee	No interests declared	No	No	No	No		03/07/2018	current	04/09/2019	06/07/2022	
Sarah **Mansuralli**	Chief Development and Population Health Officer Member of Executive Management Team Member of Primary Care Contracting Committee 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		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	06/10/2022	
Sarah **Morgan**	Chief People Officer Member of the Executive Member Team											
	Attend Remuneration Committee Attend Primary Care Contracting Committee Member of People Board and People and Culture Oversight Group Attend other Committee meetings as appropriate	Good Governance Institute	no	no	yes	Direct	Faculty member	01/12/2020	current	04/07/2022		voluntary and do not provide any services only thought leadership as a health and social care stakeholder contributor
		Fresh Visions People Ltd	no	no	yes	Direct	Trustee / Director	01/04/2022	current	04/07/2022	16/02/2023	Ensure that any contractual arrangements that may involve Fresh Visions or the parent organisation Southern Housing are declared as a conflict of interest as operate out of London

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

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
Cllr Kaya Comer-Schwartz	Leader, Islington Council
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
Usman Khan	Non-Executive Member
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
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
Ian Porter*	Executive Director of Corporate Affairs
Dr Jo Sauvage	Chief Medical Officer
Liz Sayce	Non-Executive Member
Phill Wells	Chief Finance Officer
Apologies	
Caroline Clarke*	Group Chief Executive, Royal Free Hospitals and Accountable Officer, NMUH
Dr Alpesh Patel*	Acting Chair, GP Provider Alliance
Minutes	
Steve Beeho	Board Secretary

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1 1.1.2	The Chair welcomed attendees to the Meeting. Apologies had been received from Dr Alpesh Patel and Caroline Clarke. Paul Sinden was attending on behalf of Dr Patel. Liz Sayce and Dominic Dodd were attending 'virtually' rather than in person.
1.2	**Declarations of Interest relating to the items on the Agenda**
1.2.1	The Chair invited Members to declare any interests relating to items on the agenda.

* Standing Participant

1.2.2 1.2.3	Julia Neuberger noted that she is now a member of the House of Lords Science and Technology Committee, although this did not have any bearing on today's agenda. There were no further declarations from members. The Board of Members: • **NOTED** the requirement to declare any interests relating to the agenda; • **NOTED** the Declaration of Interests Register and the requirement to inspect their entry and advise the Board Secretary of any changes; • **NOTED** the requirement to record any relevant gifts and hospitality on the ICB Gifts and Hospitality Register.
1.3	**Minutes of the NCL ICB Board of Members Meeting on 29 October 2022**
1.3.1	The Board of Members **APPROVED** the minutes as an accurate record.
1.4	**Matters Arising**
1.4.1 1.4.2	There were no matters arising. The Board of Members **NOTED** the Action Log.
1.5	**Update from the Chair**
1.5.1	The Chair noted that Caroline Clarke, who was unable to attend today, will be stepping away from the Board in order to concentrate on other commitments. He thanked her for her huge contribution to the development of the ICB and he looked forward to continuing to work with her in the future. In recognition of the pivotal part that the Royal Free Group plays in the NCL system, discussions are underway with the Royal Free Chair, Mark Lam, about joining the Board.
1.6	**Report from the Chief Executive Officer**
1.6.1	Frances O'Callaghan provided an overview of the report, highlighting the following points: • NCL is continuing to experience significant system pressures across all elements of care delivery. This is the result of a number of factors, including the post-Covid recovery and the recent industrial action. She thanked everybody involved in organising cover in response to the strikes. Jo Sauvage is leading on an important piece of work to reduce the pressures on ambulance conveyancing and an update on this will be brought to a future meeting • Excellent collaborative work is taking place with local authority colleagues around the Better Care Fund and the additional funding for discharges • The work of Sarah Morgan and everybody else involved in NCL being appointed one of the ten NHS Universal Family (Care Leavers Covenant) Pathfinder ICBs was commended • The ongoing enhanced support to people residing in care homes to enable them to receive pro-active, well planned and personalised care was highlighted, in particular the use of the Whzan 'blue box' which gives staff wider access to information around patients • Ofsted had recently visited Islington Council's children's services to inspect the arrangements for care experienced children and young people (care leavers). The ICB is committed to doing more across NCL in terms of children's and young people's services, given its commitment to the Start Well programme • A number of recent clinical and care leadership appointments were highlighted, including o the appointment of David Pennington as ICB Director of Safeguarding o Sheila O'Shea has added to her portfolio to become NCL ICB Director of Complex Care and Deputy Chief Nurse o David Connor, Director of Midwifery at Royal Free, London, and co-chair of our local Maternity and Neonatal System, will be supporting the ICB Chief Nursing Officer (CNO) with Midwifery strategic clinical leadership

	○ Dr Sonali Kinra and Michelle Johnson will be joining the ICB clinical directorate to nurture the development of clinical and care leadership within the system, as well as focusing on integration and the growth of neighbourhood multi-disciplinary teams • The ICB had received a substantially compliant 'green' rating for Emergency Planning, Resilience and Response (EPRR) as part of the NHS England assurance process • The Board was also being asked to note a Chair's Action that was taken on 12 December 2022 to approve additional funding of £1.3m (including 10% contingency) from ICS 2022/23 capital slippage to cover increased costs of existing projects.
1.6.2	The Board of Members discussed the paper, making the following comments: • also it will be important for trusts to review the wider impact on morale, retention and internal culture, although it is difficult to assess this while the strikes are still ongoing. • It was noted from a provider perspective that the current focus during the industrial action is on mitigations. • It was agreed that the People Board should reflect further on how the ramifications of the industrial action should be addressed at provider and ICS level.
1.6.3	The Board of Members **NOTED** the Report and the Chair's Action.
1.6.4	Action: Liz Sayce and Sarah Morgan to arrange for the People Board to reflect further on how the ramifications of the industrial action should be addressed at provider and ICS level.
2.	**STRATEGY AND BUSINESS**
2.1	**Quality Vision Update**
2.1.1	Dr Chris Caldwell introduced the paper which was a follow-up to an earlier paper presented in September 2022. She highlighted the following points: • The ICB has responsibility for providing system assurance on quality to NHS England. As part of this it works with providers collaboratively at neighbourhood, place and system level and reports through an integrated dashboard which is being discussed later on the meeting agenda • The ICB is developing a Population Health Improvement Strategy (PHIS) which will contain key priorities and measures that will act as the indicators to show that NCL is delivering quality care to its residents. Further work is needed to determine what quality care means *for* residents – in other words, what would they recognise as an improvement • As part of the next steps, the Quality and Safety Committee is holding a workshop next week to discuss the PHIS and the integration of quality and safety into its work, while also confirming the ICB's ambitions for quality and the role of the Committee in this • Therefore rather than the ICB having a separate Quality and Safety strategy, quality and safety will instead be at the centre of the PHIS, with clear measures that the Quality teams and the Committee can focus on.
2.1.2	Liz Sayce further noted that she and Dr Caldwell had been speaking to Quality and Safety Committee members at other ICBs regarding the role and remit of their committees. The ICB will turn a dual lens on commissioned services, obtaining assurance that providers have quality systems in place, while also taking a view through the wider PHIS with respect to people experiencing the 'mesh' of services, especially those with Long Term Conditions. The ICB aims to take a citizen-centred approach and welcomes the involvement of Healthwatch on the Committee in that regard.
2.1.3	The Board of Members discussed the paper, making the following comments: • The idea of looking at quality through a multi-dimensional lens and aligning it to the PHIS was welcomed. However, it is important to note that there will be specific detailed workplans underpinning this that will sit alongside the Strategy, rather than be incorporated within it

	• Assurance was given that there will be a large focus on reducing health inequalities within the PHIS – working at place will be key to ensuring that core standards are in place across NCL.
2.1.4	The Board of Members **NOTED** the approach set out in the paper.
2.2	**Summary of NCL ICB BCF and Section 75 Agreements (2022/23)**
2.2.1	Sarah Mansuralli introduced the 2022/23 Section 75 agreements. She acknowledged that the paper was being brought for approval late in the financial year but this reflected the fact that guidance which needed to be incorporated into the final agreements was still being received up until December 2022. It is hoped that the 2023/24 agreements will be brought to the Board for approval much earlier in the financial year. She then highlighted the following points: • Section 75 agreements are the legal agreements through which local authorities and health partners come together to either pool or align budgets which support the operational and strategic delivery of services which largely support residents to receive integrated care as well as more care provided in the community • The paper provides details of the range of services delivered through Section 75 arrangements and the associated financial values • These agreements have not been reviewed for a number of years, primarily because of the focus on operational resilience during the pandemic. The report outlines the process in place to address this, which will be overseen by the Strategy and Development Committee. Health and Wellbeing Boards will also need to be updated on the review process and timelines as part of this work • This work will inform the shape and size of future Section 75 arrangements, recognising that there is considerable variation, while also beginning to crystalise the role of Borough Partnerships and how this will support them in delivering their objectives.
2.2.2	John Hooton echoed Sarah Mansuralli's comments about funding being received at different points throughout the year. He observed that the review will be welcomed as there are some significant variations in arrangements across the budgets, particularly around pooled budgets. The commitment to involve Health and Wellbeing Boards in the review process was also welcomed.
2.2.3	The Board of Members discussed the paper, making the following comments: • It was noted that the current inequities are a result of five organisations historically taking different decisions in isolation. The review will therefore help to distil any learning about how different services provide efficiency and efficacy • Although there are significant variations between the Section 75 agreements, they are comprised of different levels of influenceable and non-influenceable spend and reflect historical legacy approaches at local level. For instance, a large value of the Section 75 in Haringey reflects a contribution to Community Services provided by Whittington Health, where the contract values are determined through the system planning process. In other areas the review will be able to look at how services can be delivered differently and make recommendations which will really have an impact on population health needs • The ICB will need to discuss with local authorities how Section 75 budgets can help Borough Partnerships fulfil their objectives to deliver integrated care and address inequalities. The latest national guidance around BCF (which is part of the Section 75 agreements) focuses on inequalities so this will be a key component going forward • It was highlighted that historically the level of Section 75 spend in Barnet and Enfield is much lower than the other three NCL Boroughs and one of the questions the review will need to consider is whether a pooled funding approach would lead to better outcomes • The 'core offer' for Community and Mental Health Services seeks to address these inequalities • It was confirmed that the review is already in train and first report on its findings will be brought to the Strategy and Development Committee in June 2023

	• It was noted that given the financial pressures facing local authorities and ICBs, the review will focus more on integration and whether pooled funding is the optimum approach, for instance, as opposed to levels of funding per se. The review will also provide an opportunity to review the services being commissioned in light of changes to population profiles in recent years • It was noted that the Section 75 agreements are a key avenue for the system working at Place. The review was therefore welcomed as it will provide leverage for the Boroughs to take ownership once agreement has been reached on the way forward.
2.2.4	The Board of Members: • **APPROVED** the BCF and non-BCF Section 75 schemes and budgets set out for financial year 2022/23 • **NOTED** that schemes stood up against the £5.4m NCL share of the new £200m national Discharge allocation may be added to the BCF or relevant Section 75 along with any additional schemes stood up in the final quarter of 2022/23 • **APPROVED** the metrics associated with the BCF schemes, noting that 2022/23 outturn performance against these metrics will act as the baseline for trajectory setting for 2023/24 and beyond • **APPROVED** the proposed joint review of Section 75 and BCF arrangements with local authority partners as outlined in section 4 of the paper.
3.	**OVERVIEW REPORTS**
3.1	**Integrated Performance and Quality Escalation Report**
3.1.1	Richard Dale and Dr Chris Caldwell introduced the paper, which provided an update on the key quality and performance measures associated with the ICB's priority strategic programmes and the national assurance and oversight process for ICBs and ICSs. They highlighted the following points: • As noted earlier, the health and care system is continuing to experience significant operational pressures. This is being driven by a number of factors, including primary care activity at 130% of pre-pandemic levels despite a smaller workforce and high bed occupancy rates at acute hospitals while also undertaking additional planned care activity to recover these services – planned care activity currently stands at 108% of pre-pandemic levels. Significant work is also taking place to recover cancer services • The ongoing industrial action inevitably has an operational cost – for example, the four days of strikes in nursing meant that over 2000 operations at UCLH had to be either cancelled or moved. A system-wide plan is being implemented to mitigate the impact of the strikes, with a consistent framework in place for escalations • The ICB is continuing to meet regularly with Royal Free London, North Middlesex University Hospital and the Tavistock and Portman, all of which are in Segment 3 of the national System Oversight Framework, where support is mandated by the Regulator to improve performance. Criteria for exiting the Framework have been agreed with Royal Free London and North Middlesex Hospital and improvement plans are being developed by the Tavistock and Portman • Guidance has been published on the Priorities and Operational Planning 2023/24. Final plans will be signed off by ICB and Trust boards for submission before the end of March 2023 • Many of the current measures do not reflect the ICB's aspirations and the Board was assured that this situation is not being normalised. The ICB is working closely with Trust colleagues to recover these services • The bed occupancy rates are in excess of what would normally be considered safe in order to maintain the flow of patients and ensure staff can have the training and support they need to carry out their work and undertake routine housekeeping. Given the circumstances, the level of positivity and creativity that staff are demonstrating is remarkable.

3.1.2	The Board of Members discussed the paper, making the following comments: • In order to meet its challenging targets, the system will need to do something fundamentally different which goes beyond simply working harder. The previously-highlighted work that Jo Sauvage is doing with LAS, which has system transformation at its heart, is a prime example of the type of innovative thinking that is needed. • It would be helpful to have a discussion at a future Board seminar about what can be done differently to have a significant impact • The progress in various areas such as the number of GP appointments and 7-day access was welcomed but it was queried whether engagement activity is also taking place with the community about where care is provided, as it is important to strike a balance between demand and need • Although the report provides a wealth of valuable information, it does not provide the metrics that would allow the Board to know when things are unsustainable – for instance, whether residents trust that they will receive timely care or if groups feel disenfranchised • It would be helpful for the Board to understand what quantitative differences new initiatives such as frailty cars and the actions being put in place to further mitigate mental health ED pressures are having, as well as their impact on patient experience and outcomes. Although the ICB is rightly focused on performance targets, it is important that the Board also understands the impact on equity and the extent to which the ICB can sustain the momentum of these developments so that it is better placed to cope with next year's winter pressures • More needs to be done to alleviate the pressures on primary care as the current position is unsustainable. This is having a negative impact on staff goodwill, as well as their health and wellbeing, with a growing number on long-term sick leave • Although the increased number of GP appointments is clearly welcome, this is probably contrary to public perception, so there is a need for the ICB to provide assurance on this point • In response to a query about whether the mental health metrics reflect what the Trusts would ideally like to report, it was noted that there are 'softer' mental health metrics, such as accommodation and employment, which make a difference to people's mental health and wellbeing but do not get measured • It was noted that the NHS generally operates within short-term horizons and therefore investing in primary care in order to tackle chronic illness and manage Long Term Conditions poses a significant challenge as the benefits of this work, such as a reduction in hospital episodes, will take time to come to fruition • While this ambition was supported, it was suggested that the more immediate priority is to return to the Long Term Conditions position that was in place before the pandemic, as there has been a rise in avoidable admissions relating to diabetes and high blood pressure • The future seminar discussion should consider things that the ICB might want to pilot which may not necessarily provide benefits within two years but would at least offer a positive direction of travel • The system faces a complex financial situation and it is imperative that it comes together to take the necessary decisions to deliver the outcomes that are needed in year to avoid a recurrence of excess winter deaths in 2023/24 • It was highlighted that the Fuller Review recommended integration as the means to sustain primary care and it is important that the ICB heeds this • It was noted that a range of solutions to the challenges are already in evidence in NCL, including the work which is underway to support some of the most vulnerable populations, such as alcohol disease management, but this work needs to be supported at scale and pace in order to have a transformational impact. Alongside this, there is a range of opportunities at neighbourhood level and in integrated urgent care, and the system needs to look at how it can shift the dial from end to end in key pathways as this will give the ICS a lot of influence which can be leveraged • There is a huge mismatch between supply and demand in the system and there are no short-term solutions to this. The importance of doing things differently at the front of the pathway across certain services is a critical theme

	• Future changes may ultimately result in a sharper distinction between more complex work which requires intimate local integration and population health management and more discrete parts of the pathway, such as certain pieces of MSK or IAPT work, which are significant drivers of primary care activity that might be done differently in a way that would free up time to focus on more complex work in a more integrated way • The UCL Health Alliance has made a bid for national funding to accelerate its plans to innovate by putting things in place at the front end of the pathway – if successful, this will bring more resource into NCL to support innovation pilots.
3.1.3	The Chair thanked members for the important discussion. This will be followed up with a seminar discussion about the need for innovation in order to break out of the current cycle as the current arrangements are unsustainable and there is a strategic risk that the focus on short-term requirements impacts the ICB's ability to shift towards a greater focus on early interventions and prevention. He further noted that the pack had been well-received, while recognising that it remains in development.
3.1.4	The Board of Members **NOTED** the key issues set out in the paper for escalation and the actions in place to support improvement.
3.2	**Finance Report**
3.2.1	Phill Wells introduced the paper, which set out the financial position for the ICS as a whole and in more detailed form for the ICB. He highlighted the following points: • The proposed amendment to the Standing Financial Instructions (SFIs) has been made to accommodate the authorisation of in extremis expenditure out of hours by an Executive Director • At Month 9 the system as a whole is £53.6m in deficit – all of this deficit sits with providers and is £32m adverse to plan. The primary causes remain consistent, including system expenditure on agency staff being higher than plan and target, delivery of planned efficiency savings, persistent excess inflationary challenges over and above those that the system was allowed to plan for as part of the 2022/23 planning round and emergent pressures in a number of areas, including prescribing. • Although the system forecast position will remain as break-even at Month 10, there will be movement among providers' positions as part of this. Providers whose positions move adverse to plan will trigger the NHSE Forecast Outturn protocol but as the overall system is still forecasting break-even, the consequences of this will be limited • It is important to note that the system is only able to maintain a break-even position as a result of non-recurrent support. A number of partners across the system have been particularly helpful in this respect from within their own positions • The ICB is still forecasting to plan which would mean a £9.4m adverse position for Months 4-12, off-set by a favourable variance in Months 1-3 • There has been a degree of capital slippage and although action will be taken to address this, it is likely that the system will undershoot its overall limit for 2022/23 • It is expected that the forthcoming planning round for both the ICB and the system will be extremely challenging. The new elective payment model appears to be more complex in returning to variable payment models for most elective activity and although NCL expects to improve elective output in the next financial year, the efficiency challenge is likely to be even more stretching than it was for 2022/23. There is a significant risk of not reaching break-even when the final plan is submitted • The ICB has enacted an assumption of 5% efficiency savings on non-pay expenditure and is working through the consequences of an anticipated running costs allowance reduction for 2024/25 in order to factor this into the pay budget for 2023/24.
3.2.2	The Board of Members discussed the paper, making the following comments: • It was clarified that providers' cash reserves are not included in this paper for operational reasons but this detail will be reinstated in the next report that the Board receives • It was suggested that it would be helpful to discuss cash reserves in the system at a future Finance Committee meeting to ensure a shared understanding of the current position

	• Draft system planning returns for 2023/24 are likely to show a deficit in aggregate and it will therefore need to take time to work through this. • Although the current financial year has been challenging, a number of non-recurrent solutions have made this more manageable and the providers' commitment to the NCL system was commended. • Some concern was expressed in relation to the calculations behind the Convergence factor applied to NCL's overall funding level. This serves to reduce its overall allocation. It was queried whether these adjustments appropriately reflect the diverse nature of the NCL boroughs, particularly the level of deprivation and unmet need in specific communities and the extent to which NCL has risen to the challenge of taking in asylum seekers and the extent to which it has a complex health economy, especially around Specialised Commissioning, while also being expected to increase its activity. The Board encouraged Phill Wells to continue to make representations to NHS England in relation to this. • It was suggested that NHS England should show greater flexibility around the application of CRL (Capital Resource Limit). As things stand, the system needs to think about different ways of delivering care within that limit, through more co-location and via an Estates Strategy that sets out the direction of travel • It was noted that cash reserves traditionally support capital spending within the confines of CRL. This is currently being stretched by the significant development schemes that the system wants to undertake as well as Electronic Patient Record (EPR) systems which need to be implemented and improvements to the primary care estate. The case for being allowed to spend more of this capital is reinforced by the fact that there are 10 large providers in NCL, a number of which provide significant services to populations from outside NCL • There is a significant gap between the revenue that NCL receives to fund elective activity and the level of activity taking place, despite the fact that as a system NCL had the second highest level of activity in the country when the current standards were set. As a result a series of conversations are taking place between Phill Wells, Tim Jaggard and the London and National teams to get a better understanding of what exactly is being asked of NCL as there is a significant gap in terms of how it will fund this activity • In response to concern about how potential changes in ICB staffing are being discussed with local authorities, particularly with regards to shared/joint roles, it was noted that ICB staff had been briefed the previous week about the expectation that the ICB will be formally asked to reduce its running costs going forward. The briefings have made it clear that Place remains an important part of the ICB's work and design work is at an early stage. Sarah Mansuralli and Sarah McDonnell-Davies are beginning discussions with borough teams of the implications of any changes and Frances O'Callaghan will be briefing local authority Chief Executives individually to emphasise the importance of collaboration around the planned integration with local authorities. The ICB is being asked to remove resource and consideration will need to be given to what it has at Place level to deliver a challenging agenda. It will be important to strike the right balance between working at system and Place and the form that this takes will need to be determined through the design process • The Board was reminded of the need to ensure that local authorities are treated as equal partners in discussions about integrated care. There have been occasions when Islington Council has struggled to get a clear picture of what would be helpful in terms of planning and although conversations have taken place about using the estate for more treatment in the community and about how to make buildings more environmentally friendly, there has been little solid progress. A plea was therefore made for collective action so that demand can be reduced in a more collaborative way. • It was agreed that the above points about local authority involvement would be addressed as part of the wider governance of estates and infrastructure planning through the Local Infrastructure Boards and other related governance committees.
3.2.3	The Board of Members • **APPROVED** the amendments to the Standing Financial Instructions and • **NOTED** the Finance Report.

3.3	**Board Assurance Framework (BAF)**
3.3.1	Ian Porter introduced the paper, highlighting the following points: • There are currently 13 risks on the BAF. The report continues to split the risks between those which are system-focused and those which are organisational • A new system risk relating to industrial action has been added since the last meeting • Discussions have taken place regarding potentially reducing the score for the risk around the delegation of Specialist Commissioning and Dental, Optometry, and Community Pharmacy Services but on balance it was agreed that it should remain unchanged • It is potentially concerning to consistently have a sea of red scores across a BAF from one quarter to another and it is clear from the discussion at today's meeting that the Board is not prepared to accept risk at this level on an ongoing basis • There will be at least two new additional risks on the next version of the BAF presented to the Board, relating to the broader workforce across the system and the ICB Change Programme • The ICB is grateful to the Audit Committee for its continued support on the organisation's risk management journey.
3.3.2	The Board of Members discussed the paper, making the following comments: • Concern was expressed about the number of risks on the BAF as this poses a risk in itself in terms of effective risk management • The work taking place to hone ICB risks was commended. It was suggested that it would be helpful to share a schematic showing which risks go to which committees • Members were encouraged to contact Ian Porter and the governance team if there are any additional risks which they believe ought to be on the Risk Register • The higher rated risk scores were discussed and it was clarified that the risk scores are based on the likelihood of something happening and the assessment of impact. The ratings are the scores assigned following discussion by the individual committees who oversee specific risks • It was agreed that it would be helpful to undertake a piece of work to see how a selection of NCL ICB risk scores compare with equivalent risks in similar ICBs • It was suggested that the lack of change in risk scores indicates either that the scores are incorrect or more work is required on the mitigations • It was agreed that in the next round of meetings, the Board Committees would review the risks they lead on and reconsider as part of this process the appropriateness of the risk scores • It was agreed that it would be helpful to share the latest Audit Committee risk snapshot • It was agreed that related risks will form part of a discussion around system pressures at a future Board Seminar.
3.3.3	The Board of Members **NOTED** the Board Assurance Framework.
3.3.4	Action: Ian Porter to arrange for the ICB to undertake some bench-marking of ICB risk scores against comparable ICBs.
3.3.5	Action: Committee Chairs and Board Secretaries to arrange for Board Committees to consider the appropriateness of the scores for the risks they lead on in the next round of meetings.
3.3.6	Action: Ian Porter to share the latest Audit Committee risk snapshot.
4.	**GOVERNANCE**
4.1	**Amendments to ICB Governance Arrangements**
4.1.1	Ian Porter introduced the paper, noting that the Board was being asked to agree some minor amendments to the ICB's governance arrangements and key governance documentation: • The addition of the NCL People Board and its purpose to the Functions and Decisions Map • An amendment to the Finance Committee Terms of Reference stating that it will meet six times per year rather than ten

	• An amendment to the Strategy and Development Committee Terms of Reference to allow for the inclusion of an additional Partner Member and the clarification that one of the Partner Members shall be the Partner Member – Local Authorities • An amendment to the Primary Care Contracting Committee Terms of Reference to allow the addition of the Chief Nursing Officer as a voting member, so that both the Chief Nursing Officer and the Chief Medical Officer are voting members.
4.1.2	The Board of Members: • **APPROVED** the amendment to the Functions and Decisions Map; • **APPROVED** the amendment to the Terms of Reference for the Finance Committee, Strategy and Development Committee and the Primary Care Contracting Committee.
5.	**ITEMS FOR INFORMATION AND ASSURANCE**
5.1	**Minutes of the Audit Committee Meetings on 26 September and 22 November 2022**
5.1.1	The Board of Members **NOTED** the minutes of the Audit Committee.
5.2	**Minutes of the Finance Committee Meeting on 1 November 2022**
5.2.1	The Board of Members **NOTED** the minutes of the Finance Committee.
5.3	**Minutes of the Quality and Safety Committee on 8 November 2022**
5.3.1	The Board of Members **NOTED** the minutes of the Quality and Safety Committee.
6.	**ANY OTHER BUSINESS**
6.1	There was no other business.
7.	**DATE OF NEXT MEETING**
7.1	9 May 2023 between 2pm and 4pm.

Draft Minutes
Meeting of NHS North Central London ICB Board of Members
28 March 2023 between 2pm and 3.15pm
Claremont Room

Present:	
Mike Cooke	Chair, NCL Integrated Care Board
Kay Boycott	Non-Executive Member
Dr Chris Caldwell	Chief Nursing Officer
Dr Simon Caplan	GP - Provider of Primary Medical Services
Cllr Kaya Comer-Schwartz	Leader, Islington Council
Richard Dale*	Executive Director of Performance and Transformation
Jinjer Kandola	Chief Executive Officer, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust
Usman Khan	Non-Executive Member
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
Ian Porter*	Executive Director of Corporate Affairs
Dr Jo Sauvage	Chief Medical Officer
Liz Sayce	Non-Executive Member
Phill Wells	Chief Finance Officer
In attendance	
Sarah Mcilwaine	Director of Primary Care (Item 2.3)
Sarah Rothenberg	Director of Finance, Primary Care (Item 2.3)
Anna Stewart	Start Well Programme Director (Item 2.1)
Emma Whicher	Clinical Director for Transformation and Lead for Children, Young People, Neonates and Maternity (Item 2.1)
Apologies	
Frances O'Callaghan	Chief Executive Officer
John Hooton*	Chief Executive, Barnet Council
Mark Lam*	Chair, Royal Free Hospitals and Accountable Officer, NMUH
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
Dr Alpesh Patel*	Acting Chair, GP Provider Alliance
Minutes	
Steve Beeho	Board Secretary

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1 1.1.2	The Chair welcomed attendees to the Meeting. Apologies had been received from Frances O'Callaghan, John Hooton, Mark Lam, Baroness Julia Neuberger and Dr Alpesh Patel.

* Standing Participant

1.2	**Declarations of Interest relating to the items on the Agenda**
1.2.1 1.2.2	The Chair invited Members to declare any interests relating to items on the agenda. There were no additional declarations. The Board of Members: • **NOTED** the requirement to declare any interests relating to the agenda; • **NOTED** the Declaration of Interests Register and the requirement to inspect their entry and advise the Board Secretary of any changes; • **NOTED** the requirement to record any relevant gifts and hospitality on the ICB Gifts and Hospitality Register.
1.3	**Update from the Chair**
1.3.1	The Chair noted that it had originally been intended to hold an informal Board seminar on this date but due to the need to progress a couple of key business items, the seminar had been switched to a formal Board meeting. He further noted that Dominic Dodd, Chair of the UCL Health Alliance, had recently tendered his resignation from the ICB Board of Members and from his role as Chair of RNOH due to a conflict of interest with some separate non-NHS work that his company is involved in. An update on this vacancy will be provided in due course.
1.4	**Report from the Chief Executive Officer**
1.4.1 1.4.2 1.4.3	Phill Wells provided an overview of the report, highlighting the following points: • The CQC has confirmed that the Barnsbury Practice in Islington has moved from a *Requires Improvement* position to *Good* in all domains and *Outstanding* in the 'well-led' category. This direction of travel was welcomed • Following the approval in February of the population health model for people at risk of or living with long term conditions, work is taking place prior to it being mobilised by September 2023 • The Enfield Borough Partnership has become one of only seven Core20plus5 Accelerator Sites that are being run by NHS England in partnership with the Health Foundation and Institute for Healthcare Improvement • Significant progress has been made in reducing the waiting lists for CAMHS and Children and Young People (CYP) Therapy Services • Operational pressures across the NHS remain challenging and the hard of work of everybody involved across the system in addressing these was commended. General practice is offering more appointments overall than it ever has before and there is a strong focus in Mental Health and acute Trusts on reducing occupancy rates • The impact of industrial action also continues to be challenging. Gratitude was expressed to staff involved in keeping patients safe during this time. The government recently made an Agenda for Change pay offer which is being considered by the trade unions concerned. However, further industrial action is planned for April by the junior doctors • The ICB has now received notification from NHS England that there will be a 30% real term reduction in its Running Cost Allowance (RCA) over 2024/25 and 2025/26. In response to this, the first phase of the organisational design programme is underway which will design a new model that meets the RCA reduction and also delivers on the ICB's population health and wider system objectives. Sarah Mansuralli then provided a brief overview of the transfer of Enfield Community Services from Barnet, Enfield & Haringey Mental Health Trust (BEHMHT) to North Middlesex University Hospital (NMUH) which will be taking place on 1 April 2023. It is expected that this model of vertical integration will be replicated further as the system evolves. It was noted that the decision had been taken 'virtually' by the Board. Potential conflicts of interest were avoided by Jinjer Kandola and Mark Lam both not participating in the decision-making. The Board of Members discussed the paper, making the following comments:

	• Assurance was given about the extensive strike mitigation work that is in place. It is recognised that the junior doctors' industrial action planned to take place after Easter will be particularly challenging and the risks around this are currently being quantified. Learning from the previous junior doctors strike, such as the higher attendance at A&E, is being taken forward • The possibility of consultants across primary care also taking industrial action over the next few months was highlighted • It was suggested it would be helpful to have a wider discussion on the elective recovery plan in the wake of the various challenges that have impacted on the system over the past few years • Assurance was given that regular discussions are taking place with partners about the impact on electives, which varies from site to site and across service areas, so the approaches to recovery will vary. The impact extends beyond the actual strike days to the aftermath as well. Plans are in place to recover the long waiters quite quickly but there is a recognised impact on people with long term conditions which forms part of the broader population health challenge • It is important that the challenges facing the ICB are used to stimulate innovation – for instance, looking at how waiting times are managed differently in order to improve outcomes • The focus on inequalities is also vital as access issues for different population groups can lead to more intensive resource utilisation. In particular, a better understanding is needed of high intensity users and the inequalities that might be driving this as part of the recovery planning • It was suggested that the learning from the system response to the industrial action and the mitigations put in place should be taken forward as part of future care models • The information and assurance that the Board receives around ICB risk management was welcomed. However, the Board will need to be mindful that there may come a time when the ICB has to acknowledge that as a result of the operational pressures confronting it, certain targets are unattainable for the time being • It was noted that the Board had previously identified, in the context of a discussion around improved access, the need to meet informally to discuss which innovations it might want to sponsor and bring to fruition. This discussion had highlighted the importance of recovery and population health work progressing in tandem, and strengthened by innovation. The Board will return to this discussion in due course.
1.4.4	The Board of Members **NOTED** the Report.
2.	**STRATEGY AND BUSINESS**
2.1	**Start Well Update**
2.1.1	Sarah Mansuralli, Emma Whicher and Anna Stewart introduced the paper, highlighting the following points: • The Board had previously approved at its November 2022 meeting the proposed future care models that would be the basis of the options appraisal to assess future service configurations and identify areas of improvement highlighted in the case for change • At that point a lot of work had taken place on the maternity, neonatal and paediatric surgical care models. However, a significant amount of clinical work has taken place since November to further refine the paediatric surgery model, including three meetings with the Clinical Reference Group (CRG) with strong engagement from organisations across NCL. This refined model will allow a wider variety of options to be considered within the options appraisal, with the aim of better outcomes • The clinical consensus is that children below the age of one should be treated in the same way as children under the age of three as the paediatric anaesthetic and surgical competencies do not differ significantly between the two age groups.

	The CRG therefore suggest that the options appraisal should consider the consolidation of emergency surgery for all children under the age of three and under the age of five for general surgery and urology • The CRG have further considered access arrangements for the centre of expertise for surgery and recommended that to improve patient pathways for children, there needs to be emergency access arrangements in place for the centre. The consensus is that this requirement could be satisfied with a paediatric emergency department, or an urgent surgical assessment unit which could act as a rapid receiving unit for transfers from other hospitals • Following consideration of workforce and potential configurations, the CRG have recommended that planned and emergency surgery should be co-located, with an option for day case surgery to potentially be on a different site.
2.1.2	The Board of Members discussed the paper, making the following comments: • Assurance was given that any potential 'front door complexity' be considered and therefore the need for very clear communications will need to be built into the care model • It was noted that the proposed model addresses feedback from parents and clinicians about the complexity of the current pathway. Assurance was also given that there is an active Patient and Public Engagement Group who have provided excellent feedback throughout the process • It was highlighted that when the outcome of the options appraisal is brought back to the Board, there will also be an accompanying integrated impact assessment (IIA). This will include a deep dive into any populations with protected characteristics, deprivation or inclusion health groups . The options appraisal will consider accessibility and then the ensuing engagement will look at mitigations for groups who may potentially be impacted by any changes • It was clarified that the risks highlighted in the cover paper relate to the current phase of the programme and there will be a greater focus on workforce challenges and risks in the event that the programme moves into an implementation phase. It was also noted that workforce and facilities are key components of the assessment in the options appraisal • It was noted that much of the transfers from one unit to another referred to in the paper are already happening – the goal is to have a far more efficient system in place so that access is improved from a patient experience perspective. Based on feedback relating to other specialist centres, patients are generally happy to travel a bit further provided that they are receiving optimum care • It is important to apply previous learning around the separation of planned and emergency surgery and ensure that the transfer times from one to the other are clinically safe.
2.1.3	The Chair thanked Members for their comments and in particular the reassuring contributions from clinicians. He also welcomed the process which had been followed and the valuable input from the CRG.
2.1.4	The Board of Members: • **NOTED** the changes to the children and young people's planned and emergency surgery care model • **DELEGATED** to the ICB Chief Medical Officer and Chair of the Start Well Programme Board, the review and endorsement of the revised children and young people's surgical care models. • **AGREED** to proceed to an options appraisal in respect to the implementation of the proposed emergency and planned surgical children and young people's care model. This recommendation replaced and superseded recommendation 3a in the November 2022 Board paper. This options appraisal would: o Set out all possible site-specific options for the creation of a centre, or centres, of expertise for the delivery of children and young people's surgery for low volume specialities and very young children.

	o Set out the appraisal of these options, compared to the status quo against a set of criteria to be agreed by the Start Well Programme Board, but which would include at a minimum an assessment of the impact of the option on quality, access, workforce, and finances (including recurrent affordability, capital and cash availability) at both an organisational and system-level over an agreed time-horizon.
2.1.5	The Chief Medical Officer and the Chair thanked Emma Whicher for her work as clinical lead and Joint SRO on this programme. Emma will be taking up a new CMO position outside NCL but would be continuing to provide some interim leadership until the conclusion of the options appraisal process.
2.2	**Population Health and Integrated Care Strategy**
2.2.1	Sarah Mansuralli introduced the paper, noting that Will Maimaris, Director of Public Health, Haringey Council was unfortunately unable to attend to co-present. She highlighted the following points: • The draft strategy had been co-produced with the involvement of all parts of the system and had evolved from the original work with the Directors of Public Health on developing an outcomes framework • The fact that the Board is discussing the health and wellbeing outcomes it wants for to achieve for local residents, rather than just focusing on units of activity, is an extremely positive development • The strategy needs to be meaningful to all parts of the system but also reach consensus about areas of focus that will achieve the biggest population health gain and the levers for a sustainable system. • The strategy, which reflects the wide input of our ICS organisations, sets out the NCL strategic intention for improved population health outcomes based on our outcomes framework which has been developed on the basis of Start Well, Live Well, Age Well and Work Well as a framework. • The five delivery areas in the strategy have been developed through more granular understanding of key priorities of borough partnerships that are instrumental to the delivery of population health interventions. • The section on sustainable levers for change describes how the system will make the transition to a greater focus on population health outcomes by being embedded in delivery across the board and strengthened integrated care through the development of neighbourhood teams. • The strategy aims to deliver greater collaboration to address the wider determinants of health, while also aligning resources to need as part of a learning system which is evidence-driven and benefits from research and innovation • The NCL delivery plan will encapsulate key system and place deliverables to achieve population health improvements and it is therefore important to ensure that milestones underpinning digital and people plans are considered in this wider planning context. • The NCL delivery plan further provides the basis for integrated planning across system partners and will inform the approach to oversight and monitoring arrangements that will provide the Board, the Integrated Care Partnership and Borough Partnerships assurance about progress and delivery.
2.2.2	The Board of Members discussed the paper, making the following comments: • The ambition of the strategy and level of engagement with partners was welcomed, as was the emphasis on building on communities' strengths • It was questioned whether the system priorities could be sharpened further and made more specific, so that it can be made clear that significant clinical energy and resource is being put into making a real difference to people's lives, as opposed to potentially spreading resources too thinly • The 'I' statements, defining how the system should feel for residents and service users, were welcomed but it was queried how these will be used to hold up a mirror to ourselves to gauge patient experience and ensure that residents can see how the statements are making a tangible difference to their lives

	• It was clarified that 'making every contact count' in this context signifies person-centred and holistic conversations which tackle a key set of factors that drive health and wellbeing inequalities, while also being mindful of the need to counter inequalities in health literacy. In response to this latter point, it was noted that there also needs to be a stronger focus on health information and education • It was suggested that the word 'vulnerable' should be avoided where possible as it can imply that this is an inherent state as opposed to something which can be ameliorated or overcome with support • The focus on health inequalities was welcomed. However, concern was expressed about the references in the delivery areas sections to "exploration" and "mapping" data when local authorities already hold this data. It was suggested that the strategy should provide more clarity about the vision for greater integration in five years' time. There are already pockets of excellence but more is needed about the big opportunities that the strategy will need to take forward – and therefore the action needs to be more ambitious than being based on the Joint Forward Plan • It was acknowledged that one of the key challenges will be around how the ICB meaningfully holds itself to account to mobilise and deliver the Joint Forward Plan, ensuring that the tendrils of the Plan are a golden thread into the plans of every organisation in the system to ensure that there is alignment around workforce to deliver 'making every contact count' • It was noted that another key challenge will be ensuring that residents feel that the strategy is making a difference but it is unclear how the Board will drive this. It is therefore important that it receives regular reports on progress from provider bodies as they grow and develop • In response it was agreed that having tangible outcomes and deadlines will help to act as a filter, as it is impractical to implement everything in the short to medium term • It would be helpful if there was a stronger emphasis in the strategy on Parity of Esteem - in particular, it needs to be made more explicit at various points in the document that the references to health encompass physical *and* mental health • The emphasis on early intervention and diagnosis needs to be strengthened in latter parts of the document • It was queried how much influence the ICB can realistically have over 'place' when it is simultaneously becoming a leaner organisation • The commitment to hyper-local delivery was welcomed but it was highlighted that this also can also potentially create multiple risks across the infrastructure. More detail about how the system will seek to mitigate this will be welcomed • In light of the fact that the health and care system is fragile and beset with significant challenges, it was suggested that a transition principle should be formulated. If a transition takes place too quickly there can be a risk of destabilisation, so it would be helpful to have a Board discussion around how the ICB will ensure that providers and existing services/teams remain sustainable through transition while remaining very clear at the same time that transition needs to happen • It was highlighted that although having a sustainable environment is a key part of the NCL ambition, air quality is not included in the risk factors in the Population Health Outcomes Framework. It would therefore be helpful if the strategy could be more specific about the role of the ICB in promoting clean air • It was suggested that a future iteration of the strategy should also include details of the learning about overcoming barriers from the mixed experiences of previous attempts at integration • It was acknowledged that implementing the strategy will inevitably be challenging in light of the financial situation the system is facing. This will necessitate choices about which parts of the strategy are prioritised and the pace of delivery, and aspects will be delivered over a longer period. • It was noted that the efficiencies achieved by greater integration can lead to more effective delivery and that inequalities drive higher cost utilisation and care in the longer term, so the system should therefore be bold and embrace this.

2.2.3	The Chair welcomed the valuable feedback and made the following points: • Sarah Mansuralli will incorporate the comments into the next iteration of the strategy and share with the Board • The draft strategy will be shared with the Integrated Care Partnership (ICP) at its meeting on 18 April 2023. Depending on the ICP feedback, there might need to be further discussion at a future Board seminar focussed on delivery. • The key themes from today's discussion were the need for a more explicit focus on mental health, broad support for the strategy as a foundation document, with a desire for prioritisation and a move to action based on the existing rich knowledge base. The strategy provides an opportunity for efficiencies through integration as well as innovation through re-thinking current models, while also learning lessons from earlier attempts at integration • Recognising that the Joint Forward Plan is a mandated document, there will need to be a complementary action plan to enable the ICB to track the progress of the strategy and demonstrate how work will be progressed at a Borough level.
2.2.4	The Board of Members **NOTED and welcomed** the progress of the strategy.
2.3	**Delegation of Dentistry, Optometry and Pharmacy (DOP)**

2.3.1	Sarah McDonnell-Davies introduced the paper, highlighting the following points:
	• The Board has received previous reports on the delegation of DOP from NHS England to the ICB and work has been taking place over the previous nine months to prepare for this
	• It is proposed that from 1 April 2023 responsibility for the following will be delegated to the ICB:
	  o Dentistry (including Primary Care Dental, Community Dental and Acute Dental)
	  o Primary Care Optometry (Specialist Ophthalmology Services fall within the specialised commissioning delegation remit)
	  o Community Pharmacy
	  o Additional primary medical services (General Practice) responsibilities
	  o Complaints relating to providers within the ICB for the above.
	• This represents a significant additional responsibility for the ICB as the scope covers 777 contracts worth £153m and hundreds of providers (many small local providers)
	• There is a clear strategic fit between DOP commissioning and the work of the ICB; there are opportunities for earlier intervention and prevention, integration within pathways and quality improvement
	• There will be a focus over the next 12 months on a 'safe landing' for these services and the team supporting the commissioning and contracting who will be transferring to North East London ICB. We do expect to support transformation in the medium term and will be working with the Board and other London ICBs to identify priorities.

2.3.2	The Board of Members discussed the paper, making the following comments: • It was clarified that the delegation of these services is proposed as a permanent move from NHS England to ICBs, with NHS England retaining overall accountability • In the short term it will be important for the ICB to fully understand these contracts and the finances and what it can do within the scope and terms set. NCL will seek to influence reserved matters such as the contract (form, terms) as appropriate and as required to deliver key objectives. • It was noted that Dentistry is an area of interest to our patients and residents, but is an extremely complex landscape. It is recognised in the context of the Population Health Strategy that poor dental health is a key marker of health inequalities and an important determinant of overall health outcomes. • It was noted that the delegation of complaints also represented an opportunity to build a picture of complaints received in NCL and triangulate this with the local knowledge • Assurance was given that all appropriate due diligence has been undertaken.

	• It was recognised that transformation will need to be addressed in the medium term given resource and capacity constraints and the need for ICBs to focus in the first instance on effective processes for the management of contracts, finance, payments, quality assurance and regulation • It was noted that in the context of the People Strategy, delegation offers the opportunity to think about the people who run these services as part of the workforce in NCL. • It was agreed that the Board would receive an update in 12 months' time.
2.3.3	The Board of Members: • **NOTED** the final position on the delegation of NHS England London Region DOP Services and Complaints • **APPROVED** the signing of the Delegation Agreement and Memorandum of Understanding by the NCL Chief Executive Officer or NCL Chief Finance Officer.
2.3.4	Action: Sarah McDonnell-Davies to bring a report to the Board in 12 months' time.
3.	**ANY OTHER BUSINESS**
3.1	There was no other business.
4.	**DATE OF NEXT MEETING**
4.1	9 May 2023 between 2pm and 4pm.
5.	**PART 2 MEETINGS**
5.1	The Board **RESOLVED** to exclude the public from the Part 2 meeting.

North Central London ICB
Board of Members Meeting
9 May 2023 - Action Log

On Agenda	🔵
Needs Urgent Update	🔴
In Progress	🟡
Completed	🟢

Meeting Date	Action Number	Action	Lead	Deadline	Update
7 February 2023	6	To arrange for the People Board to reflect further on how the ramifications of the industrial action should be addressed at provider and ICS level.	Liz Sayce and Sarah Morgan	May 2023	This is on the agenda of the People Board meeting on 15 May 2023.
7 February 2023	7	To arrange for the ICB to undertake some bench-marking of ICB risk scores against comparable ICBs.	Ian Porter	May 2023	This exercise is in progress and is due to be completed in May.
7 February 2023	8	To arrange for Board Committees to consider the appropriateness of the scores for the risks they lead on in the next round of meetings	Committee Chairs and Board Secretaries	May 2023	These reviews are currently ongoing.
7 February 2023	9	To share the latest Audit Committee risk snapshot.	Ian Porter	March 2023	The snapshot was shared with Board Members on 6 March 2023.

28 March 2023	10	To bring a report on DOP delegation to the Board in 12 months' time.	Sarah McDonnell-Davies	May 2024	This item has been added to the Board forward planner.

North Central London ICB
Board of Members Meeting
9 May 2023

Report Title	Chief Executive's Report	**Date of report**	25 April 2023	**Agenda Item**	1.6
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 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.

2. Industrial action impact update

2.1 The impact of industrial action continues to be a major concern across the system. The BMA junior doctors four day strike in April had a significant impact on the amount of cancelled elective activity particularly impacting on our acute and mental health trusts. At the time of writing, the RCN have announced another strike on 30 April over the May Bank Holiday to 2 May, for which no derogations are currently offered and therefore an even greater impact on emergency and critical care departments. Our two main affected organisations, who have been affected since the original action in November and straight after the BMA junior doctor strike, are UCLH and GOSH, who face significant challenges. Attempts to mitigate the impact will require a system response, including from primary care colleagues who will be crucial to supporting the urgent and emergency pathway. The Tavistock and Portman and the NCL ICB are also included in the RCN industrial action.

2.2 The national Staff Council are due to meet on 2 May to determine if the Agenda for Change pay deal is accepted and we await to see if those Trade Unions whose mandate is coming to an end in May, will seek to re-ballot members for a further round of industrial action.

2.3 As a system there is now work starting to determine the wider impact of the strikes, which has been hard to quantify to date due to the ongoing nature of the action.

3. Organisational change progress

3.1 The organisational change programme is currently in the second phase and remains on track. This phase is focused on engaging staff in the design features ahead of any formal process and roadshows were undertaken at the end of April. The feedback will inform the final structure design and the equality impact and personal impact assessments for all affected staff, will be undertaken ready for consultation, planned towards the end of phase two which is mid to late June.

3.2 The programme currently remains on track, however our main risk which may cause delay or change our approach, is the approvals required from NHS England, DHSC and HM Treasury to run a voluntary redundancy scheme. Our business case has been submitted; however it is currently unclear as to whether or not approval will be granted in time for the consultation launch. This remains under review.

4. Integrated Care Partnership update

4.1 The NCL Integrated Care Partnership (ICP) met again on 18 April 2023, chaired by Leader of Islington Council, Cllr Kaya Comer-Schwartz.

4.2 The ICP considered the latest iteration of the NCL Population Health and Integrated Care Strategy – a critical strategy for the ICB and ICS that captures our vision for an integrated system focused on prevention, early intervention and proactive care. The partnership considered in detail our shared priorities and outcomes and how the ICP and local partnerships can best harness their collective power to reduce inequalities and drive improvements in the health and wellbeing of our population.

4.3 The ICP identified Childhood Immunisations as an initial priority for collective action and took a report on progress. During a difficult Winter local partners in each Borough have accelerated work to ensure all children in NCL are given the opportunity to 'start well' – aiming for each child to be fully vaccinated by the time they start school (achievement of vaccination before age 5). Overall uptake has been improving across NCL since the beginning of 2022.

4.4 The ICP agreed we must continue to use our data, insight into and partnerships with local communities and relationships with trusted frontline professionals and engagement with parents/carers to drive improvements in key outcomes.

4.5 The ICP also heard from each NCL Borough Partnership and considered how it might best support the continued development and maturation of these critical spaces in our system.

5. London Ambulance Service pre-dispatch pilot

5.1 NCL ICB has been working with system partners to ensure that patients requiring urgent treatment are seen as soon as possible. This can include people awaiting an ambulance or where a conveyance to an emergency department may not provide the best route to care. In response to the ambulance hand-over delays seen during the winter, NCL ICB and London Ambulance Service (LAS) have worked in partnership to pilot the presence of Senior Clinical decision makers working alongside LAS call handlers, to provide a 'hear and treat' service. This model provided by clinicians, knowledgeable of local pathways, helps ensure those who do not require an ambulance response, are seen by the most appropriate alternative service, for example district nursing. The 4-week pilot is providing opportunities for shared learning across LAS and NCL services, helping us meet the requirements of 'NHS Delivery Plan for recovering urgent and emergency care services' (January 2023) in readiness for winter 2023.

5.2 Findings thus far indicate variation in accessibility, capacity, understanding and expectations when referring into alternative pathways; understanding and responding to this is the key to improvement. Areas of focus include standardising and simplifying referral pathways from LAS into Urgent Community Response (UCR), Same Day Emergency Care (SDEC), Frailty services and Primary Care. There is system commitment to this work through our Flow Oversight Board and weekly operational oversight via the Flow Oversight Group.

5.3 It has been agreed to utilise systematic change methodology (Quality Improvement) to accelerate change within the key areas. An NCL network of QI leaders has been re-established to promote consistency of approach, share best practice, and develop an offer to the ICS to support collaborative improvement work. Alongside this there are likely to be recommendations around realignment of capacity to demand across a range of community services, which will be progressed as part of the Community Services Review.

5.4 NCL's findings will be incorporated into a London-wide rapid-evaluation and act as a trailblazer to spread this approach pan-London.

6. Development of the Health and Care leadership model

6.1 There has been significant work undertaken in the past 12 months supporting the development of the Health and Care leadership model. This transition sees the introduction of a multi-professional clinical and care leadership model befitting the ethos of an inclusive and integrated system partnership.

6.2 Recognising the importance of equity, we are in the process of developing a bespoke programme of support, to enable the team to thrive and develop as system leaders. They will play various roles – from statutory to strategic; service redesign and quality improvement through to more technical roles.

6.3 In recent months we have been focused on transitioning to a new ICB clinical and care leadership model; developing the operational and strategic framework that underpins the model, onboarding new appointees, and undertaking further recruitment.

6.4 The model provides the clinical and multi professional leadership infrastructure for mobilisation of the population health improvement strategy. With 'improvements to population health outcomes' serving as its north star, this portfolio works to achieve three key pillars.

- Clinical and care professional leadership of the ICB's priorities – ensuring timely clinical and care professional involvement and leadership of ICB priorities, drawing on clinical and care roles from across NCL within and outside of the ICB.
- Convening of system partners and communities – promoting collaboration by establishing trusted relationships with ICS partners; facilitating clinical and care professional networks; and working closely with local communities.
- Establishing NCL ICB's framework for clinical and care professional leadership – working jointly with the Chief Nursing Officer, the framework will enable the five principles for placing effective clinical and multi-professional leadership at the heart of the integrated care system.

6.5 ICB priorities will be driven across all layers of the ICS by working together to lead, convene and influence partners at system and place as we strive to deliver population health improvement, with a strong focus on improving the impact of inequalities in our communities.

7. Re-opening of the Mental Health Crisis Assessment Service (MH CAS)

7.1 In October 2022 the MH CAS temporarily closed due to the redevelopment of the St Pancras site. The new permanent location for the service will be at Highgate Mental Health Centre (HHMHC), with negotiations going well to occupy K block pending appropriate consultations and adaptions.

7.2 Camden and Islington Foundation Trust (C&I) have sought an interim temporary location at the Peckwater Centre and as of 4 April 2023 the service reopened. Initially the service was cautiously testing the unit by accepting ED referrals only, it has received 31 ED transfers having an immediate impact on ED capacity and flow. As of 11 April 2023, the service is open to all urgent and emergency services including self-referrals and walk ins as well as direct conveyances from London Ambulance Service (LAS). The building is working well, although it is an isolated location which adds complexity.

7.3 The Highgate location fits the service ideally for campus model of care with close links and working relationships with inpatient services, Health-based Place of Safety (HBPOS), crisis teams and acute provider. Current planning assumes the MH CAS will be open at Highate between January 2024 and March 2024.

8. Crisis Cafes North Central London

8.1 Community based cafes and sanctuaries across NCL provide emotional, social, and psychological support to individuals experiencing mental distress. They offer a safe, inclusive, and welcoming space for people struggling to cope with their mental health during the evening and weekends when other services are closed. Their aim is to support people to reduce their immediate crisis and to formulate a safety plan.

8.2 On 29 March 2023 the Clinical Assessment Group (CAG) approved an Appropriate Care Pathway (ACP) between NCL crisis cafés and London Ambulance Service (LAS). This means that LAS will be able to transport patients in a mental health crisis who have been physically cleared to the nearest of the five crisis café locations across NCL, reducing the need to take people to ED or MH CAS. Commissioners will monitor the activity month by month to see how or if this will have an impact for LAS and ED.

9. Enfield SEND Inspection

9.1 Nationally, a new Ofsted and Care Quality Commission (CQC) Special Educational Needs and Disabilities (SEND) local area inspection framework was formally launched in January 2023. The London Borough of Enfield received notification on 6 March 2023 that Enfield would be the first borough in London to go through the new process. The Inspection covered a 3-week period commencing on 6 March 2023; the inspection formally closed on 24 March 2023, with a final feedback meeting with NCL ICS system and place-based executives.

9.2 In preparation for the Inspection, Enfield Borough system leadership teams arranged a series of meetings to self-assess the borough's SEND system against the new framework; keeping the

partnership updated about the work and for inspection readiness. The main theme reflected throughout the inspection was "*what it is like to be a child or young person with SEND in the local area"*. During the notified inspection period, inspectors:

- Sampled 80 Children and Young People's (CYP) case files across the system;
- Spoke with children and young people with SEND, parents and carers, representatives of the local authority and NHS officers;
- Visited a range of providers and spoke to leaders, staff and governors about how they were implementing the special educational needs and disability reforms;
- Met with local education, health and social care leaders to discuss the local area partnership's self-evaluation, strategic planning and governance arrangements.

9.3 Overall, the inspection experience with leaders was positive and balanced across the areas of Education, Health, and Care. The Inspection team were keen to listen to voices of children and young and their families and to hear about local challenges as well as national challenges. Inspectors were also looking at the impact of the local area partnership's SEND arrangements on the experiences and outcomes of children and young people, including how decisions have been made, how children, young people and their families have been involved and whether they have received the right help at the right time. It is expected that the Enfield Partnership will receive the draft SEND inspection report in May 2023, after which the partnership will have 10 working days to comment on the draft report, inspection process and findings. It is anticipated that the final report will be shared in June 2023.

10. Estates update

10.1 Through estates investment, NCL has improved patient access and health outcomes for nearly 500,000 residents across our boroughs via three specific projects delivered during 2022/23:

- Over the year, we have delivered 370,000 additional patient appointments created at 20 sites across NCL by converting 20 rooms formerly used for patient record storage spaces into virtual and in-person clinics and support spaces
- The Wood Green Diagnostic Centre (CDC) opened in The Mall shopping centre in September 2022. This £26m project offers x-ray, ultrasound, ophthalmology and phlebotomy diagnostic services to local people in the centre of Haringey, with MRI and CT scanning to be added later this year. The CDC recently won the 'Best Consultancy Partnership within the NHS' award at the 2023 Health Service Journal Partnership Awards. NCL's other CDC at Finchley Memorial Hospital has now seen over 100,000 patients since opening in 2021
- In Autumn 2022, we invested £1m of national funding and improvement grants at The Village Practice, Islington to create an additional 500 patient appointments per week, increase clinical consulting space by 40% and improve the practice layout to ensure compliance and operational effectiveness, helping to reduce pressures on surrounding healthcare services.

10.2 Over the last 12 months NCL has worked in partnership and close collaboration with a wide variety of system and other partners to make significant improvements and savings within our estates, and have delivered 13 key estates projects across the five NCL boroughs, collaborated on 15 projects with NHS Property Services, Community Health Partners and Local Authorities, saved .approximately £500k by filling empty spaces, recycled £0.9m of capital from NHS Property Services disposals into Barnet and Camden projects and invested £1.6m of Section 106 and Community Infrastructure Levy funding from the planning system across six sites.

11. Wellbeing Bus Support for adult social care staff

11.1 As part of our commitment to reducing inequalities, implementing hyperlocal approaches, and taking the learning from the Covid-19 vaccination programme, we continue to deliver services through mobile units in areas of greatest need where we can offer vaccination and a making every contact count approach. The latest innovation is a Wellbeing bus for adult social care staff delivered by the NCL wellbeing hub and the NCL nurse education team. The aim of the service is to provide adult social care staff with access to and support with wellbeing and health checks.

11.2 The service has been developed to reach a high need group who have found it hard to access physical and mental health support and services. The first sessions in Barnet saw 44 Care staff utilise the service and the feedback from the first day was that the service was very well received, and the teams did a fantastic job. The Wellbeing bus subsequently visited care homes in Enfield, where it was used by 51 care staff and it will be moving across North Central London over the coming weeks.

Frances O'Callaghan
Chief Executive

25 April 2023

North Central London ICB
Board of Members Meeting
9 May 2023

Report Title	NCL ICS People Strategy 2023-2028	**Date of report**	April 2023	**Agenda Item**	2.1
Lead Director / Manager	Sarah Louise Morgan, Chief People Officer	**Email / Tel**		sarahlouise.morgan@nhs.net	
Board Member Sponsor	Liz Sayce, Non-Executive Member				
Report Author	Sarah Louise Morgan, Chief People Officer	**Email / Tel**		sarahlouise.morgan@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Not applicable.			
Report Summary	The NCL ICS People Strategy was co-developed alongside a broad range of partners across the system between October 2022 – March 2023. Following initial discussion at the Board of Members in January 2023, the strategy has since been finalised and has subsequently been **recommended for approval** by the NCL ICS People Board (sub-committee to the Board of Members). The NCL ICS People Strategy articulates the key workforce priority areas to be addressed across system partners over the next five years (2023-2028). The paper sets out priority areas across three strategic pillars; **Workforce Supply**, **Workforce Development** and **Workforce Transformation** and the activity to be delivered within these areas has been mapped across a five-year period. **Executive Summary** Post the pandemic, there are fundamental workplace shifts taking place in the UK and in particular London, which is influencing the labour market. COVID-19 has accelerated trends such as automation and digitisation, flexible and remote working and in health and social care, as well as other sectors – there is a mismatch between employers needs and skills available. This is compounded by the need to recover our health and care services, leading to an immediate issue with a gap in the availability of skilled workforce and increasing service demands. Under-supply is the greatest risk facing our social care and health services, the World Health Organisation estimates a global shortfall of 10m by 2030. Whilst workforce issues are being tackled by individual organisations, more than ever there is a need to have a medium to long-term focus on an innovative and sustainable approach to workforce and utilisation of the immense assets				

	we have in North Central London to continue to deliver high quality care. We must develop shared solutions to shared problems: working with partners across the system so that spend on the workforce is an investment in human capital that contributes to wider economic health and benefits the local population. Our strategy sets out how we will develop an integrated approach towards the development of 'One Workforce' across our health and care providers, with an overarching ambition to provide a model that focuses on sustainable population health improvement, aligned to the delivery of the NHS Long Term Plan, the NHS People Promise and the wider ICS requirements of a people function. Through this we will support our partner organisations to: - become excellent employers, delivering high quality care in environments where staff can thrive - deliver new care models in new settings, including at place and neighbourhood level - drive social responsibility to meet our collective commitments to create the conditions for a good life for our local communities including meaningful employment opportunities, delivering of social value through our purchasing power and supporting the wider determinants of health such as air pollution through our green commitments - use our collective research and innovation resources to better serve the interests of our communities to reduce health inequalities, aligned to our Population Health Improvement outcomes. The strategy sets out the focus areas that we have collectively identified as having the potential to deliver the highest impact. The delivery of the strategy will be across the different levels of the system – region; ICS; organisation; borough (place); neighbourhood – setting out as far as possible, where the right place to deliver the ambitions are. Critical to this is identifying where our capabilities and innovation reside within the system, which will be our priority focus for the first year. It is noted that the NHSE Workforce Plan is anticipated late Spring/early Summer potentially in line with NHS75 and at the point this is published this will be factored into our strategy implementation plan. Any major changes will be agreed through the NCL ICS People Board.
Recommendation	The Board of Members is asked to **APPROVE** the strategy.
Identified Risks and Risk Management Actions	Not applicable.
Conflicts of Interest	Not applicable.
Resource Implications	Not applicable.
Engagement	System wide engagement has been conducted, with input to the People Strategy provided by a number of staffing groups and partnership forums, including, but not limited to, the following: • Primary Care (GP Federations, Primary Care Operation Groups, Training Hubs) • Acute (SWLG HRD network), Chief Nursing Officers, Chief Medical Officers, System Leadership Board (Trust Chief Execs), • Social care

	• Place Directors of Integration • Directors of Adult Social Care • Directors of Child Social Care • EDI and Talent Management NCL Working Groups
Equality Impact Analysis	The EQIA screening document is currently awaiting sign-off.
Report History and Key Decisions	Initial discussion was conducted at the informal Board Seminar on 31 January 2023. Comments and feedback from members of the board were subsequently incorporated into the strategy. The strategy was then presented to the ICS People Board on 20 February as well as an ICS People Board seminar on 22 March where it was formally recommended for sign-off by the Board of Members.
Next Steps	This paper will be taken to the ICS People Board on 15 May 2023 for noting. Following this, the content will be converted into a fully designed format for publication across the system. A summary slide deck will also be developed to aid with socialisation amongst stakeholders across North Central London.
Appendices	ICS People Strategy 2023-2028 Final Version

North Central London ICS People Strategy 2023 – 2028

1 Foreword

Over the past two years, the focus on people within health and care has become much more front and central than any other time in history. Our people are at the heart of our recovery and key to ensuring we can continue to deliver high quality, sustainable services for our population.

Our North Central London Integrated Care System (NCL ICS) People Strategy is key to the delivery of our ICS Population Health Improvement and Integration Strategy and as such is critical to our ability to pivot our health and care system to realise our ambition for improved health outcomes for our residents and beyond.

In order to meet our Population Health Improvement goals, support local social and economic development and move from reactive, episodic care to coordinated, preventative and community-based services, we need to reimagine our workforce model and realise the ambition of increasing health and social care integration over the next 5 years. Working together as an ICS is a huge opportunity but will require a seismic shift in the development of effective working relationships between health and care professionals, both spanning the levels of healthcare from primary to quaternary services and across in the wider social care, community, voluntary and third sector provision, whilst recognising the valuable work that our unpaid carers do every day.

With the advancement of technology, data science, Artificial Intelligence (AI) decision-making tools and treatments, even before the Covid-19 pandemic emerged, it was clear that a confluence of social, technological and policy change drivers would necessitate a fundamental re-consideration of how we educate, re-skill and upskill the health and care workforce.

I am proud of of the collaborative effort that has led to the development of our people strategy. Co-designed with colleagues from our many partner health and care organisations within North Central London this strategy represents the breadth, depth and diversity of workforce challenges and opportunities across our newly formed Integrated Care System. It sets out our ambition for how our workforce will operate over the next 5 years and paves the way for a future of increased efficiency and productivity and better health outcomes for our population. We are optimistic that integrated system working, leveraging the combined power of the assets we have in North Central London and continuing to have the courage to innovate will enable us to adapt to and solve for the opportunities and challenges that lie ahead.

Frances O'Callaghan, CEO NCL ICB

2 Executive Summary

Post the pandemic, there are fundamental workplace shifts taking place in the UK and in particular London, which is influencing the labour market. COVID-19 has accelerated trends such as automation and digitisation, flexible and remote working and in health and social care, as well as other sectors – there is a mismatch between employers needs and skills available. This is compounded by the need to recover our health and care services, leading to an immediate issue with a gap in the availability of skilled workforce and increasing service demands. Under-supply is the greatest risk facing our social care and health services, the World Health Organisation estimates a global shortfall of 10m by 2030.

Whilst workforce issues are being tackled by individual organisations, more than ever there is a need to have a medium to long-term focus on an innovative and sustainable approach to workforce and utilisation of the immense assets we have in NCL to continue to deliver high quality care. We must develop shared solutions to shared problems: working with partners across the system so that spend on the workforce is an investment in human capital that contributes to wider economic health and benefits the local population.

Our strategy sets out how we will develop an integrated approach towards the development of 'One Workforce'[1] across our health and care providers, with an overarching ambition to provide a model that focuses on sustainable population health improvement, aligned to the delivery of the NHS Long Term Plan, the NHS People Promise and the wider ICS requirements of a people function. Through this we will support our partner organisations to:

- become excellent employers, delivering high quality care in environments where staff can thrive
- deliver new care models in new settings, including at place and neighbourhood level
- drive social responsibility to meet our collective commitments to create the conditions for a good life for our local communities including meaningful employment opportunities, delivering of social value through our purchasing power and supporting the wider determinants of health such as air pollution through our green commitments
- use our collective research and innovation resources to better serve the interests of our communities to reduce health inequalities, aligned to our Population Health Improvement outcomes.

The strategy sets out the focus areas that we have collectively identified as having the potential to deliver the highest impact. The delivery of the strategy will be across the different levels of the system – region; ICS; organisation; borough (place); neighbourhood – setting out as far as possible, where the right place to deliver the ambitions are. Critical to this is identifying where our capabilities and innovation reside within the system, which will be our priority focus for the first

[1] Definition of 'one workforce' - NHS ICS Design Framework – 'we expect ICS NHS bodies to adopt a 'one workforce' approach and develop shared principles and ambitions for people and culture with local authorities, the VCSE sector and other partners' https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf

12 months. This will enable us to pilot initiatives and scale successful projects over the next 5 years and to start to transform our care delivery models and workforce skills and capability to make a difference to the health inequalities and wider determinants of health across our five Boroughs[2].

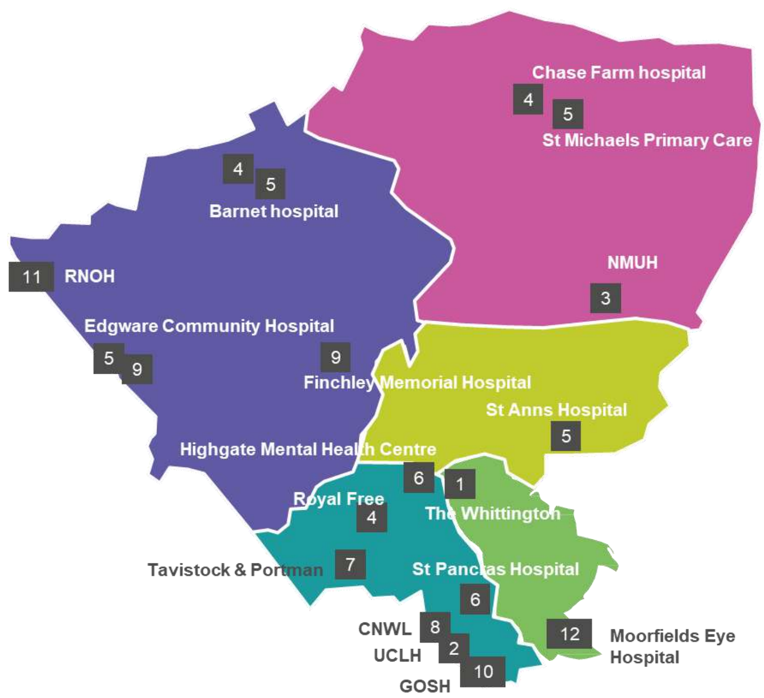
3 Our population, provision and people

Population

North Central London hosts a diverse and relatively young population of 1.8m residents, with many more travelling from other regions to access health and care services within NCL. There are areas of deprivation across all 5 boroughs, often in close proximity to areas of affluence. Enfield, Haringey and Islington have, on average, higher levels of deprivation. Around 50,000 children and young people across NCL live in poverty and the main underlying causes of early death in NCL are cardiovascular disease, cancer and respiratory diseases.

Provision

The NCL ICS was formally established on 1st July 2022 and spans five boroughs encompassing 12 NHS provider organisations, five London councils, 200 general practices, 33 Primary Care Networks (PCNs), 300 pharmacies and 200 care homes, as well as countless voluntary, community and social enterprise (VCSE) sector organisations and groups that provide essential care to our population.



[2] North Central London comprises of the five London Boroughs of Barnet, Enfield, Haringey, Camden and Islington

We have a one of the most complex integrated care systems in England, comprising of a number of nationally and internationally renowned organisations, including the majority of specialist providers in London. Additionally, NCL is home to a number of renowned education institutions such as University College London which has recently opened a Global Health Campus; Middlesex University which has invested in a brand-new high tech clinical skills simulation lab and City and the University of London which is a leading provider in applied health research. The Knowledge Quarter, located in Camden is home to The Crick Institute, Wellcome Collection, Aga Khan University, and the Institute of Physics. Meta (Facebook), Google, McKinsey and Vivendi Group have also recently completed construction of their new corporate headquarters plus we are expecting a major extension to the British Library, due to open 2025, that will provide a new headquarters for the Alan Turing Institute, the UK's National Institute for Data Science.

The co-location of these assets gives us the platform to bring to the fore an evidence-based and research informed approach to allow us to be the architects of the most cutting-edge care provision; alongside the development of the future professional roles, taking advantage of technological advancement to deliver innovative education and training to bring the best care delivery to our local population.

To ensure that we meet the needs of the populations that we serve and achieve our ambition, we need to fundamentally change the way we work, including with our residents and communities, and where we prioritise our resources and efforts. We need a new vision that will bring us together around a common purpose and approach.

As our residents have an enhanced role in shaping their care, our support to them and the services we provide need to change – this will require skills and delivery models that are different to today as well as the right culture and supporting practices and behaviours to underpin them. This will enable the rebuilding and development of services around the needs of our population. This will require long-term planning and a clear direction but also responsiveness to react to our next strategic and operational challenges.

People

The NHS workforce increased by 20.5% between 2010 and 2021, and the adult social care workforce has grown by 12%. However, at the end of 2021, 6.07 million patients were waiting for elective care in the NHS, with over 506,000 awaiting assessment, care of direct payments or reviews.

Within NCL, there are approximately 100,000 staff[3] working within the NHS, primary care, social care and VCSE workforce

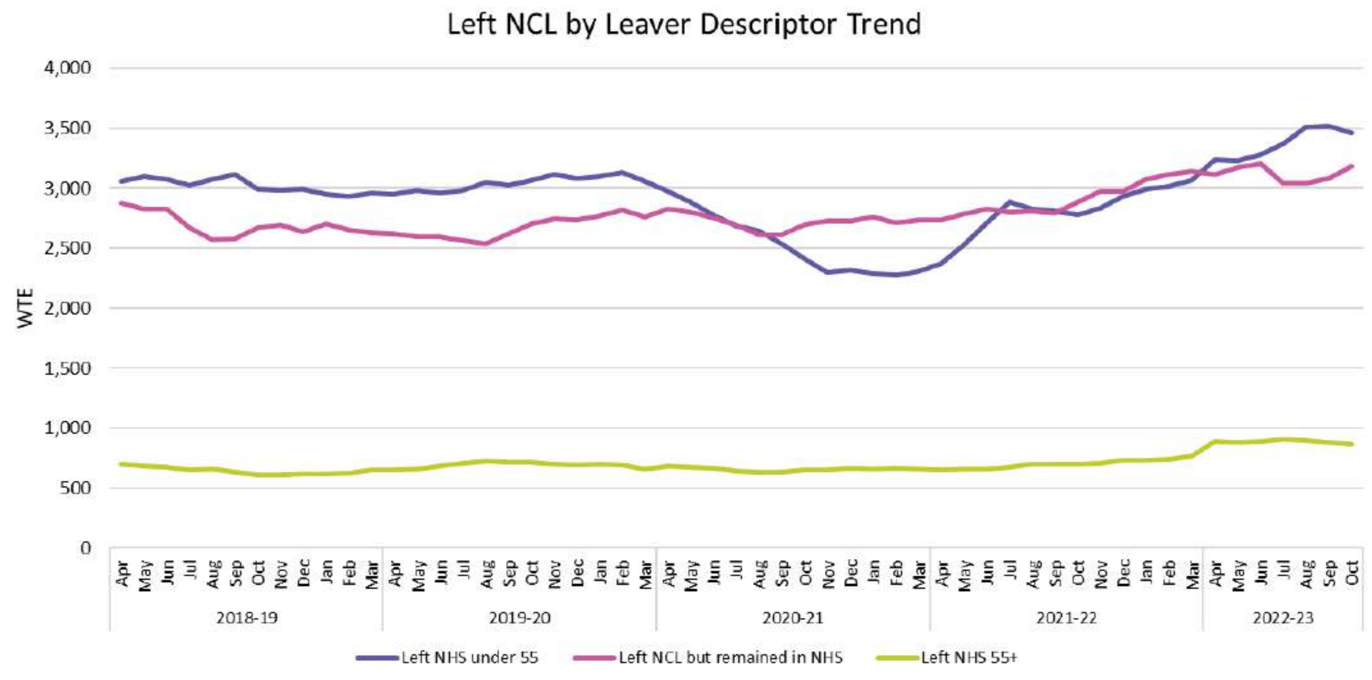
[3] 86,000 staff in the NHS, primary care and social care workforce. Additionally, dentistry, optometry and pharmacy includes an additional c5,000 as well as the numerous voluntary sector and charity organisations which account for 950,000 workforce nationally. c100,000 is an underestimate.

which is equally matched by the number of informal carers[4] across the Boroughs. Informal Carers are an important part of our care delivery, providing a significant contribution to the daily care of our residents and often to their loved ones.

Over 5% of our local population are directly employed by organisations that are part of the ICS with a further 32,000 employed in the independent social care sector. Despite the fact that we have a significant number of people working in health and care, existing trends suggest that we do not have enough staff to keep up with forecasted demand and we are currently facing a number of pressing challenges.

There is a large gap between the workforce we require to meet current system demand and workforce we have available (supply). We have outlined a likely workforce gap scenario which is based on the following challenges and trends.

Across permanent and fixed term contracted staff, the turnover rate in NCL is 19.3% - over 8,000 people leave our workforce every year and this is now increasing following a reduction over the past two years. The age band with the second highest turnover rate is under 35s, which poses a significant threat to our future workforce sustainability. The turnover rate across all staff groups is increasing, apart from our medical workforce, which is relatively stable.



The vacancy rate varies between 6 and 16% across major providers. The medical and dental vacancy rate (6%) is significantly lower than all other staff groups and the next lowest is registered nursing, midwifery and health visiting staff (9%). However, nursing (1,263 WTE) and support to clinical staff (1,278 WTE) had the largest number of vacancies in

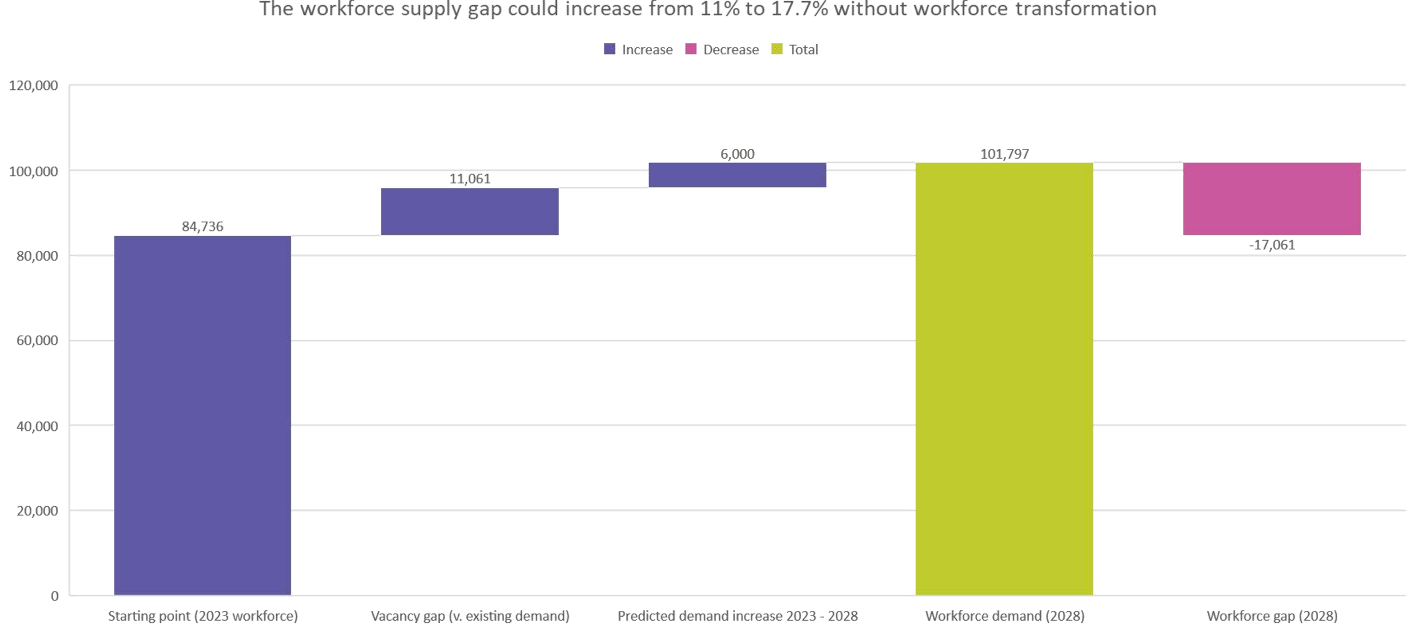
[4] Estimated from 30,000 in Enfield; 40,000 in Barnet; 25,000 Haringey, 16,000 Camden 20,000 Islington

December. A worrying trend is the wider support services, who provide vital estates, facilities and other services that are crucial to delivering safe care had the highest vacancy rate in December 2022 with c12%.

Despite huge efforts, our nursing recruitment rate is still lagging. NCL's GP nursing rates remain one of the worst in the country (13 per 100,000 compared to a national average of 27 per 100,000.) and Camden has the 3rd lowest GP Nurse: Patient ratio in London. Our Mental Health workforce is heavily reliant on temporary staffing, with 49% of the growth in the workforce over the last three years having been bank & agency rather than substantive , and the proportion of total staff who are bank/agency has increased from 12% to 15%.

The retirement profile of our social care workforce is stark. With just under one third of social care workers aged over 55 years, approximately 10,000 NCL care staff could **retire** in the next 10 years**.** Between 20/21 and 21/22, the number of filled adult social care posts in North London decreased by 2,000: this was a 6.6% reduction- the largest reduction in London**.** The turnover rate is currently over 20% and vacancy rate has increased by 70% over the last 2 years.

In totality, the combination of these factors poses a huge risk to the delivery of health and social care in NCL; the current vacancy gap against registered demand is 11.55%. We combined the trends we are observing across all staff groups within the ICS and projected the likely workforce gap we could face in 2028 based on existing supply, funding levels, our retirement profile and bank and agency spending rates. If trends continue, our workforce gap could increase by 17,061 over the next five years (see graph below).



Our People Strategy sets out how we will work together as a system to minimise this gap and leverage our 'One Workforce' to be able to flexibility work across North Central London, maximising the skills and capabilities in the system to deliver against our Population Health Improvement objectives.

4 Our Strategic Ambitions

Our vision combines our NCL Population Health outcomes and an ambition for 'One Workforce' – colleagues enjoying meaningful work, having multiple careers within NCL, working at the top of their licence and having flexibility so that their work is complementary and supportive of their roles and purpose outside the workplace. The evolving world of work and how people were already choosing to live and work differently, accelerated by the pandemic, means that flexibility, opportunity, value creation and ability to thrive are more important to people than the traditional single career or lifelong organisational commitment. We have an opportunity to create meaningful and rewarding careers that attract staff from different industries, providing new specialisms and innovative practices to our workforce whilst strengthening collaboration and integration across sectors.

Ultimately, we believe by having this direction of travel, a simple vision to coalesce staff and partners across NCL and being clear on how the system is best-placed to enable this vision will put us in good stead to deliver a happy, productive workforce proportionate to the needs of the care model.

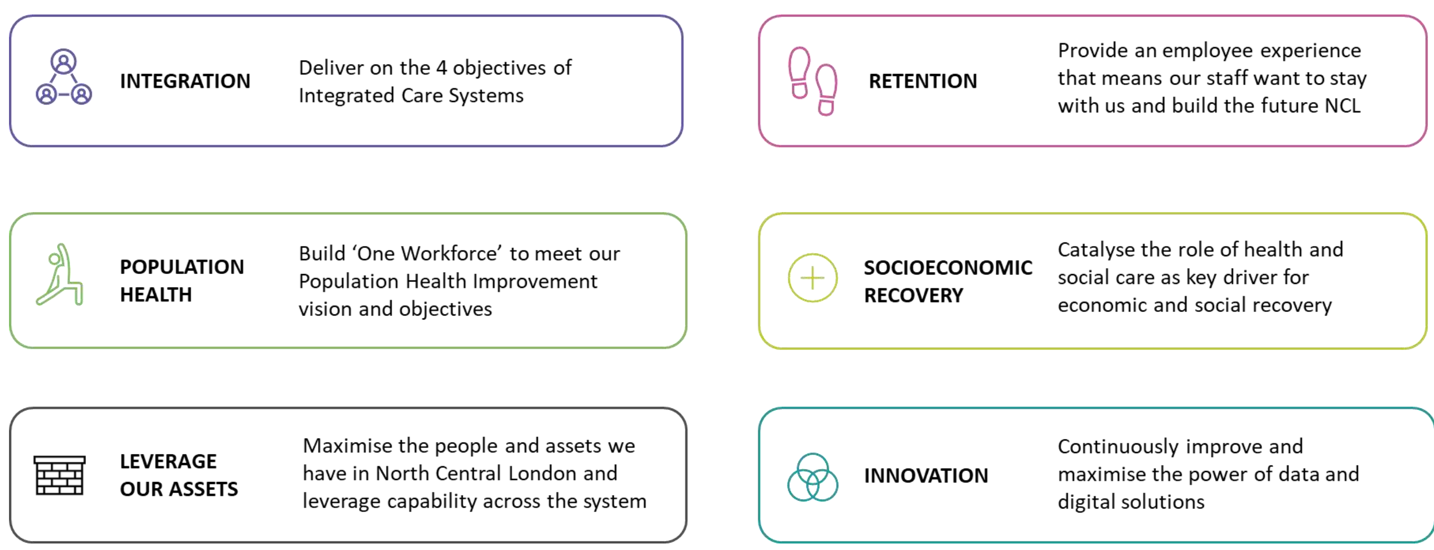
Our aims for 'one workforce'

- The NHS was set up to provide **episodic** treatment for acute illness
- The future is - **delivering person-centred experience to address more complex, longer-term health conditions**
- Our health and care workforce are our **greatest asset**
- 'One workforce' recognises the way patients and our population **experience care** and the need to **integrate health and care services**

Aims of an integrated, 'one workforce' for NCL

- Reduce fragmentation and encourage collaboration
- Improve skills and capabilities of staff
- Optimise talent, working at the top of their licence
- Create a flexible and dynamic workforce
- Adaptable to meet local needs
- Continually deliver high quality sustainable care
- Contribute to wider social determinants of health
- Provide meaningful career opportunities
- Streamline and innovate – improve productivity and efficiency

When designing initiatives and engaging partners across the ICS, we will retain the following principles to guide strategic decisions and prioritise resources:



To deliver on this ambition, we have focussed on three pillars as a system with a set of supporting enablers to improve recruitment, retention and wellbeing of staff within organisations.

1. **Workforce supply** – to close the workforce gap through improved workforce planning across all the sectors to better understand the types of skills required within each sector in the future. Working closely with our education providers (further and higher education) and our wider partner organisations to take advantage of the bulge in the 18-year-old population over the next few years, which we are unlikely to see again for the rest of the century, to offer as many routes into social care and health careers to school leavers as possible, such as apprenticeships. Offering good work to our local population is one of our key prevention levers so ensuring the visibility of roles and opportunities to our local residents is vital. All underpinned by the development of employment models that enable cross-boundary and sector working which allow staff to more easily work across different organisations within health, care and the voluntary sector.

2. **Workforce development** – supporting the development of meaningful careers, particularly for the 'poly-potential' entry level roles such as physician associates thereby increasing retention rates. Complementing the increased level of generalist roles with the development of advanced clinical practice roles, bringing in more of a digital and data focus to ensure that clinicians can take greater advantage of technological innovations. Creating the conditions for staff to thrive through the development of a diverse and inclusive workforce and a culture that enables staff to meaningfully contribute to improvements within their service area, both clinically and corporately. Ensuring all staff have the opportunity to meaningful careers to realise their potential, wherever they work.

3. **Workforce transformation** – embracing new ways of working including through technological advancement, creation of holistic roles that provide support for the population we serve across the health and care boundaries; increasing productivity through the introduction of digitally augmented pathways and development of new career pathways to attract and retain staff. Moving towards a more integrated workforce model, that starts to realise the ambition of the population health improvement strategy through pivoting to a preventative approach to care. Transforming how people care for their own health needs and improve their own health outcomes.

5 Progress so far

Despite the challenges of the past few years, we have built strong partnerships, relationships, and developed new ways of working as a system across social, primary and secondary care. Our first year as an Integrated Care System has demonstrated the impact collaboration can have on our population health outcomes, offering more joined up care through innovative workforce models. We have already started focusing work on a number of areas as an ICS, which has provided a strong platform to deliver improvements across our workforce.

- A move to single strategic commissioner for health services
- Ensuring the resident voice is heard at all levels of work
- Establishing five borough-based integrated care partnerships (ICPs) focused on the coordination, integration and development of out of hospital services based on population needs
- Supporting the development of Primary Care Networks (PCNs)
- Through our response to and recovery from the Covid-19 pandemic we have worked collaboratively with system partners to tackle challenges and find solutions to meet the needs of local people

Within the NCL workforce programme, we have focussed on:

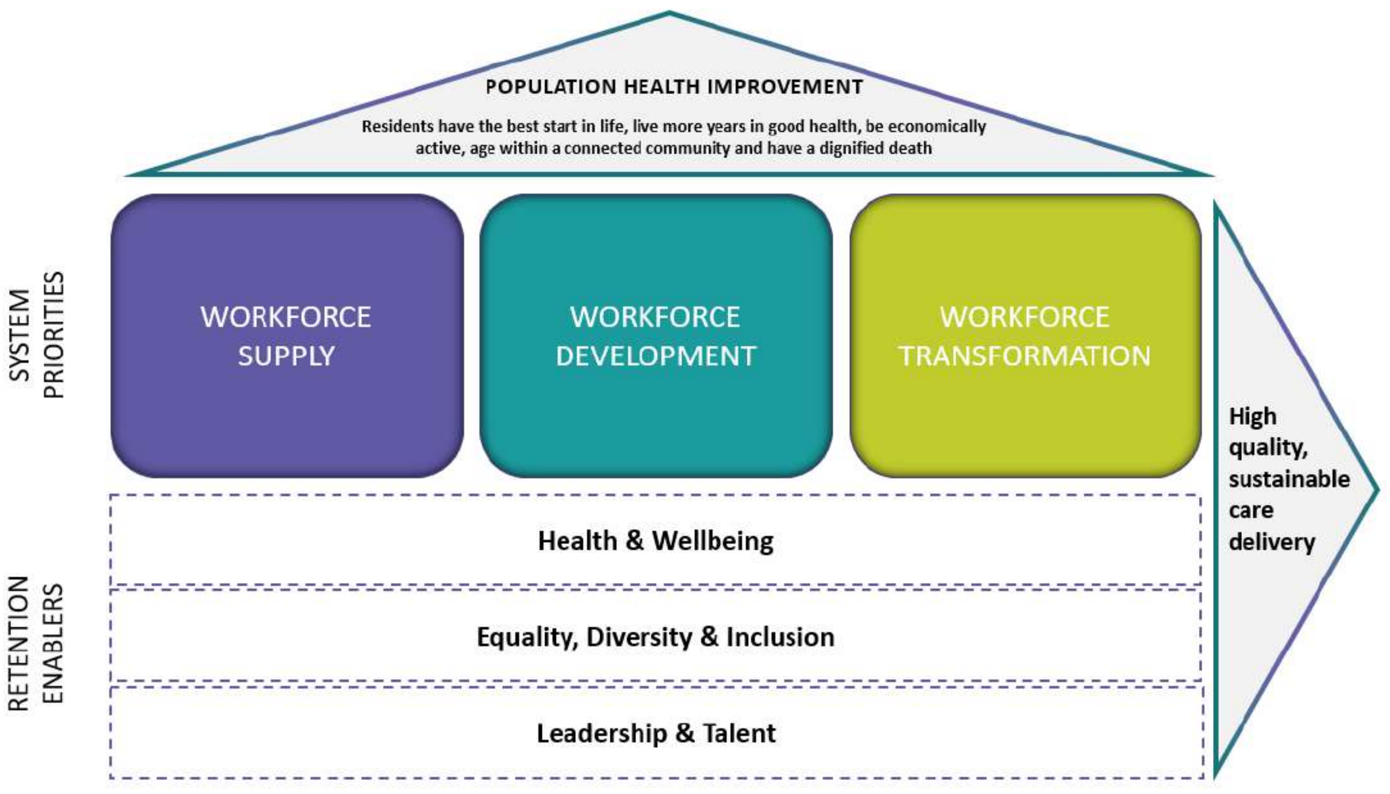
- Strengthening our workforce analytics function to develop advanced 'One Workforce' data and analytics capabilities, supporting system-wide demand management.
- Piloting new approaches to integrated workforce planning in key areas of system need. This has included developing insights into the role of skill mix and workforce flexibility in elective recovery, and how enhancing digital resource navigation can support transformation across the Children and Adolescent Mental Health Services (CAMHS) pathway.
- Building a collaborative approach to equality, diversity, and inclusion across each of our key strategic pillars. We have commissioned an inclusivity audit of recruitment services through eight diversity lenses, developed our executive talent pipeline, supporting 14 aspiring directors via our 'Future Leaders' programme and built system networks for

Equality, Diversity and Inclusion (EDI) and Talent Management.

- NCL was successful in becoming a 'Pathfinder' for the NHS Universal Family Programme, with a commitment to supporting 175 care leavers into health and social care careers over three years . Work to date has connected several system partners, including trusts and VCSE colleagues.
- Focusing on entry routes to careers in health and social care, including targeting school leavers building our availability of apprenticeships and T-levels.
- Developing our nursing workforce; we have recruited 586 international nurses and 143 trainee nurse associates.
- Focusing on workforce sustainability, a nursing, AHP and midwife workforce delivery group has been established to ensure an ongoing system approach across the key strategic pillars.
- Enhancing system reach building strong partnerships with the Training Hubs, enabling better reach into primary care services.
- Strengthening system working, wider workforce engagement and priorities co-design through strong programme management support, convening diverse stakeholder groups and supporting innovation.

6 Our People Priorities

Our new ICS People Priorities integrate existing projects, utilising the progress and momentum established over the last two years, and establish a new set of activities to deliver a step-change in pace and impact. We are committing to making a tangible difference to our workforce and their wellbeing, development and employee experience; whilst driving improved patient and population health outcomes and delivering on our system recovery. This will be supported by a set of enablers focussed on improving retention that will be supported by the ICS and delivered locally by partner organisations. It is critical that we enable organisations to prioritise workforce retention. Research in 2022 by Health Education England highlighted that if we reduce the number of people currently leaving nursing to the average leaver rate in 2019/20, then we would have 7,000 more nurses in the workforce by 2025, rising to 30, 500 by 2037.



In order to ensure we can deliver on a system-wide shift, we are prioritising the areas within each of our three pillars that we think will have the highest impact if delivered in on a consistent basis, maturing over a number of years. These are:

Workforce Supply Priorities

In order to develop a sustainable workforce, supply is a critical priority with two main areas of focus:

Data: the ICS has a unique opportunity and role to generate visibility of roles, opportunities and capabilities and use an evidence-based approach to support strategic workforce planning and coordinate planning activities across the system.

Supply routes: we need to diversify our entry routes to ensure we have the right number of staff with the right skills in the right place to achieve our population health improvement outcomes on a sustainable basis. Our focus has traditionally been on the NHS and we now need to broaden this across the care sector through engaging and advancing our relationships with our voluntary, community and social enterprise partners.

Workforce Development Priorities

To ensure we retain and develop our people and reverse our leaver rate we are focussed on two key areas:

Flexibility: designing the right policies and processes to enable staff the opportunity to have a portfolio career; a second career or to offer an approach to work that overcomes the barriers that prevent people with long term conditions or caring responsibilities joining the workforce.

Enhanced capability: increasing capability across the system, maximising the talent we have and therefore reinforcing and increasing workforce flexibility.

Workforce Transformation Priorities

In order to truly start to improve the health outcomes for our population, we will need to to transform our clinical and care delivery models and with that, our workforce skills and capabilities. This will be two-fold:

Innovation: piloting initiatives and designing an ecosystem that provides a clear route to scaling and enabling workforce transformation impact at scale; maximising the datasets and advanced technologies within the system (and explore new ones) to increase access, efficiency and continuously evolve our workforce and operating model

Ways of working: embracing new ways of working including through technological advancement, creation of holistic roles that provide support for patients across the health and care boundaries; increasing productivity through the introduction of digitally augmented pathways and development of new career pathways to attract and retain staff.

7 Phasing Delivery

Delivery will be enabled or constrained by resourcing and partnering to deliver the priorities as set out. Phasing delivery is representative of our approach to ensuring delivery is resourced appropriately, delivered by our leading partners within the system, with the requisite governance and oversight and is connected to our Population Health outcomes. We want to set out a clear ambition whilst retaining agility and the ability to flex resources to support in-demand areas of the workforce.

There are three phases to the strategy that align all priorities. However, this will not always be a linear process and some initiatives will be accelerated as and when required.

Laying the Foundations (Year 1 2023/24)

The first year of the strategy is all about defining the assets and opportunities within the system, focussing on the most in-demand staffing groups and identifying where organisations (and partners) are best-placed to deliver targeted initiatives.

EXAMPLE: Mapping supply routes and identifying gaps and opportunities to capatilise on the bulge of school leaver-aged individuals, enabling a comprehensive offer of entry-level roles to be developed across North Central London including apprenticeships and T-Levels.

Accelerating the Change (Years 2 and 3 2024 – 2026)

Delivering system efficiency and productivity benefits via targeted initiatives that close the supply and demand gap, upskill staff and provide workforce portability.

EXAMPLE – agreeing a cross-organisation flexible working policy that enables inter-NCL movement across all staffing groups and increases flexibility for staff, improving retention rates.

Transforming our Workforce (Years 4 and 5 2026 – 2028)

Expanding pilot initiatives to deliver impact at scale across the system and embracing technology to free-up staff for our most critical current and future challenges

EXAMPLE – Automated workforce data gathering and analysis feeding into operational planning and delivery; supporting proactively identifying patient needs to drive more personalised and preventative care.

The following diagram sets out the priorty actions that we will focus on as an ICS in year 1 and our ambitions for the remaining years of this strategic period.

WORKFORCE SUPPLY

	DATA	SUPPLY ROUTES
YEAR 1	Scope enhanced data analytics with system partners to determine the data sharing, quality and access requirements needed to support 'one workforce'	Identification of routes into health and social care careers. Focus on increasing opportunities for school and care leavers.
YEAR 1	Develop in-depth understanding of local labour markets; demographics and profiles to better target training and employment	Scope out opportunities to develop high-impact approach to apprenticeships across North Central London.
YEAR 2/3	Build data modelling capability (inc. system-wide metrics/benchmarks) to drive service efficiency and workforce productivity	Review workforce gaps and opportunities for rotational placements across sector boundaries to support future skills and training model
YEAR 4/5	Invest in automated data gathering and analysis; utilisation of big datasets to drive workforce planning and decision making	Systematic delivery of workforce interventions, consistently aligned and refreshed in line with Population Health goals

WORKFORCE DEVELOPMENT

	FLEXIBILITY	ENHANCED CAPABILITY
YEAR 1	System-wide mapping of requirements for the development of an 'NCL passport' to support enhanced staff portability	Identification of high impact roles that could unlock care delivery i.e. poly-potential, generalist or advanced clinical practice
YEAR 1	Development of an approach to flexible employment to support portfolio or blended careers to further attract and retain staff	Partner with higher-education institutions to develop staff upskilling and training programmes aligned to system priorities
YEAR 2/3	Expansion of collaborative staffing mechanisms and existing centralised corporate services to support sharing of staff (demand, vacancy, internal recruitment)	Redesign People processes to reflect policies supporting workforce flexibility / portability
YEAR 4/5	Realise collaborative, inclusive culture framework with systems developed to action feedback from staff (inc. system-wide staff survey and EDS2, WRES/DES)	Develop an enhanced partnering strategy with university and educational institutions to train staff

WORKFORCE TRANSFORMATION

	INNOVATION	WAYS OF WORKING
YEAR 1	Identify opportunities to accelerate, enhance and scale innovation across the system	Development of the workforce model to support the implementation of the Long Term Conditions management in Primary Care
YEAR 1	Identify, develop and support the delivery of the change management requirements for the NCL digital strategy	Integrated Neighbourhood Workforce model defined to realise the ambitions of the Fuller Review of Primary Care
YEAR 2/3	Development of a funded innovation pipeline; test and learn process and established partnerships w/ Education & Industry	Roll-out digital upskilling to workforce across the system
YEAR 4/5	Piloting of digital solutions aligned to priority staffing groups / pathways	Identify priority solutions (and training) to deliver at scale; engage partners and resource projects

8 Doing things in the right place

ICSs bring opportunities for local teams and organisations to work together differently, making the most of the collective experience and expertise within a local area, and in the way that best meets local needs. These opportunities could be facilitated by the ICP, ICB, through place-based partnerships, provider collaboratives, neighbourhoods, or other local arrangements.

We believe the NCL ICS serves four key purposes in delivering workforce initiatives:

1. Population
The ICS will determine workforce decisions when they need to be made across a local labour market and there are benefits of scale from joined-up solutions to shared challenges and opportunities. This will include;

- Assessing system-wide demand and associated workforce need
- Devising area-based workforce retention strategies

2. Partnering
NCL ICS will coordinate partnerships and leadership required across a footprint, including partners and stakeholders in health, social care, local government, the voluntary, community and social enterprise (VCSE) sector as well as in education. This will include;

- Control of local, long-term funding streams to support system-wide workforce planning, innovation and collaboration
- Co-developing system-wide curricula, in association with local education providers
- Managing strategic workforce relationships with local external partners, including universities, colleges, the GLA, combined authorities and LEPs

3. Planning
The ICS will play a leading role where consistent planning is needed over a medium-term period across the system (for example, up to five years plus annual refresh). This will include;

- System architecture design, remit and direction of local workforce action via People Board
- Developing system-wide health and care approaches to local supply/pipeline
- Establishing an in-built expectation of flexible working across clinical and non-clinical boundaries throughout the system

4. Prioritising
The ICS will coordinate strategic priorities for the system and ensure plans are underpinned by a shared resource strategy (workforce, finance, digital infrastructure, commissioning, estates.) This will include;

- Managing the on-going, system-wide deployment of the health and care workforce, including through schemes such as passporting
- Future talent management development programmes, within health and care (including clinical) and in collaboration with other sectors locally (as part of place-based leadership)
- Advanced training of existing roles
- Developing, or evolving, different health and care roles, including across both new and existing positions

9 Next Steps – Laying the Foundations

Immediate work will focus on defining the deliverables against the following year 1 priorities for 2023-24 and determining the best level of the system to deliver the various elements of the strategy;

1. Mapping existing work across the system to the three workforce pillars; supply, development and transformation.
2. Development of the workforce model that better supports the delivery of long-term condition management
3. Identification of routes into health and social care careers. Focus on increasing opportunities for school and care leavers.
4. Scope enhanced data analytics to determine data sharing, quality and access requirements with system partners for 'one workforce'
5. Further exploration as to how we might expand the functionality and utilisation of the 'NCL passport' for staff portability
6. Identification of high impact roles that could unlock care delivery i.e. poly-potential, generalist or advanced clinical practice
7. Identify opportunities to accelerate, enhance and scale innovation across the system
8. Development of the workforce model to support the implementation of the Long Term Conditions management in Primary Care

To socialise our objectives, NCL ICB colleagues will undertake a period of engagement, during which the People Strategy priorities will be communicated with key stakehlders across the NCL health and care system. This exercise will help us to identify existing or planned activity and will give our partners the opportunity to develop and shape their own strategic plans and align them to these system workforce priorities.

People Board sub-committees will be established for each of the three pillars. These sub-committees will be tasked with driving the work that aligns to their respective pillar objectives. Representation for the sub-committees will be sought from across a broad range of health and care partners in NCL to maximise the breadth of knowledge, learning, delivery and opportunities for collaroative working.

Progress against the delivery of the strategy priorities will be brought back to the NCL ICS People Board.

North Central London ICB
Board of Members Meeting
9 May 2023

<table>
<tr><td>Report Title</td><td>ICB Priorities – 2023/24</td><td>Date of report</td><td>24 April 2023</td><td>Agenda Item</td><td>2.2</td></tr>
<tr><td>Lead Director / Manager</td><td>Sarah Mansuralli,
Chief Development & Population Health Officer</td><td colspan="2">Email / Tel</td><td colspan="2">sarah.mansuralli@nhs.net</td></tr>
<tr><td>Board Member Sponsor</td><td colspan="5">Frances O’Callaghan, Chief Executive Officer</td></tr>
<tr><td>Report Author</td><td>Sarah Mansuralli,
Chief Development & Population Officer

Ian Porter, Executive Director of Corporate Affairs</td><td colspan="2">Email / Tel</td><td colspan="2">sarah.mansuralli@nhs.net

ian.porter3@nhs.net</td></tr>
<tr><td>Name of Authorising Finance Lead</td><td>Not applicable.</td><td colspan="4">Summary of Financial Implications

Whilst the report does not set out specific financial requests, organisational capacity will be aligned to the delivery of these priority areas across 2023/24.

,</td></tr>
<tr><td>Report Summary</td><td colspan="5">The Integrated Care Board (ICB) has a clear mission, which is to:
• improve outcomes in population health and healthcare
• tackle inequalities in outcomes, experience and access
• enhance productivity and value for money
• help the NHS support broader social and economic development

We will work with residents of North Central London so they can have the best start in life, live more years in good health in a sustainable environment, age within a connected and supportive community and have a dignified death.

We will achieve these objectives through our focus on population health improvement and key areas of development – and we will have a relentless focus on inequalities and wider determinants of health which we know impact so many of our residents. Partnership working across statutory and voluntary organisations and with local communities and stakeholders is critical to achievement of our priorities.

We recognise that population health improvement interventions will have a longer term impact on the health and wellbeing of our residents. As a result, we will need a dual focus on meeting current needs (and making the distinction</td></tr>
</table>

	between need and demand), while continuing to advance towards more proactive, integrated models of care. To support the progressing with this mission and building on the strong foundations in place for the first year of the ICB – the Executive Management Team has developed a set of corporate (organisational) priorities for 2023/24. The priorities are set out within the enclosed document – and are classified across three key headings: • Getting the basics right • Advancing our ambitions towards population health improvement • Delivering our statutory and business as usual activities The priorities incorporate key requirements associated with the operational planning guidance that recovers core services and productivity, makes progress in delivering the Long-Term Plan ambitions that are incorporated into our service development programmes and continue to transform the NHS for the future. The priorities reflect key areas of work that the ICB needs to ensure additional focus on and delivery of in 2023/24 – informing allocation of capacity and resources. They are not an exhaustive list of all important activities but seek to identify where we will focus our energies as an organisation. The priorities will further aid the ICB's approach to forward planning, resource allocation, performance monitoring, objective setting for teams and staff members, communications, engagement, and risk management activity. The challenging financial environment we operate in will result in the need for choices and difficult decisions about what we can progress over the short, medium and longer term within each of these priority areas. We will also need to focus on releasing efficiencies to enable us to invest in priorities that we know will achieve our strategic aims. Clear priorities informed by population need and an understanding of our system challenges provides a solid foundation but is only part of the story. Coupled with our population health and integrated care strategy, recently endorsed by the Integrated Care Partnership, these priorities and our system strategy provide the strategic direction of travel underpinned by tangible deliverables for 23/24 for the ICB. We must now progress to delivery plans and describe 'how' we will achieve this. This is all the more important in our financially challenged context where resources are constrained. We will not just pivot overnight to our vision for a population health system. It will be a process of transition, with us working steadily together, learning from our communities and each other about what is needed to make the change happen. We have an exciting yet challenging year ahead, which will require all of us to think and work differently across system, place and neighbourhood. This shift will require us to consider our operating model and how we work together and with providers and stakeholders to deliver both our corporate objectives as an ICB but also our collective ambitions for population health improvement as an ICS that are the basis of the strategic priorities described in the slides attached.
Recommendation	In accordance with the ICB's Scheme of Reservation and Delegation (SORD) the Board of Members is asked to **APPROVE** the organisational priorities for 2023/24.
Identified Risks and Risk	Key risks to delivery of these priority areas for the ICB are:

Management Actions	• Ongoing external influences on the NCL health and care system that continue to draw on significant strategic and operational ICB capacity • Impact of the organisational redesign process and timeliness of delivery of the new operating model • Ongoing financial constraints within the NCL system
Conflicts of Interest	Not applicable.
Resource Implications	Organisational capacity will be aligned to the delivery of these priority areas across 2023/24. Individual business cases and / or programme plans will be developed as appropriate for respective priority areas.
Engagement	The priorities have been developed by the Executive Management Team and reflect the recognised key areas for strategic progression by the ICB throughout 2023/24. Where required, engagement activity will be undertaken on programme activity for individual priority areas.
Equality Impact Analysis	Equality Impact Assessments will be undertaken, where required, for key work programmes that form part of delivery of the ICB priority areas.
Report History and Key Decisions	The priorities set out in this report are consistent with a number of key areas previously discussed through the ICB Board – including the development of the Population Health and Integrated Care Strategy, Urgent and Emergency Care, Elective Recovery, NCL People Strategy, ICB Organisational Change Programme.
Next Steps	Our progress against our priorities will be measured as part of our ongoing work on monitoring the indicators that form part of our outcome framework, which is being baselined to agree our level of ambition against these areas. We will also use the standards/metrics contained within the Long Term Plan ambitions and operating planning guidance, setting out national objectives for the NHS in 23/24. Progress monitoring and reporting will also take place for individual work programmes within the priority areas based on the development of delivery plans. Subject to approval from the Board, the Priorities document will be shared with ICB staff including to support the current round of staff appraisals / objectives setting.
Appendices	Priorities 23/24 slides.

ICB Priorities

2023/2024

Getting the basics right

Urgent and emergency care

Improve A&E 4 hour performance (76% of patients seen within 4 hrs)
Improve Cat 2 ambulance response times to an average of 30 min across 23/24
Increase speed of discharge and reducing long lengths of stay to achieve GA bed occupancy levels to 92% or below
Consistently meet or exceed the 70% 2 hr UCR standard; including direct access routes for community services

Elective recovery and cancer

Eliminate waits over 65 weeks for elective care
Deliver the system specific activity target (agreed through operational planning processes)
Continue to reduce the no of patients waiting over 62 days
Diagnose 75% of cancers at stage 1 and 2 (CORE20PLUS5)
Deliver the cancer faster diagnosis standard so that 75% of patients referred by their GP are diagnosed within 28 days

Safe & compassionate care

Lead quality oversight and drive quality improvement across all commissioned services
Deliver the improvement programme in maternity and neonatal services through the Local Maternity & Neonatal System (LMNS), and for residents with mental health needs and learning disabilities and autism requiring ongoing care in partnership with service users and providers

Primary Care

Develop and implement plans for primary care transformation to deliver Fuller stocktake actions to deliver proactive integrated care and place and neighbourhood (AARS an enabler)
Improve access in line with operating plan targets (access and no of appointments)
Primary care focus on population health and outcomes through improved management of Long Term Conditions

Organisational Development

To ensure ICB is fit for purpose and can deliver the range of functions (existing and delegated)
Development of our People Strategy and workforce plans

Advancing our ambitions towards population health improvement

North Central London

Our population health ambitions are aimed at improving health outcomes across the life course of our residents and where the potential for population health gain is the greatest through focussing on multiple common risk factors and wider determinants of health. This will involve working closely with our ICS partners to develop opportunities that enable broader social and economic development in NCL that improves the quality of life for NCL residents, all of which will require data capability/infrastructure and workforce changes to advance. Our work on population health improvement will be based on the areas of focus and levers for sustainable change that are set out in the Population Health and Integrated Care Strategy.

Start Well – children, young people and maternity services

Improve take up childhood immunisations to the London/England average across NCL – to include MMR
Narrow health inequalities in access, outcomes and experience including mental health services (CORE20PLUS5)
Progress on Start Well options appraisal to identify options to address inequalities of access and outcomes in secondary care
Improve national safety outcomes and staffing levels with respect to maternity care.

Whole system approach to end of life care for adults and children

Delivering our ageing well outcomes and ensuring that those at the end of life receive personalised and dignified care
Improve access, quality and sustainability to good quality end of life care

Prevention and early intervention focus on cancer, cardiovascular disease and respiratory conditions

Cancer screening to increase early detection and deliver faster diagnosis standards, especially breast screening (CORE20PLUS5)
Improve health checks for those with learning disabilities and reduce reliance on inpatient care for this population group
Improved support to patients with long term conditions e.g. proactive care out of hospital, take up of flu vaccine for those with COPD

Mental health and well being

Increase access and take up of community mental health services including psychological therapies
Eliminate inappropriate out of area placements to support more patients in their local areas and near their communities
Recover the dementia diagnosis rate to improve early detection and preventative interventions
Improve access to perinatal mental health services and reduce reliance on inpatient care for those with learning disability and autism

Health inequalities – CORE 20PLUS5

Delivery of our population health and integrated care strategy with a focus throughout every programme on the 20% most deprived and those population groups who have the worst outcomes in NCL, including inclusion health populations
Implement core offers to ensure equity of access to core offers for community and mental health)

Delivering our statutory and business as usual activities

Planning, commissioning and contracting of services (to meet population health outcomes)

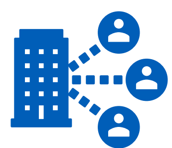
Effective contract management of all commissioned services
Ensure safe landing of delegated commissioning responsibilities
Service development of operational planning requirements into service delivery plans and contractual arrangements

Engaging our residents and communities

Engaging our service users, residents and communities to ensure that the services we plan and commission meet the needs of residents and improve take up as well as access
Work with our voluntary sector organisations to improve population health outcomes, addressing wider determinants Ensuring service changes are undertaken in line with statutory requirements and guidance

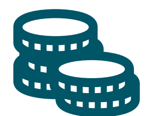
Quality, Safety and Safeguarding responsibilities for services commissioned/delivered

Ensuring high quality and safe services including prescribing
Discharging statutory responsibilities for safeguarding
Delivery of continuing healthcare and complex care/case management



ICB System Support

Enabling delivery of operational planning targets e.g. primary care access, urgent community response standards, etc
Capital prioritisation as an enabler to strategic and operational developments
Digital infrastructure developments to enable population health support both direct care and secondary care usage
System oversight framework support and dashboard to improve system performance improvement



Finance

Maintaining financial balance and eliminating legacy organisation deficits
Deliver organisational efficiency plan to achieve value for money, increase productivity and reduce duplication.
Focus on efficiency, productivity and value for money through strategic programmes and developments.

North Central London ICB
Board of Members Meeting
9 May 2023

Report Title	Integrated Performance and Quality Report	**Date of report**	24 April 2023	**Agenda Item**	3.1
Lead Director / Manager	Richard Dale, Executive Director of Performance and Transformation 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 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 NCL ICB Integrated Performance and Quality Report presents the latest analyses of key system operational performance and quality indicators against national and locally agreed targets relating to acute, mental health, community and primary care services. Areas of progress: • NCL made significant progress towards eliminating the number of long-waiting patients on our elective care waiting lists with a 40% reduction of 78-week waiters since January 2023 to 248 as at the end of March 2023. Further reductions are expected in the coming months although a slightly slower pace due to the adverse impact of recent industrial actions. The				

	ICB continues to lead a collaborative approach to recovering this patient backlog as quickly as possible. • The proportion of patients waiting over 6 weeks (backlog) for a diagnostic test has been reducing steadily in recent months, the net impact of increasing capacity, improving productivity, and stable demand. NCL successfully delivered the objective of the national 'Optimisation Month' initiative with a 12% reduction in diagnostic long waits between December 2022 and March 2023, in line with the National NHS initiative. Further work underway to ensure the system remains on track to achieve the national backlog ceiling of 5% by March 2025. • Cancer waiting times performance has improved since the last report to the Board largely driven by significant efforts at NMUH to reduce the number of long-waiting (>62 days) on their cancer waiting list. Latest data shows NCL performance is in line national average at 9% of total waiting list, and NMUH halving its long waiters since January 2023. Intensive work continues to embed the gains made. Ongoing challenges and further work; • The ICB is undertaking an analysis to understand the medium to long term impact of recent industrial actions. The report highlights a significant proportion of planned appointments (inpatient, outpatient, and day cases) were postponed for safety and capacity reasons. Providers are working at pace to rebook all cases in clinical priority order to mitigate risks recover against operational plans where possible. • Access to community mental health services for Children & Young People (CYP) in NCL is projected to fall short of the March 2023 target of over 23,000 by 20% due to staff shortages in services. Plans to recruit additional staff is progressing well, with improvements expected during 2023/24. • Performance against the A&E 4-hour has been relatively stable at 68% compared to previous months, with no material variation at provider level, and against a national ambition of 76% by March 2024. The number of patients spending more than 12 hours in EDs remains high, reflecting high occupancy and constraints relating to patient flows through hospitals. Demand for social and community care beds and resources continue to exceed supply, resulting in delayed discharges. The system is prioritising interventions that support improvements in this area such as effective use of SDEC and in some cases redesigning the capacity and use of the 'hot floor' at our most challenged sites. Significant efforts have been made over recent months to provide step-down bed capacity in community settings. Virtual ward capacity is increasing with senior medical cover from acute hospitals. Further work is still required to deliver the step change towards the national performance ambition of 76% by March 2024.
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: • COMM14 - Failure to Achieve NHS Constitutional Targets - Urgent and Emergency Care (Threat). • STR9: Failure to Deliver the 2023/24 ICB CIP (Cost Improvement Plan including elements of Transformation Programmes) (Threat).

	• PERF8: Failure to Deliver Referral-To-Treatment ('RTT') Waiting Time Standard (Threat). • PERF25: Failure to ensure ambulance patients are handed over to emergency departments in a timely manner (Threat).
Conflicts of Interest	Not applicable.
Resource Implications	The report does not set out specific resource requests, but some of the improvement programmes do have resourcing implications.
Engagement	Not applicable.
Equality Impact Analysis	Not applicable – although quality processes do take account of equity when reviewing specific incidents.
Report History and Key Decisions	This report is underpinned by the Quality Report to the Quality and Safety Committee and the Performance Report shared across the organisation and system.
Next Steps	The report will continue to iterate based on board and stakeholder feedback, as well as develop once the work on the NCL Outcomes Framework is complete.
Appendices	Full dashboards for quality and performance measures, and a glossary of terms used in this report are set out in the appendix for reference.

NCL ICB Integrated Performance & Quality Report

April 2023

Authors:

NCL ICB Performance and Quality Teams

Executive Summary

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

The report focusses on the following key areas:

- NCL system response to Industrial action (slide 3 and 4)
- Primary Care (slide 6)
- Mental Health Services (slide 7)
- Urgent and Emergency Care (UEC) (slide 5)
- Community Health Services (slide 8)
- Planned Care – Electives & Diagnostics (slide 9), Cancer Services (slide 10)

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

- Royal Free London (slide 11)
- North Middlesex Hospital (slide 11)
- Tavistock and Portman (slide 12)

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

The report incorporates aspects of the 2023/24 NHS Priorities and Operational Plans which were submitted to NHSE at the end of March 2023. NCL ICB continues to work with system partners to develop the plans for finance, workforce, activity and performance ahead of the final submission in early May 2023. In addition to the risks posed by industrial actions, further work is required to deliver compliance against elective activity targets, improve bed capacity to secure A&E performance improvement trajectories, and the efficient use of mental health beds to reduce the reliance on out of area beds.

Dashboards for performance and quality measures are included in the appendix for reference.

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

NCL system response to Industrial action (1/2)

Overview

In April 2023, junior doctors across the NHS carried out 4 consecutive days of industrial action, the second such action in 2023 following the strikes in March 2023. The April 2023 action encompassed a full stoppage inclusive of night shifts and on-call duties, with the only scenarios excluded from the action being a potential major incident or a mass casualty event. Junior doctors in GP training practices were also part of the industrial action, although GPs were expected to maintain patient access on strike days. Significant disruption was expected, resulting in the decision to postpone elective activity in order of clinical priority.

Key NCL System & Provider Actions

NCL CEOs led the system response to the strikes, including collective consideration of mitigations for hospital sites with the highest risk of gaps in rotas for critical areas. Where required, routine elective appointments and procedures were also postponed using a two-stage cancellation process (1st – notification, 2nd letters to patients). London Ambulance Service supported EDs and UTCs, with key support requirements focussing on resus and cardiac arrest teams, and increasing the presence of Hospital Ambulance Liaison Officers (HALO) on site. Multi Agency Discharge Events (MADE) continued in the lead up to the strike action, focusing on reducing occupancy and facilitating discharges with the overall aim of halving the number of beds occupied by medically optimised patients. ICU transfer services remained, however, heralded bookings from NHS 111 to EDs were suspended.

Medical rotas for inpatients services were covered during the period with a few exceptions (overnight shifts in anaesthetics and paediatrics) which were managed appropriately. Advanced life support and basic life support training was provided at each NCL site to Multi Disciplinary Team members who were designated to support the effort. In addition, all providers undertook a review of their emergency pathways including medical and surgical units to assess the potential available capacity to run these services. The provision of critical services including EDs were prioritised in accordance with the available medical staffing. Providers also operated incident coordination centres to support the delivery of services, with command and control structures inclusive of executive oversight to manage proceedings and any escalations. This was supported by a system control centre as part of the real time management of services through this period.

Mental Health Providers

The provision of critical services were prioritised and this covered crisis services, places of safety and A&E psychiatric liaison support in EDs. Consultants covered gaps where necessary, and services minimised outpatients and community appointments to release capacity.

NCL Support for British Medical Association Strikes (2/2)

Primary Care/NHS 111

Meetings were held with GP staff, providers and operational staff to agree the support available to practices and NHS111. Mitigating actions involved the increased flexibility of acute respiratory hubs for practices and 111 bookings, alongside an increased focus on extended hub provision to provide additional capacity where possible in each NCL borough. Practices focused on same day urgent care activity, while there was also increased NHS111 call handler and GP out of hours capacity laid on.

Community Providers

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

OFFICIAL

Overview of Primary Care

The overall number of core primary care appointments offered in NCL continues to rise, with General Practice experiencing significant pressure to meet patient demand. Approximately half of all appointment are same day appointments, and continues to offer 65% of appointments are face to face. There is no defined optimal blend of appointment type alongside virtual contacts, and this is tailored to the needs of local populations. NCL ICB is supporting General Practice to seek sustainable ways to meet this demand without risking workforce burnout.

Outside core hours, a mix of urgent and planned primary care activity is provided by PCNs on weekday evenings and Saturdays. NCL ICB had continued to commission borough-based hubs to deliver urgent appointments on Saturday evenings, Sundays and Bank Holidays, and to ringfence appointments for NHS 111 on weekday evenings and Saturday daytimes – this had ended with the introduction of the national PCN DES Enhanced Access Specification.

Over winter, additional primary care capacity was added to cover periods of industrial action. National funding was used to establish Acute Respiratory Infection Hubs in all boroughs to ease demand elsewhere in the system. Winter funding was also made available to boroughs to boost capacity to see patient cohorts most in need e.g. children and young people, or the frail elderly.

The 2023/24 GP Contract and PCN specifications both continue the national focus on improving access to GP appointments. Additional funding is available to PCNs who can demonstrate improvements in patient experience of access against locally agreed improvement plans - the Quality and Outcomes Framework has been re-aligned to incentivise practices to undertake dedicated work to understand and manage their demand and capacity. NCL ICB is developing its approach to supporting General Practice to deliver the requirements of these new specifications.

Work continues on the development of a consistent locally commissioned service focused on the identification and management of long term conditions, with an emphasis on personalised care planning and continuity of care for those who will most benefit. This will ensure that the national focus on access to General Practice is balanced by a commitment to protecting capacity for planned work, and proactive care for people with long term conditions to help them stay well.

	Dec '22	Jan '23	Feb '23
Core primary care appointments	590,561	658,821	620,268
% face to face appointments	64%	64%	65%
% same day appointments	53%	51%	49%

Primary care quality reporting

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

- Clinical and quality – including health checks and care plan implementation, patient experience, CQC ratings and complaints.
- Activity – e.g. appointments by type, referral rates, and progress on the adoption of advice services
- Workforce – GP, nurses and the Additional Roles Reimbursement Scheme (ARRS).

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

Overview of Mental Health Services

In relation to **Talking Therapy Service** (IAPT), 30,528 people accessed psychological therapy services in NCL between April 2022 and February 2023, against a target of 39,050. The key drivers of the under-performance remain workforce recruitment and retention, coupled with a reduced number of trainees allocated to services. Providers are undertaking year long recruitment and staff wellbeing campaigns, commissioning capacity from VCS and digital providers, as well as increasing outreach to BAME and other protected groups. Provisional data for February 2023 indicates the IAPT recovery rate was 52% (target 50%), 6-week wait performance was 84% (target 75%), with 18 weeks wait achievement of 98% (target 95%).

NCL continues to utilise more **Out of Area Placements (OAP)** beds than planned due to high bed occupancy and longer inpatient stays for people detained under the Mental health Act with very complex needs. The impact of focussed interventions to reduce occupied bed delays for patients who are clinically ready for discharge, amongst other initiatives, is seen a steady reduction in recent weeks. Other improvement actions aim to improve patient flow and discharges, and reduce preventable admissions through medicines optimisation reviews by mental health pharmacists, reducing clinical variation, enhanced infrastructure support for Multi Agency Discharge Events, rapid access to enablement pathways, alternative housing options for people who are 'fit for discharge', and enhanced crisis intervention plans for high intensity users.

Access rates for community mental health services for **Children & Young People (CYP)** in NCL is projected to fall short of the March 2023 target of over 23,000 by 20% due to staff shortages in services. Plans to recruit additional staff is progressing well, with improvements expected during 2023/24. Memory services in NCL are developing plans to ensure delivery against the **Dementia Diagnosis Rate** national ambition of 67%, is maintained throughout 2023/24. Data reporting is expected to resume by June 2023.

NCL met two of the three targets relating to the use of inpatient facilities for people with **Learning Disability/Autism,** and marginally missed the third in 2022/23 – the result of better assessments in mental health settings to identify patients with a diagnosis of Autism Spectrum Disorder who arrive from prisons, or may have been missed in the community. This has enabled services to meet their needs by ensuring reasonable adjustments are made and appropriate support provided. Access to suitable accommodation remains a barrier to timely discharge, however.

	Dec '22	Jan '23	Feb '23
IAPT Access *[February YTD Target: 39,050]*	24,880	27,810	*30,528**
Out of Area Placements *[Target Q4: 2,270]*	942	762	470
CYP MH Access *[Year End Target: 23,291]*	15,570	15,755	TBC
Dementia Diagnosis Rate *[National Target: 67%]*	*Data publication is temporarily suspended by NHS Digital due a to change in the data collection process.*		

	Q2 22/23	Q3 22/23	Q4 22/23
LD/Autism Inpatients (ICS) *[Q4 Target of 22 residents]*	20	24	21
LD/Autism Inpatients (NHSE) *[Q4 Target of 16 residents]*	18	17	18
LD/Autism Inpatients(<18yrs) *[Q4 Target of 5 residents]*	8	8	5

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

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Overview of Urgent & Emergency Care Services

Performance against the A&E 4-hour has been relatively stable at 68% compared to previous months, with no material variation at provider level, and against a national ambition of 76% by waits by March 2024. The number of patients in ED waiting 12 hours or more from arrival remains high at over 3000 in March 2023, reflecting high number of presentation, bed occupancy and constraints relating to patient flows through hospitals including discharges.

Hospital services in 2023 have been impacted by industrial actions by ambulance staff, nurses, junior doctors and physiotherapists. To maintain patient safety during the strikes, and the periods leading up to and after, the ICS put in place a robust clinical response which required the cancellation of elective appointments and procedures in order to safeguard urgent and emergency care services, and the highest clinical priority cases. The ICS effectively managed the risks associated with UEC pathways with patient safety remaining a priority throughout the period, resulting in NCL aggregate A&E 4-hour performance of 78.5%.

NCL is prioritising interventions to improve flow such as the effective use of SDEC, and in some cases redesigning the capacity and use of the 'hot floor' at our most challenged sites. Significant efforts have been made over recent months to provide step-down bed capacity in community settings. Virtual wards have started to provide significant bed capacity, with senior medical cover from acute hospitals. NCL providers continue to report high acuity presentations, and long lengths of stay. Demand for social and community care beds and resources continue to exceed supply, resulting in delayed discharges. ED and LAS collaborative action has reduced ambulance handover delays with LAS led cohorted patient bays when possible. This has led to an improvement in Category 2 ambulance performance and improved patient safety.

The NHS 111 service continues to experience variable performance with call answering and call abandonment performance below target, due to variable demand and staff shortages. The additional new staff have yet to deliver the improvement and consistency hoped for. NHS 111 remains key to enhancing utilisation of local pharmacy and available primary care slots to reduce reliance on ED services. Patients presenting with mental health conditions continue to experience the longest ED waits due to bed congestion. Consequently, out of area placements at 762 bed nights in January 2023 were higher than anticipated.

	Jan '23	Feb '23	Mar '23
A&E 4-hour Waits *[2023/24 national target – 76%]*	70%	68%	68%
Long Lengths of Stay (>21 days) *[Year end target – 380]*	576	566	577
Ambulance Handover Delays (>60 minutes) *[Occasions over 60 mins]*	837	720	889
NHS 111 – Calls Abandoned *[National target <5%]*	19%	29%	TBC
A&E 12 Hours in Department *[From time of arrival at ED]*	3,041	3,110	3,035

Overview of Community Health Services

The waiting times for **children and young people (CYP)** have remained steady in recent months but remains an area of concern**.** In February 2023, the total volume of CYP waiting less than 18 weeks was 67% - the waiting list for therapy services which contributes to 45% of the total CYP waiting list has seen a reduction of 55 from the previous month, with 78% waiting 18 weeks or less. There has been an increase in referrals in some areas of Speech and Language Therapy and Occupational Therapy services at Whittington Hospital. The CYP Community Board is overseeing the development of improvement plans for prioritised areas, and is led by provider trusts.

The waiting list for an initial autism assessment appointment remains high, to reduce this, the new NCL face-to-face autism diagnostic hub which commenced in December 2022, and has picked up the longest waits from each NCL borough. As of the end of March 2023, 199 patients had been referred and accepted by the Hub, with an additional 55 cases referred and accepted by the new digital assessment provision from Healios. Despite the additional provision enabling an increase in activity, the waiting list position for autism remains relatively unchanged, owing to an increase in the number of referrals in Barnet (Royal Free London), and Islington (Whittington Health), coupled with staffing shortages.

In February 2023, the 18-weeks waiting time compliance for **adult community services** remained at 84% from referral, out of a total waiting list of over 33,000 patients. Less than 1% of patients have been waiting 52 weeks or longer, with most long waiting cases remaining in rehabilitation, podiatry and respiratory services - all patients have been offered access to virtual classes and supported self-education but have made a choice to be seen face-face. Through waiting list validation, prioritisation of resources, and mutual aid, NCL community service providers plan to reduce waiting times, particularly in high-priority areas such as MSK, diabetes, podiatry and respiratory.

As part of the NCL 2023/24 Operating Plan submission, trajectories for CYP and adult waiting lists were submitted that plan to deliver a reduction in volume each quarter. The underlying action to facilitate the improvement, is expected to be additional investment enabling further recruitment to progress patient flow.

	Dec ’22	Jan ’23	Feb’23
Waiting Times % <18 weeks (CYP)	67%	67%	67%
Waiting Times >52 weeks (Numbers of CYP)	72	75	81
Waiting Times % <18 weeks (Adults)	85%	84%	84%
Waiting Times >52 weeks (Adults)	71	80	68

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Overview of Elective & Diagnostics Services

NCL made significant progress towards eliminating the number of patients waiting more than 78 weeks from Referral to Treatment (RTT), reducing cases by 40% since January 2023 to 248 as at the end of March 2023. Recent industrial actions have adversely impacted plans to eliminate all 78-week waiters, and reduce the waiting list size. NCL is forecasting that 160 patients will be waiting longer than 78 weeks at the end of April 2023. The ICB continues to lead a collaborative approach to recovering this patient backlog as quickly as possible.

Elective activity levels continue to exceed the 2019/20 baseline. Key NCL System interventions to reduce waiting times remain in Q1 of 2023/24, and cover:

- Referral optimisation – GP referrals to be manged appropriately first time
- Improving productivity – theatre utilisation, outpatient clinics, and adopting clinical best practice pathways
- Increasing capacity – additional sessions to deliver more appointments and procedures
- Outpatient transformation – innovative delivery including digital and patient initiated follow-ups
- Mutual aid – reducing inequity in access through sharing of resources and redistribution of demand

NCL recorded a total backlog position of 4,426 patients waiting more than 6 weeks for a diagnostic test at the end of 2022/23, which is a 12% reduction from Q3 into Q4. When benchmarked against London's other ICSs, NCL delivered the second highest backlog reduction throughout the March 2023 Optimisation initiative. NCL performance remained ahead of both the regional average, and the nationally mandated ambition for 2022/23. When assessing 2022/23 as a whole, NCL has delivered a 21% backlog reduction for the year, and a 47% reduction from the backlog peak of 8,412 patients waiting longer than 6 weeks in July 2022.

The total waiting list for diagnostic tests has been stable in recent months – the net impact of increasing demand and capacity which continues to track above 2019/20 levels. A consistent reduction to the proportion of patients waiting over 6 weeks (backlog) has been delivered throughout March 2023, with an 'optimisation month' throughout March 2023, in line with the National NHS initiative.

	Jan '23	Feb '23	Mar '23
RTT 78ww *[cases waiting, target – 0]*	395	317	*248**
RTT 65ww *[cases waiting – target 0 by March 2023/24]*	1,798	1,593	*1,553**
RTT 52ww *[cases waiting]*	6,152	6,162	*7,203**
RTT Waiting List *[Total cases waiting]*	251,934	255,892	*270,508**
Electives YTD *(Inpatients + Day Cases)*	107%	107%	TBC
Outpatients YTD *(FA, FU + OPPROC)*	105%	105%	TBC
Diagnostic Waits > 6 weeks	12	8%	*11.5%**
Diagnostic Activity *(% of 2019/20)*	87%	106%	*114%**

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

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Overview of Cancer Services

Performance of cancer services remain variable. The number of first cancer treatments delivered up to February 2023 exceeded plan and the level required to recover the shortfall in cancer treatments stemming from the pandemic.

Challenges in the diagnostic phase of cancer pathways, however, continues to adversely impact on the number of patients waiting 62 days or longer (backlog) which stood at 783 across NCL as of the week ending 16th April 2023, which is in line with revised plans that accounts for current service constraints. The breakdown by provider is on the right. Lower GI and urology pathways continue to account for most of the variance.

The NCL Cancer Alliance is leading a transformation programme aimed at optimising capacity through the development of an alternative pathway for breast pain. Options to streamline access are also being considered. 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. This will build on the roll-out of Teledermatology for non-urgent referrals which commenced in NCL in September 2022. Individual Trusts also have plans in place to increase capacity (breast radiologist, dermatologist and endoscopy) to deliver improvements on a sustainable basis. To tackle the recurring administrative workforce shortages which adversely impacts on waiting list management, providers are undertaking detailed analyses of their establishment to improve their understanding of any potential gaps.

The ICB, working in conjunction with the regulator, has enhanced oversight arrangements in place for RFL (SOF3 Trust for cancer) and NMUH (SOF3 and Tier 1 Trust for cancer). These arrangements are accompanied by additional resources provided by the NCL Cancer Alliance and NHSE.

Of note, NMUH has made good progress in recent months in reducing their backlog, with further work required to reduce it further and embed the gains made. The Trust's backlog as a proportion of total waiting list remains an outlier. Further details are provided under the SOF3 update section of this report.

	Jan '23	Feb '23	Mar '22
Cancer Waits 62-Day Backlog *[Year end target - 488]*	782	656	665
Cancer Diagnosis Standard (FDS) *[Target – 75%]*	65%	73%	TBC
Cancer Treatments YTD *[Year End Target – 8,065]*	7,272	7,971	TBC

NCL Providers	**Cancer Backlog as % of Waiting List**
North Middlesex	10.4%
Royal Free London	7.9%
University College London	8.1%
Whittington Health	7.2%
Royal National Orthopaedic	5.2%
England Average	**8.2%**

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

Royal Free London (RFL)

SOF arrangements are in place to support RFL's exit from Segment 3 of the national framework. The exit criteria jointly agreed with NHSE and monitored through regular formal meetings with the Trust in 2022/23, focused on improvements in financial performance, UEC, cancer and RTT. Serious incidents, clinical harm reviews and significant quality alerts that relate to the SOF3 areas, are also discussed.

In relation to RTT, RFL made significant progress in 2022/23 in reducing the number of long waiting patients – 104-, 78-, and 52-week waiters in line with the agreed exit criteria. NCL ICB is therefore supporting the Trust's request for RTT to be removed from its SOF 3 exit criteria, and this is currently being considered by NHSE.

The Trust is close to delivering against its trajectory for the cancer 28-day Faster Diagnosis Standard (FDS) as of February 2023. Achievement of the FDS will remain as a cancer priority for 2023/24 exit criteria monitoring, alongside reductions to the 62+ day backlog, and patients waiting for more than 104 days.

Plans to improve UEC performance are in place although performance remains challenged. The UEC focus in 2023/24 is likely to centre on delivering the 4-hour waits in A&E target of 76% by March 2024, an increase in the percentage of ambulance handovers to ED in less than 30 minutes, and a reduction in the number of patients waiting for 12 hours or more in ED. RFL are also working on improving data capture in respect of the nationally mandated Emergency Care Data Set – data completeness and accuracy will be a priority throughout 2023/24.

North Middlesex University Hospital (NMUH)

Similar SOF arrangements are in place at NMUH. This includes a quarterly joint oversight meeting for both Trusts chaired by the ICB CEO, partly in recognition of the existing partnership between the two organisations. Key areas for NMUH requiring improvements with NHSE and NCL ICS support, are finance, UEC and cancer. Exit criteria to be monitored in 2023/24 for UEC and cancer trajectories, are expected to mirror those listed for RFL.

For cancer, NMUH has been placed in Tier 1 (national oversight) in addition to the SOF Segment 3. NMUH is in receipt of additional funding from NHSE and the NCL Cancer Alliance to support recovery in backlogs (62 and 104 days), and the FDS, focusing on increased MRI, CT, histology, and endoscopy capacity. In Q4 of 2022/23, in conjunction with RFL, NMUH developed a proposal for a hub and spoke model ensuring all colorectal services are appropriately located and staffed to facilitate all colorectal pathways, by streaming the right patients to the right place at the right time. This proposal is expected to be fully implemented during 2023/24.

UEC performance remains challenged, due to ongoing demand and capacity pressures. Plans focus on initiatives covering implementation of alternative pathways including the expansion of Same Day Emergency Care, utilisation of the existing Acute Medical Unit, and the creation of a Clinical Decisions Unit. NMUH plans also include the use of virtual wards, and improvements in internal processes to expedite discharges such as the "Home for Lunch/Tea" initiatives. Medically optimised patients occupying beds remain high, although the Cape Town ward remains open to support flow through the department.

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

Tavistock & Portman (T&P)

The System Oversight Framework process in place at T&P is focussed on the development of plans for workstreams aligned to the agreed exit criteria alongside agreed milestones. These are set out below. Key issues and progress identified at the March 2023 oversight meeting are listed below:

Gender Identity Development Service (GIDS) – There is now a new draft service and staffing model for the new national service being delivered by the early adopter trusts. Work continues on the transfer of the T&P waiting list to Arden and GEM, scheduled to be finalised in Q1 of 2023/24 before this is taken on by the early adopter trusts.

Longer-Term Strategy – The T&P Emerging Strategy has identified 5 critical aspects. These cover the People Plan Priorities, service improvement (reporting and clinical strategy), commercial strategy, estates strategy, and also financial stability. Work will continue to be developed through Q1 in line with the new executive appointments.

Finance – T&P is confident that the 2022/23 full year £3.8m deficit plan will be delivered. The action plan regarding the HFMA self assessment is currently being implemented.

Leadership and Governance – A fortnightly task and finish group chaired by the T&P CEO is now established to oversee implementation of the recommendations from the external governance report, and also the SOF 3 plan and associated actions. A project management approach is utilised to ensure grip and the monitoring of improvements, with regular meetings with the Executive Leadership Team to review progress. There is also a new interim Director of Governance in post (pending an ongoing substantive recruitment process), who will lead on all work covering corporate governance actions. Development of the Board Assurance Framework continues, with a Board development seminar session scheduled for Q1 of 2023/24.

Quality – The Quality Framework Improvement Plan continues to be reported to the oversight meeting. This covers 13 identified areas where improvement is required, ranging from issues such as the enhancement of patient safety, to ensuring the quality of services through strengthened leadership.

As part of the SOF 3 process, NCL ICB is working closely with both T&P and National and Regional NHSE 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.

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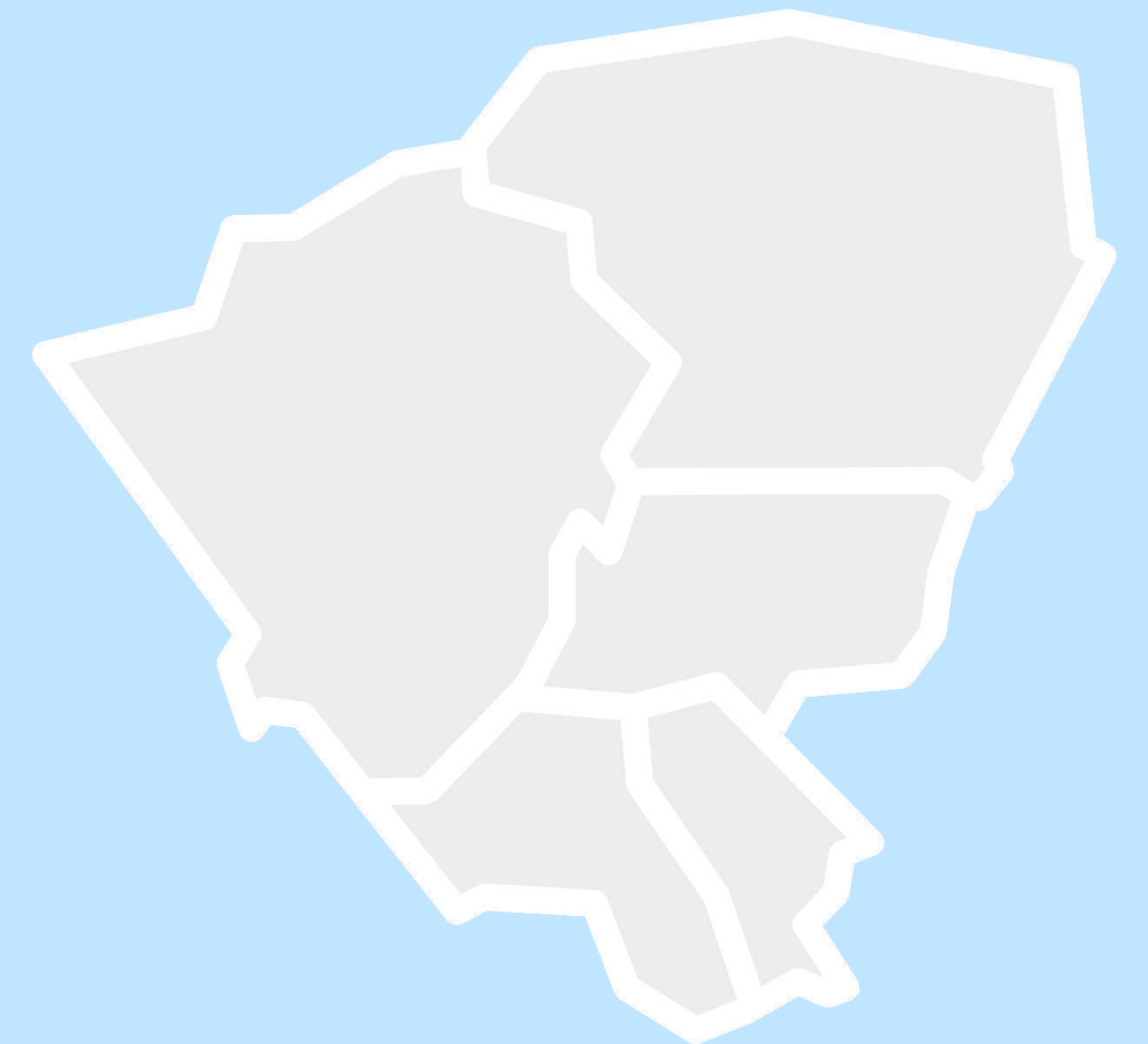

Appendices

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

North Central London ICS - Mental Health LTP/ICS Trajectories (Monthly)		TARGET 22/23 - Q1	2022/23			TARGET 22/23 - Q2	2022/23			TARGET 22/23 - Q3	2022/23			TARGET 22/23 - Q4	2022/23	
			April	May	June		July	August	September		October	November	December		January	February
Summary of Monthly Measures	IAPT access	10,650	2,850	6,025	8,745	21,300	11,635	14,405	16,900	31,950	19,590	22,570	24,805	42,600	27,735	30,453
	IAPT recovery rate	50.0%	50.0%	51.0%	48.0%	50.0%	48.0%	48.0%	49.0%	50.0%	53.0%	52.0%	51.0%	50.0%	50.0%	52.4%
	IAPT first treatment 6 weeks finished course rate	75.0%	88.0%	87.0%	87.0%	75.0%	84.5%	84.7%	85.0%	75.0%	83.0%	83.0%	83.0%	75.0%	84.0%	83.7%
	IAPT first treatment 18 weeks finished course rate	95.0%	99.0%	99.0%	98.0%	95.0%	97.9%	98.1%	98.0%	95.0%	97.0%	97.0%	97.0%	95.0%	98.0%	98.2%
	CYP access - One contact	16,485	15,790	15,910	15,835	17,474	15,875	15,845	15,695	19,221	15,645	15,570	15,570	23,291	15,755	TBC
	Dementia diagnosis rate 65+	69.0%	68.7%	68.8%	68.9%	70.0%	68.8%	68.3%	68.4%	71.0%	TBC	TBC	TBC	73.0%	TBC	TBC
	EIP entering treatment - treatment received <2wks	60.0%	88.0%	82.0%	71.0%	60.0%	66.7%	71.0%	79.0%	60.0%	84.0%	80.0%	83.0%	60.0%	74.0%	TBC
	Number of inappropriate OAP days (YTD by quarter)	1,189	547	910	1,058	323	410	668	1,198	822	294	905	1,847	2,270	762	1,232
	1 hour response time %	95.0%	93.3%	92.8%	93.3%	95.0%	95.6%	95.9% (BEH)	96.1% (BEH)	95.0%	89.5% (BEH)	86.5% (BEH)	90.7% (BEH)	95.0%	88.0% (BEH)	88.1% (BEH)
	24 hour response time %	95.0%	94.0%	94.9%	95.4%	95.0%	96.0%	98.2% (BEH)	96.5% (BEH)	95.0%	91.3% (BEH)	90.6% (BEH)	96.6% (BEH)	95.0%	92.9% (BEH)	92.6% (BEH)
	Women accessing perinatal mental health (PMH)	2,002	1,030	1,045	1,075	2,002	1,075	1,015	930	2,002	905	865	830	2,002	775	700

Values in grey cells are based on provisional data, subject to further validation

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

North Central London ICS - Mental Health LTP/ICS Trajectories (Quarterly)		2022/23							
		TARGET 22/23 - Q1	Q1	TARGET 22/23 - Q2	Q2	TARGET 22/23 - Q3	Q3	TARGET 22/23 - Q4	Q4
Summary of Quarterly Measures	Children and young people (CYP) eating disorders - urgent	95%	43.6%	95%	54.1%	95%	57.1%	95%	TBC
	Children and young people (CYP) eating disorders - routine	95%	25.4%	95%	27.2%	95%	28.1%	95%	TBC
	People accessing individual placement and support (IPS)	285	308	570	400	855	494	1,141	TBC
	Severe mental illness - physical health check (SMI-PHC)	10,142	8,567	10,909	8,949	11,677	10,342	12,445	13,322
	Adult Community Access	16,795	15,200	17,825	14,985	18,555	14,945	19,887	TBC
	Learning disabilities - annual health checks	12.4%	17.0%	29.4%	37.4%	49.2%	59.5%	75%	90.3%
	Learning disabilities - adult inpatients (ICS Commissioned)	26	27	24	26	22	24	22	21
	Learning disabilities - adult inpatients (NHSE Commissioned)	19	16	19	18	16	17	16	18
	Learning disabilities - CYP inpatients	5	6	5	8	5	8	5	5

Values in grey cells are based on provisional data, subject to further validation

Appendix 3 – NCL Acute Dashboard

NHS NCL ICB - Selected Acute Services		2021/22	2022/23										
		March	April	May	June	July	August	September	October	November	December	January	February
Urgent care	*A&E attendances plan*	*77,544*	*70,062*	*73,413*	*72,461*	*75,110*	*71,250*	*73,403*	*75,934*	*74,778*	*76,505*	*75,330*	*70,000*
	A&E attendances	74,041	67,867	75,335	73,557	71,282	62,094	65,515	72,863	72,837	72,462	64,079	63,453
	A&E conversion rate	13%	13%	13%	12%	12%	14%	13%	12%	12%	12%	13%	12%
	4 hour performance (95% Target)	71%	72%	71%	69%	68%	71%	69%	66%	67%	62%	70%	68%
	12 hour waits	1,144	756	818	972	1,168	956	1,309	1,722	1,484	2,003	2,031	1,653
	LAS Conveyances	7,117	7,124	7,555	6,897	6,979	6,913	6,877	6,658	6,914	6,270	6,815	6,425
	Ambulance handovers 30 min+	2,985	2,319	2,379	2,493	2,758	2,339	2,392	2,453	2,259	2,441	2,272	2,011
	Ambulance handovers 60 min+	1,045	576	608	753	979	681	783	1,008	866	1,251	837	720
RTT	*New RTT Pathways (Clockstarts) plan*	*64,825*	*53,853*	*59,540*	*57,426*	*59,902*	*56,792*	*57,639*	*57,788*	*58,686*	*49,012*	*55,305*	*54,398*
	New RTT Pathways (Clockstarts)	64,047	54,513	62,373	57,711	58,046	58,134	58,004	61,870	63,712	50,549	61,568	59,707
	RTT incompletes plan	*240,624*	*251,276*	*250,657*	*250,487*	*250,380*	*249,372*	*249,050*	*248,613*	*247,659*	*248,886*	*248,766*	*248,614*
	RTT incompletes	240,641	244,429	245,881	248,104	251,048	248,362	248,517	251,186	252,172	254,630	251,934	255,892
	52+ waits plan	*10,204*	*8,393*	*7,285*	*7,085*	*7,049*	*5,787*	*5,454*	*5,462*	*6,729*	*6,468*	*7,311*	*7,580*
	52+ waits	8,300	8,353	7,888	8,099	7,984	7,650	7,285	7,090	7,095	6,699	6,152	6,162
	65+ waits plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*
	65+ waits	3,769	3,416	2,936	2,915	2,658	2,514	2,350	2,205	1,985	2,026	1,798	1,593
	78+ waits plan	*n/a*	*1,395*	*982*	*697*	*443*	*222*	*158*	*562*	*470*	*377*	*230*	*96*
	78+ waits	1,245	1,233	1,088	1,012	859	713	571	475	454	481	395	317
	104+ waits plan	*100*	*113*	*24*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	104+ waits	234	121	64	15	8	2	7	5	24	13	9	5
Diagnostics	*Imaging plan*	*53,885*	*51,401*	*54,018*	*52,447*	*54,811*	*54,436*	*56,591*	*57,123*	*58,799*	*53,323*	*58,371*	*55,206*
	Imaging activity	63,676	55,511	63,695	59,121	59,776	60,500	62,108	60,390	64,524	54,979	63,316	61,216
	Endoscopy plan	*4,422*	*3,743*	*4,433*	*4,265*	*4,469*	*4,196*	*4,298*	*4,277*	*4,437*	*3,911*	*4,210*	*4,215*
	Endoscopy activity	3,652	2,991	3,572	3,200	3,694	3,487	3,784	3,416	3,939	2,976	3,757	3,647
	Total Diagnostic 6+ weeks	3,760	5,068	6,141	6,084	5,531	5,756	4,857	3,473	3,366	4,237	4,754	3,232
	Total Diagnostic 6+ weeks Achievement	91%	87%	86%	86%	87%	85%	88%	91%	92%	89%	88%	92%
Cancer	*Cancer treatments plan*	*698*	*673*	*677*	*688*	*691*	*636*	*690*	*671*	*674*	*662*	*673*	*626*
	Cancer treatments	754	642	723	714	739	775	743	741	795	697	703	699
	63+ backlog plan	*558*	*725*	*670*	*607*	*580*	*558*	*518*	*769*	*702*	*636*	*563*	*521*
	63+ backlog	665	834	952	928	907	879	866	915	753	884	782	656
	Total 62 GP ref	343	310	313	335	352	392	337	339	416	332	308	301
	Cancer 62 days	57%	57%	56%	55%	47%	49%	61%	60%	56%	54%	44%	48%
	28-day faster diagnosis	73%	68%	68%	67%	68%	69%	72%	70%	70%	70%	65%	73%

Appendix 4 – Glossary of Terms and Abbreviations

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

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North Central London ICB
Board of Members Meeting
9 May 2023

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<tr><td>Report Title</td><td>2023/24 Financial Planning Update</td><td>Date of report</td><td>24 April 2023</td><td>Agenda Item</td><td>3.2</td></tr>
<tr><td>Lead Director / Manager</td><td>Phill Wells,
Chief Finance Officer</td><td colspan="2">Email / Tel</td><td colspan="2">phill.wells@nhs.net</td></tr>
<tr><td>Board Member Sponsor</td><td colspan="5">Dr Usman Khan</td></tr>
<tr><td>Report Author</td><td>Becky Booker,
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<tr><td>Name of Authorising Finance Lead</td><td>Phill Wells,
Chief Finance Officer</td><td colspan="4">Summary of Financial Implications

The ICB submitted a final plan to NHS England on 30 March 2023. The plan reported a breakeven position. To achieve this there are a number of risks built into the ICB position that will require in-year management, this includes the;
Requirement to identify non-recurrent funding as the ICBs recurrent cost base is higher than expected allocations - £10.8m,
Full achievement of the ICBs efficiency targets - £30.5m,
Assumption that the ICB can mitigate identified risks not included in the financial plan - £67.9m,</td></tr>
<tr><td>Report Summary</td><td colspan="5">On 23 December 2022, NHS England published a suite of guidance documents for the 2023/24 planning cycle, including 2023/24 priorities and operational planning guidance.

The main priorities set out in the planning guidance include;
Prioritise recovering our core services and productivity,
Getting back to delivering the key ambitions in the Long Term Plan, and,
Continuing to transform the NHS for the future.
In addition, the system is expected to deliver a balanced financial position and continue to address health inequalities whilst maintaining quality and safety within services.

ICB Planning Update
The ICB submitted a financial plan to NHS England on 30 March 2023, which reported a planned breakeven position for the year. This means that the ICB is</td></tr>
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	planning to spend in line with the allocations it is due to receive from NHS England. The Integrated Care System 2023/24 financial planning is still underway, with the next submission due on 4 May 2023. It is important to note that although the ICB is planning to spend in line with it's allocations there are a number of risks that could prevent the ICB from doing so (as per Financial Implications Summary above). Please note that the final plan position is subject to change based on on-going discussions within the System. **LSS closedown and Transfer** On 1 July 2022 London Shared Services (LSS) closed down and all services were transferred to the four London ICBs, North Central London (NCL), North East London (NEL), South West London (SWL) and South East London (SEL). As part of this transfer, NCL ICB received the majority of the LSS balance sheet. The balance sheet includes all the assets and liabilities of LSS at the time of closedown, and it was the responsibility of the ICB to clear outstanding balances e.g. by ensuring outstanding invoices that LSS owed were paid, and any income owed was collected. The balance sheet close down process has now been completed. The ICB received funding as part of the transition to ensure all costs were fully covered and did not cause a cost pressure.
Recommendation	The Board of Members is asked to: • **DISCUSS** the financial plan, noting that the plan is subject to change based on on-going discussions within the System and • **NOTE** that the LSS balance sheet has been closed down in 2022/23.
Identified Risks and Risk Management Actions	As part of the planning process the ICB has identified c£67.9m of potential risks reported outside of the financial plan. The ICB has fully mitigated all risks with in-year non-recurrent actions.
Conflicts of Interest	This paper was written in accordance with the Conflicts of Interest Policy.
Resource Implications	The report highlights the allocations for the ICB.
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 financial plan has been approved by The Board before its final submission to NHS England on 30 March 2023.
Next Steps	This report is to be reviewed by the Board and **DISCUSS** the financial plan.
Appendices	None.

2023/24 Financial Planning Update

Planning for 2023/24

2023/24 Planning Guidance

On 23rd December 2022, NHS England published a suite of guidance documents for the 2023/24 planning cycle, including 2023/24 priorities and operational planning guidance.

The main priorities set out in the planning guidance include;

1) *Prioritise recovering our core services and productivity,*
    - Improve ambulance response and A&E waiting times,
    - Delivering the elective goals for reducing long waits, cancer backlogs and improved performance against the core diagnostic standard,
    - Make it easier to access primary care services, in particular general practice.

2) *Getting back to delivering the key ambitions in the Long Term Plan, and,*

3) *Continuing to transform the NHS for the future.*

Alongside the above, the system is expected to deliver a balanced financial position and continue to address health inequalities whilst maintaining quality and safety within services.

ICB Planning Update

The ICB submitted a financial plan to NHS England on 30th March 2023, which reported a planned breakeven position for the year. This means that the ICB is planning to spend in line with the allocations it is due to receive from NHS England. The table on the next slide details the expected allocations and expenditure for the forthcoming year.

ICB Plan for 2023/24

Planning Update

Below sets out the expected allocations and expenditure for 2023/24. The total expected recurrent allocation is £144m more than what was received in 2022/23 and is mainly due to expected growth, for example the growth in expenditure linked to the Mental Health Investment Standard.

NCL ICB 23/24 Financial Plan		Submitted 2023/24 Plan £m
Allocations	**Total Allocations**	**(3,253)**
Expenditure	Acute	1,682
	Mental Health	433
	Community Services	338
	Continuing Care Services	140
	Primary Care Services	246
	Primary Care Co-Commissioning	290
	Other Programme Services	108
	Running Cost	27
	Total Expenditure	**3,264**
	In Year Surplus / (Deficit)	**(11)**
	Non-Recurrent Measures required to Breakeven	*11*
	Revised ICB Surplus / (Deficit)	**0**

It is important to note that although the ICB is planning to spend in line with it's allocations there are a number of risks that could prevent the ICB from doing so.

These include the;

- Requirement to identify non-recurrent funding as the ICBs recurrent cost base is higher than expected allocations - **£10.8m,**
- Full achievement of the ICBs efficiency targets - **£30.5m,**
- Assumption that the ICB can mitigate identified risks not included in the financial plan - **£67.9m,**

Please note that the final plan position is subject to change based on on-going discussions within the System.

ICB Plan for 2023/24

Risk	Value of Risk £m	Notes
Efficiencies Target	(12.8)	Risk that the ICB might not meet its efficiency targets
Cost Pressures	(11.5)	Potential cost pressures from activity growth within the ICB
Acute Pressures	(13.2)	Risk of increased costs mainly relating to Winter Pressures and tariff changes
Organisational	(7.0)	Change Programme
Discharge	(6.8)	Additional Discharge to Asses (D2A) pressures
Inflation	(16.4)	Mainly consisting of CHC and Prescribing inflation
Estates	(0.2)	Additional Estates costs e.g. cost of utilities
TOTAL RISKS	**(67.9)**	

Risks

As mentioned on the previous slide, the ICB has identified potential risks that could create extra cost pressures if these materialise.

The full value of these risks has been calculated at £67.9m. This means that the ICB would have to identify additional sources of funding and/or increase the level of efficiency targets should these materialise.

The ICB has fully mitigated all risks with in-year non-recurrent actions.

LSS closedown and Transfer

On the 1st July 2022 London Shared Services (LSS) closed down and all services were transferred to the four London ICBs, North Central London (NCL), North East London (NEL), South West London (SWL) and South East London (SEL).

As part of this transfer, NCL ICB received the majority of the LSS balance sheet. The balance sheet includes all the assets and liabilities of LSS at the time of closedown, and it was the responsibility of the ICB to clear outstanding balances e.g. by ensuring outstanding invoices that LSS owed were paid, and any income owed was collected.

The balance sheet close down process has now been completed. The ICB received funding as part of the transition to ensure all costs were fully covered and did not cause a cost pressure.

North Central London ICB
Board of Members Meeting
9 May 2023

Report Title	Board Assurance Framework ('BAF') Report	**Date of report**	26 April 2023	**Agenda Item**	3.3
Lead Director / Manager	Ian Porter, Executive Director of Corporate Affairs	**Email / Tel**		Ian.porter3@nhs.net	
Board Member Sponsor	Frances O'Callaghan, Chief Executive Officer				
Report Author	Kate McFadden-Lewis, Governance and Risk Lead	**Email / Tel**		katemcfadden-lewis@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. **System Risk Management** The ICB has been working with key partners across the Integrated Care System ('ICS') to develop a system approach to risk management. To reflect the developing system approach to risk management this report highlights both system risks and ICB-only risks. In addition, and following discussion at the Board of Members meeting in February 2023, the risk tracker has been repositioned as an overview report with the strategic update (contained in this Report Summary) being replaced with the full description of each risk. This allows Board members to have greater understanding of each of the full risks and to see how they are progressing. **Organisational Change Programme Risk** A risk has been developed regarding the ICB's Organisational Change Programme. It is currently rated at 12 and does not meet the threshold to be included in the BAF risk report. This risk will be overseen by the Strategy and Development Committee. **Board Assurance Framework ('BAF')** There are 14 risks on the BAF with 10 being system risks and 4 being ICB only risks. The threshold for inclusion on the BAF is a Current Risk Score of 15 or higher.				

Since the last meeting of the Board of Members in February 2023, 2 new system risks and 2 new ICB only risks, have been added. 1 risk has increased, 1 risk has fallen below the BAF threshold and 1 risk has been closed. The ratings of the remaining risks are unchanged.

Full BAF Risk Register
The full version of the BAF risk register, including the details of each risk including the risk descriptions, risk owners, controls, actions, updates and scores is here.

Key Highlights:

New System BAF Risks
Since the last meeting of the Board of Members, the following risks have been added to the BAF:

QUAL68: *Failure to recruit into CHC and CIC Learning Difficulties core roles on a permanent basis impacting on team effectiveness and service delivery (Threat).*
Oversight Committee: Quality and Safety Committee.
Current Risk Rating: 16.

This is a new risk.

As the ICBs are the statutory bodies with responsibility for NHS Continuing Healthcare, it is our duty to deliver a person-centred approach to the most vulnerable of our population who are entitled to such care.

There have been some delays in the recruitment process for the substantive Continuing Health Care ('CHC')/ Community Integrated Care ('CIC') workforce which may have a significant impact on the ICB not meeting its statutory obligations to deliver on patient outcomes and experience and NHS targets.

Additionally, this may impact on the ICB's ability to fully deliver against the NHS Long Term Plan priority of improving services for people with a learning disability and autistic people by ensuring that they have annual health checks and reduce their reliance on inpatient care.

Should there be a gap in resources, the delays in assessments/reviews may lead to significant concerns around patient care, given that the care is insufficient/non-existent. There may also be an increase in appeals and complaints, financial burden on patients and their families and system pressures due to increased admissions and complexity of case to enable discharge.

The CHC/CIC team has thoroughly reviewed its functions and has identified the resources it needs to deliver, and these have been fed into the 2023/24 Staffing Structure review.

Establishment Control Process ('ECP') forms have been completed for the permanent vacant posts and approved by the Director/Budget Holder and are awaiting ECP Panel approval.

Core vacant posts will be covered by interims until the end of Q1 2023/24.

PERF8: *Failure to Deliver Referral-To-Treatment ('RTT') Waiting Time Standard (Threat).*
Oversight Committee: Quality and Safety Committee.

	Current Risk Rating: 16 (previously 12). This is a pre-existing risk, however the risk rating has increased above the BAF threshold and is included in this report for the first time. NCL is delivering additional capacity to reduce waiting list sizes and the number of long waiters. Further work is underway to fully operationalise surgical hubs. As part of the Mutual Aid programme, NCL has developed a Demand Smoothing Initiative. This aims to reduce variation in waiting times across the system, by focussing on enabling equity of access to address patient need through temporary re-alignment of capacity to meet demand and reduce inequity of access. This is most effective at the front end of the pathway with a focus on the non-admitted pathways. However, it can also be applied to evaluate admitted pathway pressures. A data driven approach and framework has been developed to identify capacity opportunities and raise alerts for demand pressures as a signal to act. NCL's approach has been clinically led, with Clinical Networks using the data for informed decision making. Due to the ongoing recovery of the long waits position, the major focus is on those waiting 78 weeks+, and those patients waiting longer than 65 weeks who do not have a treatment date scheduled. The NCL system is in constant discussion with NHSE London in respect of managing the remaining patients waiting 104 weeks or more, and the actions ongoing to reduce the total number of patients in this cohort. The key areas of focus across Q4 were: 1. **The elimination of waits over 78+ weeks by the end of April 2023** Following a second round of BMA Industrial Action between 11 – 15 April, NCL Providers focussed on keeping operational services running safely, prioritising urgent and cancer related activity over elective long waiting patient clearance. This approach was in line with all London ICSs, with NHSE London confirming with National that the ambition for zero 78ww clearance would not be deliverable at the end of April 2023. NCL Providers are scheduling 78+ week waiting patients across May 2023, working to book and provide treatment to these long waiting patients as quickly as possible. 2. **Allocation of treatment/ to come in ('TCI') dates to all patients currently waiting.** Providers were on course to deliver this objective prior to the BMA Industrial Action between 13 -16 March, however, the reduction in elective capacity across this week, and the subsequent requirement to reschedule 78ww patients, has resulted in vacant capacity across April being allocated to this cohort as a priority. The majority of patients scheduled to breach 78 weeks at the end of April have been allocated TCI dates in May. 3. **A reduction in 65+ week waits where possible before year end.** NCL has delivered a 60% reduction to the total number of patients waiting longer than 65 weeks for treatment during 2022/23. 4. **A reduction in 52+ week waits where possible.** NCL has delivered a 20% reduction to the number of patients waiting beyond 52 weeks in 2022/23. 5. **Diagnostic backlog recovery across imaging and endoscopy in line with provider trajectories.** Across imaging services, NCL achieved a year end position that was 295 patients or 17% ahead of plan for 2022/23. Across endoscopy services, NCL ended the year 767 patients above plan. This was driven predominantly by backlog growth at RFL throughout Q4. Recovery

	plans have been developed collaboratively between NCL ICB and providers through the Endoscopy Network to support backlog recovery and provide additional capacity through 2023/24. When assessing the year as a whole, NCL has delivered a 21% backlog reduction for 2022/23, and a 47% reduction from the in-year diagnostic backlog peak of 8,412 patients waiting longer than 6 weeks in July, finishing the year with a total backlog of 4,426 patients. System performance has also improved consistently throughout the year, reducing to 10.6% during the last week of the financial year, sustaining the waiting list proportion on average throughout March. NCL performance remains ahead of both the regional average and nationally mandated target for 2022/23. **6. Diagnostic 13+ week wait reduction / elimination across Audiology & Sleep Studies by the end of March 2023.** 13ww reductions have been delivered to plan in Sleep Studies during Q4. Audiology reductions are behind plan driven by a lack of audiologist capacity at the Whittington during February & March, however positive reductions have been delivered as part of the National NHS March Optimisation initiative. NCL submitted a revised March end forecast of 207 patients waiting beyond 78 weeks for treatment against a revised national target of zero 78 week waits by the end of April 2023. Following subsequent BMA Industrial Action in April, revised April and May forecasts have been requested from NHSE which are due for submission on 25 April 2023. The junior doctor strikes, had a significant and direct impact on elective capacity and thus long waiting patient recovery delivery, across all acute providers. Following the national impact on long waiting patient backlogs, the national delivery target for the treatment of all patients waiting longer than 78 weeks was extended to the end of April 2023. It was confirmed that Royal Free London Hospital ('RFL') and Great Ormond Street Hospital ('GOSH') would not eliminate all 78+weeks waits by March 2023. NCL submitted a revised March end forecast on 21 March 2023 of 207 patients waiting beyond 78 weeks for treatment against a revised national target of zero 78 week waits by the end of April 2023. NCL ICB led the work to produce credible plans for finance, workforce, activity and performance for the 2023/24 priorities and operational planning guidance. Final plans were submitted to NHSE on 30 March 2023. System Oversight Framework ('SOF') Segment 3 covers providers where significant delivery challenges have been identified, requiring coordinated actions across the system. RFL is in SOF 3 in respect of RTT performance, so attend monthly provider performance review meetings led by NCL ICB, where the focus is on the collaborative actions required to deliver sustainable performance improvements against agreed exit criteria and measures that will enable progress out of SOF3. The provider performance review meetings are supporting the joint Quarterly Oversight meetings, which will oversee plans in place to address performance challenges, and the associated risks. The risk rating was increased from 12 to 16 as it had been confirmed that RFL and GOSH would not eliminate all 78+weeks waits by March 2023.

	Continuing System Risks **PERF7:** *Failure to manage patient flow during heightened periods of pressure, including winter, Easter and other Bank Holidays (Threat).* **Oversight Committee:** Quality and Safety Committee. **Current Risk Rating:** 16 (unchanged). The Winter High Impact Action plan continues and is monitored by the weekly Flow Operational Group. Across NCL, work continues to embed the main actions and strategies outlined in 'Going Further For Winter' to improve operational resilience. An evaluation of winter schemes is expected to run through April 2023. This will inform winter and resilience planning for 2023/24. Detailed plans are being developed in response to the Urgent and Emergency Care ('UEC') Recovery Plan for 2023/24. **PERF18:** *Failure to effectively develop the primary care workforce (Threat).* **Oversight Committee:** Primary Care Contracting Committee. **Current Risk Rating:** 16 (unchanged). 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'). 2022/23 was year 4 of the 5 year scheme which enabled PCNs to access national funding to recruit into a range of 15 different roles. PCNs continue to recruit to these roles and are supported by Training Hubs with induction and professional development. There is an expectation that ICBs and systems will explore different ways of supporting PCNs to recruit. Other 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; • Delivery of the Primary Care Nursing Strategy and NCL Primary Care Nursing Programme Priorities for 2022-23 developed by NCL Training Hub; • Expansion and promotion of Clinical Placements in NCL to attract, support and embed more new entrants to the practice workforce; • Additional GP Nursing funding received to enable workforce development schemes focussing on Reception & Admin staff, Healthcare Assistants ('HCA'), GP Nurses ('GPN'), Nursing Associates ('NAs'), Trainee Nursing Associates ('TNAs'), retention of volunteers; • The completion of the Primary Care Flexible Staff Pool and an offer to strengthen links between practices and GPs and GPNs wishing to work flexibly is live; • Mentoring scheme first developed under the GP and GPN Fellowship and Mentoring scheme to be expanded out to wider workforce; • 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, 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 has continued throughout 2022/23 with a Primary Care Wellbeing Lead recruited.

PERF25: *Failure to ensure ambulance patients are handed over to emergency departments in a timely manner (Threat).*
Oversight Committee: Quality and Safety Committee.
Current Risk Rating: 20 (unchanged).

The agreed regional protocol (January 2023) outlines the process that will take place where there is not sufficient capacity within the emergency department to allow for ambulance handover as soon as possible. A significant element of the process focusses on London Ambulance Service ('LAS') led cohorting arrangements being in place across emergency departments. All North Central London hospital providers have facilitated putting this cohorted space in place.

If there are still patients waiting to be handed over, or further cohorting is not possible, then patient handover / trolley clear should occur at 45 minutes.

NCL is supporting improving ambulance handover times. Key actions include:

- Implement regional handover protocol for LAS-led cohorting and clinical escalation across all sites;
- Implement RCA mechanism to capture and learn from hospital handover delays (3hrs+).

Key updates:

- Sites are using the new regional 45mins handover and clinical escalation standard as a mitigating action to delays;
- All acute sites have the facility to implement patient Cohorting in conjunction with LAS;
- All sites across NCL have strengthened proactive senior clinical handover to help meet the new 45-minute standard;
- Enhancing the 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;
- Further embedding the direct access to Rapid Response services and Same Day Emergency Care ('SDEC') pathway.

COMM14: *Failure To Achieve NHS Constitutional Targets - Urgent and Emergency Care (Threat).*
Oversight Committee: Strategy and Development Committee.
Current Risk Rating: 16 (unchanged).

The NCL system-wide industrial action plan continues to be refreshed in response to planned strikes. The plan sets out actions in place to mitigate expected pressures across, primary care, London Ambulance Service ('LAS') /NHS111, community, mental health, acute and maternity, ensuring services remain safe. Actions continue to focus on expediting discharges, avoiding long delays for mental health patients in A&E, improving ambulance handover and maintaining patient flow. The plan continues to be reviewed regularly via the system Flow Operational Group.

Work is ongoing to improve the 4hr A&E performance across NCL by developing site-based recovery and improvement plans to reduce the overall time spent in A&E for admitted and non-admitted patients.

	Key updates: • NCL providers have submitted initial plans that show how the 76% standard will be met by March 2024; • Delivery of plans rely on key interdependencies particularly sufficient acute and out of hospital capacity, without which it will prove difficult to meet the A&E waiting times ambitions stated in the plans. • Key measures include: o Sites have enhanced specialist in-reach to Emergency Departments ('ED') e.g. 30 min professional standard at UCLH; o Early access to clinical decision makers to enable prompt admission or admission avoidance to improve overall hospital flow; o Ensure appropriate capacity within admission units to care for patients out of ED following a decision to admit. **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 (unchanged). One of the core purposes of the Integrated Care System ('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, including how we deploy our resources differently, with the emphasis on prevention, self-care and early intervention. In Autumn of 2022, system partners agreed that the draft NCL Population Health Improvement Strategy will be adopted as the NCL Integrated Care Strategy given there is significant overlap in the content required and a desire by partners to have one NCL system strategy. There was wide engagement with system partners on the population health and integrated care strategy in the lead up to Integrated Care Partnership ('ICP') endorsement on 18 April 2023. We continue work to incorporate feedback into the strategy. Given that this is an ICP document, work has been taking place to ensure ongoing mapping of stakeholders from across the system and appropriate consultation, endorsement, and sign-off is achieved. Content-wise, the strategy sets out a clear call to action to our providers to reflect on how their organisations will look and feel when they align to the principles and areas outlined in this strategy. To make this approach a reality, the strategy outlines principles which will guide our news ways of working. This will require us to fundamentally change the way we work, including with our residents and communities, and where we prioritise our resources and efforts. In order to embed and test our principles, the strategy outlines delivery areas where we can make the greatest impact and to learn about our approach to system, borough partnership and neighbourhood working. Each delivery area describes the rationale for its selection in NCL as well as what we plan to do next. We also acknowledge that NCL as a system is currently not set up to deliver according to these principles in a sustainable way. Therefore, we have identified levers for change which will help the ICS create the right conditions for sustainable delivery and improved outcomes. Each of these levers consists of system-wide deliverables which will set our system up for long-term success.

	Although this document forms a milestone in our population health journey, we will continue to develop our partnership working as well as our engagement with our communities to deliver these goals. Work is now ongoing to oversee transition into delivery of the strategy in the form of the NCL delivery plan, which will take the deliverables of the strategy and ensure appropriate sequencing and milestones are in place for delivery. Linked to the strategy, the guidance for the Joint Forward Plan ('JFP') has been published, with a draft version was to be submitted to NHS England by 31 March and final version by 30 June 2023. It is proposed for the joint forward plan to be used as the delivery plan for the population health and integrated care strategy and joint local health and wellbeing strategies, with development of the plan starting shortly. Although the strategy is authored by the ICP, the JFP is to be authored by the ICB, constituent trusts and Health and Wellbeing Boards. Work has also progressed on Childhood Immunisation after it was identified by the ICP as the first of five priorities for the whole system to test and learn about population health approach, and working through borough partnerships to drive hyper-local delivery. The Childhood Immunisation approach was presented and endorsed at the ICP Board on 18 April 2023. **FIN3:** *Long Term Financial Sustainability (Threat).* **Oversight Committee:** Finance Committee. **Current Risk Rating:** 20 (unchanged). NCL revised its Forecast Outturn positions for 2022/23 at Month 10, working in conjunction with regional colleagues and in line with a Forecast Outturn protocol which was made available in late November. Through the year to date a number of NCL providers have experienced challenges to their financial plans which arise largely from inflationary pressures outside of their control – most notably on the cost of utilities. Offsetting this, some have benefited from changes to the interest rate payable on cash holdings with the Government Banking Service as well as successfully controlling costs. Subject to confirmation of one critical accounting issue, it is likely that NCL will be able to deliver a breakeven financial position for the 2022/23 financial year. It is though crucial to note that this is underpinned by a significant level of non-recurrent benefit which will not be available in 2023/24 and that continued improvement to the underlying position of the system as whole is required. Our control processes have remained strong and collaboration, mutual support and a culture of financial transparency has been a key part of delivering this level of financial performance in 2022/23. Operational and Financial Planning Guidance for 2023/24 was issued on 23 December 2022 and indicates the re-introduction of a variable payment for most elective activity in 2023/24 as part of a flat-real financial allocation. Planning processes are underway and the plan, submitted at the end of March 2023, is likely to show a System-wide deficit of approximately £120 million. The main pressures arising are from excess inflation on utilities and other CPI-driven contracts, as well as from the elective recovery scheme for 2023/24, which requires NCL to deliver a stretched target in excess of almost all other ICBs but for the same share of money as other ICBs. **QUAL64:** *Failure to undertake timely Continuing Healthcare assessments and reviews within 28 days (Threat).* **Oversight Committee:** Quality and Safety Committee. **Current Risk Rating:** 16 (unchanged).

	Significant collaborative work is underway with Local Authority ('LA') partners for allocation of Social Workers, via Task and Finish Groups, Weekly Borough Local Authority Meeting, weekly escalation to the executive team and the Social Workers Delays Tracker activity analysis. Focused discussions are on-going with LAs on specific patients where delays persist. The ICB and LA are under a statutory duty to undertake patient assessments within 28 days of positive referral for Continuing Healthcare ('CHC') (referred via 'Discharge to Assess', Community, Local Health, GPs, and Fast Track patient with a material change in need who subsequently require an assessment for CHC). The formulation of Multi-Disciplinary Teams from the ICB and other stakeholders poses a significant workforce resourcing challenge in meeting this measure, and currently delivering 39% against the revised national target of 30%-39.9%. The ICB continues to keep NHSE apprised of situation through bi-monthly assurance meetings. High level discussions are ongoing between the ICB and other system stakeholders to address these challenges with the aim to ease some pressure. NHSE held discussions with LA Directors of Adult Social Service regarding their statutory duties and there has been an improvement with some boroughs regarding the allocation of social workers for assessment of cases. The business case to support the short-term recruitment of Multi-Disciplinary Teams (Occupational Therapists and Physiotherapists) ended on 31 March 2023. Assessments will continue under business as usual. **New ICB Only Risks** Since the last Board meeting the following ICB only risk has been added to the BAF: **STR9:** *Failure to Deliver the 2023/24 ICB CIP (Cost Improvement Plan including elements of Transformation Programmes) (Threat).* **Oversight Committee:** Finance Committee. **Current Risk Rating:** 16. This is a new risk. The ICB Cost Improvement Plan ('CIP') planning process for the 2023/24 financial year is underway. The portfolio will be built with input from all Directorates to support the financial recovery plan as well as system transformational programmes. Meetings are held jointly by Finance and System Efficiency Plans ('SEP') teams via the Efficiency and Productivity Group ('EPG') to produce a CIP portfolio, listing the efficiencies to be made, and monitor progress on a monthly basis to ensure CIP is on track for delivery. Following the initial planning Budget Holder meetings, the portfolio will include the efficiencies to be made across Continuing Health Care ('CHC')/ Community Integrated Care ('CIC'), Primary Care Prescribing, Non-NHS contracts and Corporate Services. The organisational change process is underway and will form part of this programme in due course. In addition, all efficiencies from system wide transformation programmes will be captured and co-ordinated. These schemes will be monitored on a monthly basis via a gateway process at the Efficiency and Productivity Group which is chaired by Richard Dale and Phill Wells. This oversight group will monitor scheme delivery progress and benefits against plan including examining the risks and mitigations to deliver these

	schemes. A progress update will be shared with the Finance Committee on a bi-monthly basis. **FIN15:** *Failure to Deliver 2023/24 Statutory and Other Financial Requirements set by NHS England (Threat).* **Oversight Committee:** Finance Committee. **Current Risk Rating:** 20. This is a new risk developed to address the in-year financial risk for 2023/24 and replaces FIN11 which was the risk for 2022/23. The 2023/24 ICB draft financial plan is reporting a break-even position for the ICB. This plan was presented to the Finance Committee on 21 March 2023 and was approved by the Board on 28 March 2023. To achieve a balanced position the 2023/24 plan assumes c£40m of efficiencies and non-recurrent actions will be achieved. In addition, there is an estimated c£60m of risk which, if it emerges, is assumed will be fully mitigated in year. The finance position is being monitored through EMT and the Finance Committee. **<u>Continuing ICB Only Risks</u>** **COMM22:** *Failure of the Integrated Care Board in effectively managing the risks of devolution for Specialist Commissioned Services (Threat).* **Oversight Committee:** Strategy and Development Committee. **Current Risk Rating:** 16 (unchanged). Feedback has been received on the Joint Working Agreement ('JWA') and this has now been signed by the ICB Chief Executive. Providers are engaged and involved in discussions about prioritising the issues that have been identified concerning existing services. Additionally, a paper is being prepared which will set out a new approach to delivering delegation more effectively with provider input, while addressing the residual issues identified in our Roadmap (now being used at a London level). A Joint Committee is being formed involving all London ICBs as outlined in the JWA. **PERF24:** *Failure of the Integrated Care Board in effectively managing the risks of devolution for Dental, Optometry and Pharmacy Services from April 2023 onwards (Threat).* **Oversight Committee:** Strategy and Development Committee. **Current Risk Rating:** 16 (unchanged). The NCL ICB Board of Members has confirmed support to sign National Delegation Agreement (March 2023). National Delegation Agreement and MOU is now signed. The impact of these arrangements will be closely monitored, and a progress report will be reported to the Board of Members after the first 12 months. **<u>Increasing Risk</u>** **PC3:** *Strikes by NHS staff (Threat).* **Oversight Committee:** NCL People Board **Current Risk Rating:** 20 (previously 15).

	This risk has emerged from national industrial action taken by unions and NHS staff regarding pay and working conditions disputes. Within NCL ICS the strikes are impacting providers as follows: • NCL ICB, Great Ormond Steet Hospital ('GOSH'), Tavistock and Portman ('T&P') and University College London Hospital ('UCLH') in the next round of Royal College of Nursing ('RCN') strikes; • Unite and GMB have no mandate in London; Unison only have a mandate in London Ambulance Service; • The Chartered Society of Physiotherapists has announced that they have a mandate for industrial action until June 2023. Sector and pan-London Management, to keep minimal services running and protect the Urgent and Emergency Care pathway, is co-ordinated through the Flow Oversight Group, System Management Board and Clinical Advisory Group. A national pay deal was put to the Agenda for Change unions between 28 March and 14 April 2023. During this period industrial action was paused for these unions. Members of the RCN voted to reject the government's pay offer and have announced further strike action on 30 April to 2 May. This impacts UCLH, GOSH, T&P and the NCL ICB. There are current planning meetings in place to determine and manage the impact of this strike. Talks between the government and the British Medical Association broke down on 23 March 2023 and further strike action took place between 11 April and 15 April. The Regional Incident Management Response meetings have commenced daily meetings from 27 March 2023 and preparedness is being undertaken within NCL. With the ongoing strike action, this risk rating has increased from 15 to 20. **<u>Decreasing Risk</u>** Since the last meeting of the Board of Members, the following risk's rating has reduced below BAF threshold. This risk will continue to be scrutinised at committee level: **COMM21:** *Variation in Community and Mental Health Services across NCL (Threat).* **Oversight Committee:** Strategy and Development Committee. **Current Risk Rating:** 12 (previously 16). Investment priorities against core offer gaps across community and mental health services are being identified based on extensive system engagement and being signed off through programme governance in Q1. For the community services review, the lack of agreed system savings impact or agreed productivity initiatives from community providers has created a risk around the financial sustainability of the programme. To mitigate this risk the programme has modelled the impact on Occupied Bed Days against a "do-nothing" projected baseline to support the transfer of resources to support investment in the Core Offer transformation. A provider Chief Finance Officer Finance Sponsor is to be identified and join the implementation steering group ('ISG') from April 2023. And a senior Chief Executive Officer/ Chief Operating Officer level Community Provider representative is to join the Finance Subgroup from April 2023. Providers will be supported to develop plans for the delivery of productivity savings within Community Services providers and given and extension to the timeline for sharing these.

	A revised timeline and methodology for confirming size of envelope for 2023/24 is to be developed, with a focus on (i) those initiatives which allow optimised productivity (ii) an adjustment in impact phasing to allow for slippage in delivery due to recruitment delay (iii) continued focus on key gaps and priorities from bottom up and top down review in line with programme and financial principles and (iv) incorporation of year 1 learning. As the current controls are proving effective at reducing the likelihood of the risk, the score has reduced from 16 to 12 since the last meeting. **Closed Risk** Since the last meeting of the Board of Members, the following risk has been closed: **STR8:** *Failure to Deliver the 2022/23 System Efficiency Plans and Transformation Programme (Threat).* **Oversight Committee:** Finance Committee. The System Efficiency Plan target has been met with non-recurrent finance resources. This is no longer a risk. Risk STR9 has been developed to address the equivalent risk for financial year 2023/24. **Annual Internal Audit Report** The annual internal audit on risk was recently concluded with the ICB receiving a substantial (green) assurance rating. **Looking Forward** The ICB's approach to risk management continues to evolve with oversight by the Audit Committee. A report on the development of system risk management is presented at each Audit Committee meeting. This includes a 'snapshot' of current key risks. This provides the Audit Committee with a high-level overview of the ICB's key risks that are overseen by the ICB's Board of Members and its committees. Strong foundations are in place for NCL's approach to continue to develop, and it will be important to maintain organisational focus on current key risks including through increased focus at each of the ICB Committees. It will similarly be important to maintain a broader overview of the risk portfolio, considering new areas of risk including opportunity-risks.
Recommendation	The Board of Members is asked to: • **NOTE** the report and provide feedback on the risks and • **IDENTIFY** any strategic gaps within the Board's remit, and propose any areas where further investigative work may support further risk mitigation.
Identified Risks and Risk Management Actions	The BAF is a risk management document which highlights the most significant risks to the achievement of the ICB's strategic objectives.
Conflicts of Interest	Conflicts of interest are managed robustly and in accordance with the ICB's Conflict of Interest Policy.

Resource Implications	Updating of the BAF is the responsibility of each risk owner and their respective directorates. The Governance and Risk Team helps to support this by providing monitoring, guidance and advice.
Engagement	The BAF report is presented to each Board of Members meeting. 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	The next steps are as follows:
	• To continue to manage risks in a robust way;
	• To continue the development of the ICB's approach to system risk management. This includes:
	    o Increased independent scrutiny and oversight of our key risks and our developing approach through the Audit Committee;
	    o Further identification and development of system risks;
	    o Building relationships with key system colleagues including the Local Authorities;
	    o Strengthening the role of the NCL Governance Leads Network as a key mechanism for collaboration and information sharing on key health system risks.

Appendices	The following documents are included: • BAF Risks Overview Report; and, • Risk Scoring Key.

North Central London ICB BAF Risks - Overview Report

Risk ID	Risk Title	Risk Owner	Risk description	2022-2023 Current Risk Score					Movement From Last Report	Target Risk Score
				SEPT	DEC	FEB	MAY			
New BAF System Risks										
QUAL68	Failure to recruit into CHC and CIC Learning Difficulties core roles on a permanent basis impacting on team effectiveness and service delivery (Threat).	Dr Chris Caldwell - Chief Nursing Officer	**CAUSE:** If the ICB fails to approve recruitment of permanent candidates to key CHC & CIC LD posts which are vacant and held by interim staff **EFFECT:** There is a risk that CHC & CIC LD will have gap in resources, place additional pressure on current staff and may be reliant on costly interims. **IMPACT:** This may result in a failure to meet our statutory duties in patient assessments/reviews and outcomes, low staff morale, high staff turnover, a significant increased financial burden, system-wide pressures and reputational damage. It may also impact the ICB's ability to meet its NHSE targets.				16		→	9
PERF8	Failure to Deliver Referral-To-Treatment (RTT) Waiting Time Standard (Threat).	Richard Dale - Executive Director of Performance and Transformation	**CAUSE:** If there is a lack of adequate capacity and operational resilience to effectively manage waiting times. Year end pressure and industrial action impacts on capacity and adds further challenge and risk to operational delivery and elective waiting list management. Low volume, high complexity long waiting patients within specialised services requiring treatment remain on acute/tertiary waiting lists. **EFFECT:** There is a risk that the system will not meet the national ambitions around RTT or the system level plans agreed with NHSE, resulting in poor experience and outcomes for patients. **IMPACT:** This may result in the ICB missing the national expectations for long waits and adversely impact on SOF segmentation.	12	12	12	16		↑	16
Continuing System Risks										
PERF7	Failure to manage patient flow during heightened periods of pressure, including winter, Easter and other Bank Holidays (Threat).	Richard Dale - Executive Director of Performance and Transformation	**CAUSE:** If NCL ICS Providers fail to manage non-elective flows within planned hospital and community capacity to meet surges during periods of heightened pressure, **EFFECT:** there is a risk that patients may receive sub-optimal care and long waiting times. Patients may also remain in inpatient placements longer than anticipated. There may be an impact on capacity for elective pathways **IMPACT:** This may result in the local system being unable to deliver against the priority areas as set out in the UEC Recovery Plan and improvement trajectories not being met.	16	16	16	16		→	9
PERF18	Failure to effectively develop the primary care workforce (Threat).	Sarah McDonnell-Davies - Executive Director of Places	**CAUSE:** If the ICB is ineffective in developing the primary care workforce, **EFFECT:** There is a risk that it will not deliver the primary care strategy . **IMPACT:** This could mean that, for example, patients with long term conditions are not fully supported in primary care and require more frequent hospital care.	16	16	16	16		→	9
PERF25	Failure to ensure ambulance patients are handed over to emergency departments in a timely manner (Threat).	Richard Dale - Executive Director of Performance and Transformation	**CAUSE:** If the ICB does not adequately support the management of high bed occupancy, constraints to flow through hospitals and delays to discharge, **EFFECT:** There is a risk that there will be continued delays in ambulance handovers and delays to admit patients. **IMPACT:** This may result in a negative impact on patient experience and quality of care.	20	20	20	20		→	9
COMM14	Failure To Achieve NHS Constitutional Targets - Urgent and Emergency Care (Threat).	Sarah Mansuralli - Chief Development and Population Health Officer	**CAUSE:** If NCL ICB fails to ensure Provider delivery of commissioned capacity to meet emergency care demand within the system, **EFFECT:** there is a risk that the ICB will fail to achieve urgent and emergency care national performance standards. Pressures may result in patients being located in the wrong part of the system, which may have an adverse effect on their health outcome. **IMPACT:** This may result in the ICB missing the national standards expected for all patients, increasing patient waiting times in the Emergency Department ('ED') and potential risk of harm.	16	16	16	16		→	12
COMM26	Failure to make 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	**CAUSE:** If the ICB / ICS does not develop the necessary strategies, develop funding / investment models and alter culture / ways of thinking or alternatively has unaffordable contracts. **EFFECT:** There is a risk that the necessary changes to allow resources / funding to be redeployed to drive prevention & proactive care will not materialise (and will stay reactive / crisis / acute focused). This will slow the ability of the system to improve outcomes and potentially increase cost pressures and demand in acute care even further. **IMPACT:** This may result in the improvement in population health outcomes and reduction in health and care inequalities not being delivered as resources will not be deployed according to need and increasing acute care costs and activity further.	16	16	16	16		→	9

PC3	Strikes by NHS staff (Threat).	Sarah Morgan - Chief People Officer	**CAUSE:** If industrial action taken by various Unions within healthcare, due to pay and working conditions disputes, continues without resolution, **EFFECT:** There is a risk that services will face significant reduction, cancellations of elective activity, and a reduced ability for London Ambulance Service ('LAS') to respond to non-life and limb patients during the time of industrial action. **IMPACT:** This may result in an increase in negative patient experience and negative patient outcomes, and a reduction in the quality of service delivered and capacity. This may also result in a disengaged workforce, and may exacerbate exiting system-wide workforce challenges.			15	20		↑	15
FIN3	Long Term Financial Sustainability (Threat).	Phill Wells - Chief Finance Officer	**CAUSE:** If there are unavoidable cost pressures for commissioners and providers, under-delivery of QIPP activity and population growth exceeding funding levels, staffing shortages and recruitment difficulties, **EFFECT:** There is a risk of failure to maintain long term financial sustainability. **IMPACT:** This may result in reputational damage, inability to invest as desired to improve patient care and a threat to existing services.	20	20	20	20		→	16
QUAL64	Failure to undertake timely Continuing Healthcare assessments and reviews within 28 days (Threat).	Chis Caldwell - Chief Nursing Officer	**CAUSE:** If the ICB fails to undertake patient assessment within the statutory target of 28 days, as well as patient package of care reviews, **EFFECT:** There is a risk that patients will not be in receipt of the appropriate package of care in the most appropriate setting and patients/families will be left not knowing who will fund their care, and/or increase expectation for continuation of interim funding under Discharge to Assess ('D2A') due to delays. **IMPACT:** This may result in a increase in negative patient experience (linked to increase in complaints and appeals). It has also negatively impacted patient choice for patients awaiting assessment whilst in interim funded placement. It may also result in significant increased cost to the ICB as well as reputational damage, and an increase in complaints and appeals. It may also impact the ICB's ability to meet future NHSE targets.		20	16	16		→	16
New ICB Only Risks										
STR9	Failure to Deliver the 2023/24 ICB CIP (Cost Improvement Plan including elements of Transformation Programmes) (Threat).	Richard Dale - Executive Director of Transition	**CAUSE:** If the Integrated Care Board (ICB) fails to deliver the 2023/24 Cost Improvement Plan **EFFECT:** There is a risk that the ICB will not achieve a balanced budget and control total, and will be unable to release sufficient funds to invest in services and deliver the quality improvements to patient care. **IMPACT:** This may result in a negative impact on patient care and financial sustainability.				16		→	12
FIN15	Failure to Deliver 2023/24 Statutory and Other Financial Requirements set by NHS England (Threat).	Phill Wells - Chief Finance Officer	**CAUSE:** If the Integrated Care Board ('ICB') fails to meet the 2023/24 financial plan due to the impact of material 2023/24 cost pressures and the deficit underlying financial position, **EFFECT:** There is a risk of significant overspend, that NHS England may take action against the ICB and there may be a lack of funds to invest in strategic priorities. **IMPACT:** This may result in the ICB being placed in legal directions and under a requirement to reduce or cease some services, negatively impacting on patient care.				20		→	12
Continuing ICB Only Risks										
COMM22	Failure of the Integrated Care Board in effectively managing the risks of devolution for Specialist Commissioned Services (Threat).	Sarah Mansuralli - Chief Development and Population Health Officer	**CAUSE:** If the Integrated Care Board (ICB) fails to manage the transfer of risks (Financial, Clinical & Operational) for Specialist Commissioning Services from April 2024 effectively then the system could be left with significant challenges in the short to medium term. **EFFECT:** There is a risk of significant overspend and negative impacts on such areas as outcomes and access that the ICB might need to divert budgets and management effort to address therefore reducing the ability to invest in other service priorities. **IMPACT:** This may result in an inability to invest as desired to improve patient care, and a threat to existing services and impact negatively on the improvement in outcomes. This may also have a negative impact on the reputation and function of the ICB, with NHS England taking action against the ICB.	16	16	16	16		→	12
PERF24	Failure of the Integrated Care Board in effectively managing the risks of devolution for Dental, Optometry and Pharmacy Services from April 2023 onwards (Threat).	Sarah Mansuralli - Chief Development and Population Health Officer with Sarah McDonnell-Davies - Executive Director of Places	**CAUSE:** If the Integrated Care Board ('ICB') fails to manage the transfer of Dental, Optometry, and Community Pharmacy ('DOP') Services from April 2023 effectively, **EFFECT:** Risks associated with the transfer (financial, ICB staffing, reputational) crystalise with negative impacts on commissioning and/or provider sector that the ICB might need to divert budgets and management effort to address. **IMPACT:** Inability to realise the potential benefits of delegation of these services e.g. improve quality and transform service in line with population health vision. This may also have a negative impact on the reputation and function of the ICB, and in the worse case may result in NHS England intervention.	16	16	16	16		→	12
Risk dropping below BAF threshold										

COMM21	Variation in Community and Mental Health Services across NCL (Threat).	Sarah Mansuralli - Chief Development and Population Health Officer	**CAUSE:** If historic funding differences across the 5 legacy CCGs, which has led to distinctive variations in Community and Mental Health services across the boroughs, is not addressed. **EFFECT:** There is a risk that residents have differential access, experience and outcomes. Additionally this will continue an over reliance on acute inpatient care which is at odds with the ICBs plans for more proactive and preventative care closer to home. **IMPACT:** This may result in the ICB not meeting its commitment on patient access and reducing health inequalities, inefficient use of resources, poor quality services, wasted financial resources and fragile/unsustainable services. It will also continue to impact on performance of acute hospital targets and potentially reduce the range and capacity of community based care for those with a mental health and or physical health care need.	16	16	16	12		↓	9
Closed Risk										
STR8	Failure to Deliver the 2022/23 System Efficiency Plans and Transformation Programme (Threat).	Richard Dale - Executive Director of Performance and Transformation	**CAUSE:** If the Integrated Care Board ('ICB') fails to deliver the 2022/23 SEP and transformation programme; **EFFECT:** There is a risk that the ICB will not achieve a balanced budget and control total and will be unable to release sufficient funds to invest in services and deliver the quality improvements to patient care. **IMPACT:** This may result in a negative impact on patient care and financial sustainability.	20	20	16	-			16

Risk Scoring Key

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

1. Overall Strength of Controls in Place

There are four levels of effectiveness:

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

2. Risk Scoring

This is separated into Consequence and Likelihood.

Consequence Scale:

Level of Impact on the Objective	Descriptor of Level of Impact on the Objective	Consequence for the Objective	Consequence Score
0 - 5%	Very low impact	Very Low	1
6 - 25%	Low impact	Low	2
26-50%	Moderate impact	Medium	3
51 – 75%	High impact	High	4
76%+	Very high impact	Very High	5

Likelihood Scale:

Level of Likelihood the Risk will Occur	Descriptor of Level of Likelihood the Risk will Occur	Likelihood the Risk will Occur	Likelihood Score
0 - 5%	Highly unlikely to occur	Very Low	1
6 - 25%	Unlikely to occur	Low	2
26-50%	Fairly likely to occur	Medium	3
51 – 75%	More likely to occur than not	High	4
76%+	Almost certainly will occur	Very High	5

3. Level of Risk and Priority Chart

This chart shows the level of risk a risk represents and sets out the priority which should be given to each risk:

LIKELIHOOD	**CONSEQUENCE**				
	Very Low (1)	Low (2)	Medium (3)	High (4)	Very High (5)
Very Low (1)	**1**	**2**	**3**	**4**	**5**
Low (2)	**2**	**4**	**6**	**8**	**10**
Medium (3)	**3**	**6**	**9**	**12**	**15**
High (4)	**4**	**8**	**12**	**16**	**20**
Very High (5)	**5**	**10**	**15**	**20**	**25**

1-3 **Low Priority**	**4-6** **Moderate Priority**	**8-12** **High Priority**	**15-25** **Very High Priority**