NHS
North Central London
Integrated Care Board

NHS North Central London ICB
Board of Members Meeting

Tuesday, 26 March 2024
2pm – 3.30pm
Clerkenwell Room
2nd Floor, Laycock Professional Development Centre
Laycock Street
N1 1TH

AGENDA
Part 1

Item	Title	Lead	Action	Page	Time
1.	**INTRODUCTION**				
1.1	Welcome and Apologies	Mike Cooke	Note	Oral	2pm
1.2	Declarations of Interest (not otherwise stated)	Mike Cooke	Note	3	
1.3	Draft Minutes of the NCL ICB Board of Members Meetings on 7 November and 5 December 2023	Mike Cooke	Approve	9 19	
1.4	Matters Arising	Mike Cooke	Note	24	
1.5	Report from the Chief Executive Officer	Phill Wells	Note	26	2.10pm
2.	**STRATEGY AND BUSINESS**				
2.1	Population Health and Integrated Care Strategy – NCL Joint Forward Plan	Sarah Mansuralli	Endorse/ Note	32	2.20pm
2.2	Sustainable Healthcare: Green Plan Annual Report	Dr Jo Sauvage	Note	57	2.35pm
2.3	Primary Care Access Recovery Plan	Sarah McDonnell-Davies	Approve	73	2.45pm
3.	**OVERVIEW REPORTS**				
3.1	Integrated Performance and Quality Report	Richard Dale and Dr Chris Caldwell	Note	88	3pm
3.2	Finance Report	Bimal Patel	Note	112	3.10pm
3.3	Board Assurance Framework	Ian Porter	Note	133	3.20pm

4.	**ITEMS FOR INFORMATION AND ASSURANCE**				
4.1	Minutes of the Audit Committee Meeting on 19 September 2023, 14 November 2023 and 16 January 2024	Kay Boycott	Note		3.25pm
4.2	Minutes of the Finance Committee Meeting on 10 October and 12 December 2023	Usman Khan	Note		
4.3	Minutes of the Integrated Medicines Optimisation Committee Meetings on 26 September and 28 November 2023	Jonathan Levy	Note		
4.4	Minutes of the People Board Meeting on 20 November 2023	Liz Sayce	Note		
4.5	Minutes of the Procurement Oversight Group Meetings on 20 September, 8 November and 13 December 2023	Bimal Patel	Note		
4.6	Minutes of the Quality and Safety Committee Meetings on 18 July and 24 October 2023.	Liz Sayce	Note		
4.7	Minutes of the Strategy and Development Committee Meeting on 27 September and 6 December 2023	Mike Cooke	Note		
5.	**ANY OTHER BUSINESS**				
6.	**DATE OF NEXT MEETING**				
6.1	7 May 2024				
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.				

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Board of Members Meeting
26 March 2024

Report Title	Declaration of Interests Register – NCL ICB Board of Members	**Date of report**	15 March 2024	**Agenda Item**	1.2
Integrated Care Board Sponsor	Mike Cooke Chair, NCL ICB	**Email / Tel**		mike.cooke4@nhs.net	
Lead Director / Manager	Phill Wells Interim Chief Executive, NCL ICB	**Email / Tel**		Phill.wells@nhs.net	
Report Author	Steve Beeho Senior Board Secretary	**Email / Tel**		s.beeho@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications**		Not applicable.	

Report Summary

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

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

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

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

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

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

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

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

Name	Current Position (s) held- i.e. ICB Board, Trust, Member practice, Employee or other	Declared Interest - (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or Indirect?	Nature of Interest	Date of Interest				Actions to be taken to mitigate risk (to be agreed with line a manager of a senior CCG manager)
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	Date declared	Updated	
Members												
Mr Mike **Cooke**	Chair North London Integrated Care System		Yes			direct						BEAT is commissioned by some commissioning organisations to provide services. This declaration is for transparency. There is no conflict of interest between the roles flagged in this declaration.
		BEAT, the national Eating Disorders Charity	No	no	yes	direct	Chair of Trustees	19/11/2019	current	18/11/2019	11/07/2023	
	Chair of ICB Board											
	Member of ICB Finance Committee											
	Chair of ICB Strategy and Development Committee											
	Attend Remuneration Commmittee											
	Chair of ICS Community Partnership Forum											
	Attend other committees as and when required											
Ms Frances **O'Callaghan**	Chief Executive of North London Integrated Care System	Labour Party	no	no	yes	direct	Member of Labour Party	25/05/2023	current	26/05/2023	26/05/2023	This declaration and any potential conflicts of interest were fully assessed by the Governance and Risk Team. Appropriate mitigating actions have been put into place and will be adhered to.'
	Member of ICB Board of Members											
	Member of ICB Finance Committee	career break 01/12/2023 to 31/07/2024										
	Member of ICB Strategy and Development Committee											
	Member of ICB Executive Management Team											
	Member of ICB Community Partnership Forum											
	Attend other ICB Committees as necessary											
Mr Phill **Wells**	Chief Executive Officer							01/12/2023	31/07/2024	06/12/2023		
	NCL ICB Board Member									10/07/2023	06/12/2023	
	Member of ICB Finance Committee									10/07/2023	06/12/2023	
	Member of ICB Executive Management Team									10/07/2023	06/12/2023	
	Member of Strategy and Development Committee	The Air Ambulance Service	no	yes	no	direct	Trustee and Chair of Audit and Risk Committee	27/02/2022	current	23/06/2022	06/12/2023	Where decisions to be taken by the ICB contain a potential or perceived conflict, I will recuse myself from the decision making process and a suitable deputy will act in my place
	Member of ICB Community Partnership Forum									06/12/2023		
	Attend other ICB Committees as necessary									06/12/2023		
Gary **Sired**	Director of System Financial Planning Attendee at ICB Finance Committee	none	n/a	n/a	N/A	N/A				16/10/2018	10/10/2022	
Mr Bimal **Patel**	Chief Finance Officer									14/12/2023		
	NCL ICB Board Member and Chief Finance Officer									14/12/2023		
	Member of ICB Finance Committee									14/12/2023		
	Attend Audit Committee									14/12/2023		
	Member of ICB Executive Management Team									14/12/2023		
	Member of Strategy and Development Committee									14/12/2023		
	Chair of Procurement Oversight Group									14/12/2023		
		North Middlesex University Hospital	yes	yes	yes	direct	seconded from NMUH to NCLICB	18/12/2023	31/07/2024	14/12/2023		
		Greenside Court Management Limited	yes	yes	yes	direct	Director	16/01/2020	current	14/12/2023		
		Kingston University	no	yes	no	direct	Independent Governor Board member		current	14/12/2023		
Dr Jo **Sauvage**	Chief Medical Officer		yes	yes	yes	direct		01/07/2022	current	10/07/2022	06/07/2023	
	Member of ICS Community Partnership Forum		no	yes	no	direct			current	10/07/2022	06/07/2023	
	Member of ICB Board	London Clinical Executive Group	no	yes	no	direct	NCL Clinical Representative		current	10/07/2022	06/07/2023	
	Member of ICB Executive Management Team	London People Board	no	yes	no	direct	Commissioning Representative		current	10/07/2022	06/07/2023	
	Member of Quality and Safety Committee	London Primary Care School Board	no	yes	no	direct	ICS Representative		current	10/07/2022	06/07/2023	
	Member of the Strategy and Development Committee	London Primary Care Board	no	yes	no	direct	NCL Representative		current	10/07/2022	06/07/2023	
	Member of Primary Care Committee	London Urgent and Emergency Care Board	no	yes	no	direct	NCL Representative		current	10/07/2022	06/07/2023	
	Member of Population Health Improvement Committee	Greener NHS England, London	no	yes	no	direct	Clinical Director		current	10/07/2022	06/07/2023	
	Also participate in multiple work streams NHS England & Improvement and Health Education England, London Region:	Membership Expert Advisory Group for Evidence based interventions. Hosted by Academy of Royal Colleges	no	yes	no	direct	Member		current	10/07/2022	06/07/2023	
		Net Zero Clinical Transformation Advisory Board	no			direct	Member		current	06/07/2023		
		London Sustainability Network	yes	yes	no	direct	Clinical Director		current	06/07/2023		
		Islington GP Federation	yes	yes	yes	direct	GP Practice is a member	2016	current	10/07/2022	06/07/2023	
		City Road Medical Centre	yes	yes	yes	direct	GP Partner	06/11/2018	current	10/07/2022	06/07/2023	
		South Islington PCN	no	yes	yes	direct	GP Pracitce is a member	01/07/2019	current	01/07/2022	06/07/2023	
Mrs Kay **Boycott**	Non Executive Member, Member of the ICB Board,		yes	yes	yes	Direct		01/07/2022	current	11/07/2022	17/07/2023	
	Member of ICB Strategy and Development Committee	Eakin Healthcare Group	yes	yes	yes	Direct	Director	01/09/2021	current	11/07/2022	17/07/2023	
	Member of ICB Quality and Safety Committee	London Fire Brigade	yes	yes	yes	Direct	Independent Audit Committee Member	30/10/2020	current	11/07/2022	17/07/2023	
	Chair of ICB Audit Committee	Durham University	no	yes	yes	Direct	Lay member of Council and Audit and Risk Committee Chair	25/11/2018	current	11/07/2022	17/07/2023	
	Member of ICB Finance Committee	English Heritage Trust	no	yes	yes	Direct	Director	30/12/2021	current	11/07/2022	17/07/2023	
	Member of ICB Remuneration Committee	Isle of Wight Youth Trust	no	yes	no	Direct	Chair	12/07/2023	current	12/07/2023		They are commissioned by the Hampshire and Isle of Wight ICB to provide counselling services, not involved in any NCLICB work

		Various	yes	yes	yes	Direct	Advisor		current	11/07/2022	17/07/2023	These are infrequent and under NDA - In previous NHS roles I have agreed I would declare if relevant to a specific agenda item
		PWC	no	no	no	Indirect	Husband is a partner	06/07/2023	current	06/07/2023		
Ms Liz **Sayce OBE**	Non Executive Member, Member of the ICB Board							01/07/2022	current	26/08/2022	10/07/2023	
	Chair of ICB Remuneration Committee										10/07/2023	
	Chair of ICB Quality and Safety Committee	Action on Disability and Development International	no	yes		direct	Trustee	26/01/2021	current	26/08/2022	10/07/2023	
	Member of ICB Audit Committee	London School of Economics	yes	yes		direct	Visiting Professor in Practice		current	26/08/2022	10/07/2023	
	Vice-Chair of ICB Integrated Medicines Optimisation Committee	Social Security Advisory Committee	yes	yes		direct	Member and Vice-Chair	2016	current	31/07/2023	10/07/2023	
	Member of ICB Primary Care Committee	Fabian Society Commission on Poverty and Regional Inequality	yes	yes		direct	Commissioner	2021	current	26/08/2022	10/07/2023	
	Chair NCL People Board	Royal Society of Arts	no	no	yes	direct	Fellow		current	26/08/2022	10/07/2023	
		Institute for Employment Studies Commission on the Future of Employment Support	yes	yes	no	direct	Commissioner	2022	2024	26/08/2022	10/07/2023	
		Recovery Focus (a national voluntary organisation)	no	no	no	indirect	Partner is a Trustee		current	26/08/2022	10/07/2023	
		Furzedown Project, Wandsworth, Charity no 1076087	no			direct	Trustee	24/11/2022	current	24/11/2022	10/07/2023	
		Consultancy roles	no	no	no	indirect	My partner offers consultancy across the UK to mental health services, sometimes working with NHS Trusts, local authorities or voluntary sector organisations		current	26/08/2022	10/07/2023	I would declare a specific interest if my partner at any point worked with an organisation in North Central London, and recuse myself from any discussions relating to that organisation as needed
Professor Ibrahim Ibrahim **Abubakar**	Non Executive Member, Member of the ICB Board									23/11/2023		
		University College London	yes	yes	no	direct	Pro-Provost (Health)	2023	current	23/11/2023		
		Faculty of Population Health Sciences, UCL Professor of Infectious Disease Epidemiology.	yes	yes	no	direct	Dean	2016	current	23/11/2023		
		Lancet Migration	no	yes	no	direct	Chair	2016	current	23/11/2023		
		Lancet Nigeria Commission	no	yes	no	direct	Chair	2022	current	23/11/2023		
		Fotude Ltd, Company number 13479358	yes	yes	yes	direct	Director	Jun-21	current	23/11/2023		Fotude does no business with the NHS and is a global health entity but registered in the UK
		National Institute for Health and Care Research	yes	yes	no	direct	Senior Investigotor	2017	current	23/11/2023		
		Global Preparedness Monitoring Board.	no	yes	no	direct	Member	2022	current	23/11/2023		
		NIHR RID-TB Programme Grant	yes	yes	no	direct	£2.5 million awarded to UCL via Whittington Health to conduct 2 trials nationally	2019	current	23/11/2023		
		Horizon Europe	yes	yes	no	direct	10 million Euros to UCL conduct covid variant work in the UK and 18 other countries	2022	2025	23/11/2023		
		Employment by Mount Vernon Cancer Centre	no	no	no	indirect	Partner	2018	current	23/11/2023		
		NTM Network UK (new charity for Non Tuberculous Mycobacteria)	no	yes	no	direct	Trustee	Dec-23	2025	23/11/2023		
Dr Christine **Caldwell**	Chief Nursing Officer	Middlesex University	no	yes	no	Direct	visiting honorary Professor	30/03/2023	current	30/03/2023	14/02/2024	
	Member of ICB Board	Barnet Enfield Haringey MHT	no	no	no	indirect	daughter is an employee	01/01/2023	current	06/07/2023	14/02/2024	
	Member of Executive Management Team											
	Member of Quality and Safety Committee											
	Member of Strategy and Development Committee											
	Member of Primary Care Committee											
Mr Mark **Lam**	Board Member ICB		no	yes	no	Direct	Member	01/03/2023	current	12/04/2023	08/06/2023	
		Royal Free Hospitals	yes	yes	no	Direct	Chair	01/04/2021	current	12/04/2023	08/06/2023	
		North Middlesex University Hospital	yes	yes	no	Direct	Chair	01/10/2021	current	12/04/2023	08/06/2023	
		UCL Partners	yes	yes	no	Direct	Director	12/04/2021	current	12/04/2023	08/06/2023	
		UCL Health Alliance	yes	yes	no	Direct	Vice Chair	12/12/2022	current	12/04/2023	08/06/2023	
		JT Group	yes	yes	no	Direct	Non Executive Director	01/04/2023	current	12/04/2023	08/06/2023	
		Games Workshop Group PLC	yes	yes	no	Direct	Non Executive Director	12/04/2023	current	12/04/2023	08/06/2023	
		Hastings International Piano	no	no	yes	direct	Trustee	27/05/2010	current	12/04/2023	08/06/2023	
		Lowland Investment Company PLC	yes	no	yes	Direct	Non Executive Director	17/12/2023	current	11/01/2024		
Dr Usman **Khan**	Board Member ICB		no	yes	no	Direct	Member		current	07/09/2022	18/07/2023	
	Chair of ICB Primary Care Committee	ModusEurope	yes	yes	yes	Direct	director	29/11/2012	current	07/09/2022	18/07/2023	
	Chair of ICB Finance Committee	Motor Neurone Disease (Sales) Ltd	no	yes	yes	Direct	director	27/06/2022	current	07/09/2022	18/07/2023	
	Member of ICB Audit Committee	London Metropolitan University	yes	yes	yes	Direct	Vice Chair of Governors and Chair of Finance & Audit Committee	01/08/2022	current	07/09/2022	18/07/2023	
	Member of ICB Remuneration Committee	Motor Neurone Disease Association	no	yes	yes	Direct	Chair of Trustees / director	01/07/2021	current	07/09/2022	18/07/2023	
		FIPRA, a European public affairs consultancy	yes	yes	yes	Direct	Senior Advisor for EU Health Policy	01/50/2020	current	07/09/2022	18/07/2023	
		KU Leuven University, Belgium	yes	yes	yes	Direct	Visiting Professor in Health Management and Policy		current	07/09/2022	18/07/2023	
		Good Governance Institute	no	yes	No	Direct	Senior Advisor / Associate	01/02/2022	current	07/09/2022	18/07/2023	
Baroness Julia **Neuberger DBE**	Board Member ICB			yes	yes	direct	Member	01/07/20222	current	07/07/2022	16/07/2023	
	Member of ICB Strategy and Development Committee	UCLH	yes	yes	yes	direct	Chair	25/02/2019	current	07/07/2022	16/07/2023	
		Whittington Health Trust	yes	yes	yes	direct	Chair	01/04/2020	current	07/07/2022	16/07/2023	
		Walter and Liesel Schwab Charitable Trust	no	yes	no	direct	Trustee	06/12/2001	current	07/07/2022	16/07/2023	
		Rayne Foundation	no	yes	no	direct	Trustee	09/09/2018	current	07/07/2022	16/07/2023	
		Independent Age	no	yes	no	direct	Trustee	09/10/2019	current	07/07/2022	16/07/2023	
		The Lyons Learning Trust	no	yes	no	direct	Trustee	13/04/2016	current	07/07/2022	16/07/2023	
		Leo Baeck Institute	no	yes	no	direct	Trustee	15/07/2020	current	07/07/2022	16/07/2023	
		Yad Hanadiv Charitable Foundation	no	yes	no	direct	Trustee	2021	current	07/07/2022	16/07/2023	
		UK Commission on Bereavement	no	yes	no	direct	Member / Bereavement Commissioner	2021	current	07/07/2022	16/07/2023	
		UCL Health Alliance	no	yes	no	direct	Vice Chair	2021	current	07/07/2022	16/07/2023	
		House of Lords	yes	yes	no	direct	Independent Cross Bench Peer	2011	current	07/07/2022	16/07/2023	

		West London Synagogue	no	yes	no	direct	Rabbi Emirata	01/03/2020	current	07/07/2022	16/07/2023	
		Public Voice Representative	no	no	no	direct	Public Voice Representative	01/11/2022	current	16/07/2023		
Mr David **Probert** (represents Julia Neuberger in her absence)	Member of ICB Finance Committee		no	yes	no	Direct	Member		current	21/06/2023		
		UCLH	yes	yes	yes	direct	Chief Executive		current	21/06/2023		
		UCL Global Business School for Health	no	yes	yes	direct	Honorary professor		current	21/06/2023		
		UCL Partners	no	yes	yes	direct	Board Member		current	21/06/2023		
		St Dunstan's College	no	yes	no	direct	School governor		current	21/06/2023		
		Audio Books for Dad (Bedside Books 1195094)	no	yes	no	direct	Trustee		current	21/06/2023		
		Homerton NHSFT	no	yes	no	indirect	spouse is Chief Nurse and Director of Clinical Governance		current	21/06/2023		
Ms Harjinder **Kandola MBE**	Board Member ICB							01/07/2022	current	21/07/2022	10/07/2023	
		Barnet Enfield Haringey Mental Health Trust	yes	yes	yes	direct	Chief Executive	16/07/2018	current	21/07/2022	10/07/2023	
		Camden and Islington Foundation Trust	yes	yes	yes	direct	Chief Executive	01/10/2021	current	21/07/2022	10/07/2023	
Mr Ian **Porter**	Executive Director of Corporate Affairs	no interests declared	No	No	No	No		01/11/2016	current	01/07/2022	12/07/2023	
	Board Attendee ICB											
	Audit Committee, attendee											
	Procurement Oversight Group, voting member											
	Remuneration Committee, attendee											
	Member of ICB Executive Management Team											
	System Management Board, attendee											
	Member of ICS Community Partnership Forum											
Mr John **Hooton**	Board Attendee ICB		no	yes	no	direct		01/07/2022	current	06/07/2022	06/07/2023	
		Barnet Borough Coiuncil	yes	no	yes	direct	Chief Executive	01/02/2017	current	06/07/2022	06/07/2023	
		Live Unlimited Charity (no 1176418)	no	yes	no	direct	Chair of Trustee	01/03/2018	current	06/07/2022	06/07/2023	
Dr Jonathan **Levy**	Board Member ICB		yes	yes	no	Direct		01/07/2022	current	04/07/2022	01/03/2024	
	Member of ICB Quality and Safety Committee	James Wigg and Queens Crescent Practices	Yes	Yes	No	Direct	GP Partner	01/11/2015	current	10/09/2019	01/03/2024	
		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	01/03/2024	
		South Kentish Town Primary Care Network	Yes	Yes	No	Direct	Practice is a member of PCN	06/07/2020	current	06/07/2020	01/03/2024	
		South Kentish Town PCN Ltd (Company number 12723647)	Yes	Yes	No	Direct	Practices are members of the PCN and I am the Clinical Director	06/07/2020	current	06/07/2020	01/03/2024	
		Enterprise Textiles (Properties) Ltd (00995733)	Yes	Yes	No	Direct	Director and Shareholder	10/01/2024	current	01/03/2024		This company does not contract with NCLICB / any part of the NHS
		Camden Health Partners (06584530)	Yes	Yes	No	Direct	Shareholder in GP Federation	01/09/2015	current	10/09/2019	01/03/2024	
Dr Simon **Caplan**	Board Member ICB		yes	yes	no	Direct		01/07/2022	current	04/07/2022	10/07/2023	
	Member of ICB Audit Committee	Fernlea Surgery	yes	yes	yes	Direct	Partner	1990	current	26/01/2021	10/07/2023	
	Member of ICB Strategy and Development Committee	NCL GP Providers Alliance	no	yes	yes	Direct	Board Member	01/05/2022	current	04/07/2022	10/07/2023	
	Chair of Medicines Clinical Reference Group	Jewish Care (National charity)	no	yes	yes	Direct	Member of Clinical Governance Committee	2010	current	26/01/2021	10/07/2023	
		Federated4Health	no	yes	yes	Direct	Practice is a member	2016	current	26/01/2021	10/07/2023	
		Welbourne PCN	no	yes	yes	Direct	Practice is a member	01/06/2020	current	26/01/2021	10/07/2023	
		NHSE & I (London region) Medical Directorate	yes	yes	yes	Direct	Senior Clinical Advisor NHSE & I	01/04/2020	current	26/01/2021	10/07/2023	
Dr Alpesh **Patel**	Board Member Attendee and Chair of GPPA	White Lodge Medical Practice	Yes	Yes	No	direct	GP Partner	1998	current	27/01/2016	11/07/2023	
		General Practice Providers Alliance (GPPA)	Yes	Yes	No	direct	Chair	2022	current	11/07/2023		
		UCL Health Alliance	Yes	Yes	No	direct	Director	03/04/2023	current	11/07/2023		
		Gemini Health	Yes	Yes	No	indirect	Director	Aug-17	current	27/01/2016	11/07/2023	
		Enfield Healthcare Cooperative	Yes	Yes	No	indirect	Co Chair and Executive Director	Sep-17	current	27/01/2016	11/07/2023	
		Enfield One Ltd	Yes	Yes	No	indirect	Director			27/01/2016	11/07/2023	
		White Lodge Medical Practice Ltd	Yes	Yes	No	indirect	Director	2009	current	27/01/2016	11/07/2023	
		Equity Health LLP	Yes	Yes	No	indirect	Director	Nov-08	current	27/01/2016	11/07/2023	
		Enfield Health Partnership Limited, Provider of community gynaecology service	Yes	Yes	No	indirect	Shareholder 5%	Mar-13	current	27/01/2016	11/07/2023	
		Enfield Healthcare Alliance	Yes	Yes	No	indirect	Shareholder less than 5% (as White Lodge	2015	curremt	27/01/2016	11/07/2023	
		Local Medical Committee	No	Yes	No	indirect	member	11/09/2014	current	31/07/2023	11/07/2023	
		BEH MHT	No	Yes	No	indirect	spouse is a Pyschiatrist at Trust	27/01/2016	currrent	27/01/2016	11/07/2023	
		Evergreen Surgery	Yes	Yes	Yes	direct	Director	2007	current	27/01/2016	11/07/2023	
		NCL training Hub	Yes	Yes	Yes	direct	Clinical Lead	01/04/2022	current	12/12/2022	11/07/2023	
		NHSE	Yes	Yes	Yes	direct	GP Appraiser	2016	current	12/12/2022	11/07/2023	
		Enfield Borough Partnership Convenor	Yes	Yes	Yes	direct	Convenor	01/05/2023	current	11/07/2023		
		Enfield Health Partnership Limited (Federation)	Yes	Yes	Yes	direct	co-chair	mid 2020	current	12/12/2022	11/07/2023	
		Enfield Care Network	Yes	Yes	Yes	direct	Practice is a member of PCN	01/07/2019	current	08/05/2020	11/07/2023	
Ms Kaya **Comer-Schartz**	Board Member attendee and Leader of Islington Borough Council	Islington Borough Council	yes	yes	yes	direct	Leader of the Council		current	14/12/2022	03/08/2023	
		Junction Ward - Islington Borough	yes	yes	no	direct	Councillor Representative, Labour		current	14/12/2022	03/08/2023	
Mr Richard **Dale**	Executive Director of Transtion and Performance	No interests declared	No	No	No	No		03/07/2018	current	04/09/2019	24/07/2023	
	Member of Executive Management Team											
	ICB Board of Members, attendee											
	Finance Committee, attendee											

	Audit Committee, attendee											
	Strategy and Development Committee, attendee											
	Quality and Safety Committee, member											
	ICS Community Partnership Forum, member											
Sarah **Mansuralli**	Chief Development and Population Health Officer and Interim Deputy CEO	No interests declared	No	No	No	No		07/11/2018	current	07/11/2019	07/07/2023	
	Member of Executive Management Team											
	Attend ICB Board of Members											
	Exec Lead for Strategy and Development Committee											
	Attend Finance Committee											
	Attend Procurement Oversight Group											
Sarah **McDonnell-Davies**	Executive Director of Place	No interests declared	no	no	no	no		20/06/2018	current	20/06/2018	14/07/2023	
	Member of Executive Management Team											
	Attend ICB Board of Members											
	Attend Strategy and Development Committee											
	Exec Lead for Primary Care Committee											
	Exec Lead for Integrated Medicines Optimisation Commmittee											
	attend other NCL / Borough related meetings as required											
Sarah **Morgan**	Chief People Officer Member of the Executive Member Team	Good Governance Institute	no	no	yes	Direct	Faculty member	01/12/2020	current	04/07/2022	13/12/2023	manage contributions in line with ICB guidance
	Attend Remuneration Committee											
	Voting member Primary Care Committee											
	Member of People Board											
	Chair of People and Culture Oversight Group											
	Member of the Strategic Development and Population Health Committee											
		Fresh Visions People Ltd Charity no 1091627	no	no	yes	Direct	Trustee / Director and Chair from 6 December 2023	22/04/2022	current	04/07/2022	13/12/2023	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
		Kaleidoscope Health and Care (not for profit Social Enterprise)	no	yes	no	Direct	Member of a professional network of health and care professionals including alumni of the NHS general management graduate scheme	2016	current	13/12/2023		Manage any contractual arrangements through procurement team
		University of Birmingham, School of Social Policy, Health Services Management Centre	no	no	yes	Direct	Honorary Associate Professor	01/10/2023	current	13/12/2023		
Becky **Booker**	Director of Financial Management Attendee of Audit Committee, Finance Committee, other committees as required including Board	None	No	No	No	None	n/a	n/a	n/a	18/10/2017	28/02/2024	
Gary **Sired**	Director of System Financial Planning Attendee of Finance Committee, other committees as required including Board	none	n/a	n/a	N/A	N/A				16/10/2018	21/02/2024	

North Central London
Integrated Care Board

Draft Minutes
Meeting of NHS North Central London ICB Board of Members
7 November 2023 between 2pm and 3.30pm
Clerkenwell Room

Present:	
Mike Cooke	Chair, NCL Integrated Care Board
Frances O'Callaghan	Chief Executive Officer
Ibrahim Abubakar	Non-Executive Member
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
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
Mark Lam*	Chair, Royal Free Hospitals and NMUH
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Sarah Mansuralli*	Chief Strategy and Population Health Officer
Sarah McDonnell-Davies*	Executive Director of Place
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
Sarah Morgan*	Chief People Officer
Ian Porter*	Executive Director of Corporate Affairs
Dr Jo Sauvage	Chief Medical Officer
Liz Sayce	Non-Executive Member
Phill Wells	Chief Finance Officer
In Attendance:	
Katie Coleman	Clinical Director, Primary Care
Apologies:	
Dr Alpesh Patel*	Acting Chair, GP Provider Alliance
Minutes:	
Steve Beeho	Senior Board Secretary

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	Mike Cooke welcomed attendees to the meeting. He noted that this would be the last Board meeting attended by Frances O'Callaghan prior to her going on sabbatical and he took the opportunity to wish her well and thank her for her hard work over the past 18 months, particularly in terms of steering the ICB through a number of challenges, while also setting a course for the future under her leadership through the various transformations now underway and the renewed focus on population health, as well as working closely with fellow Chief Executives to address more immediate challenges, such as waiting lists.

* Standing Participant

1.1.2	He then thanked Phill Wells for agreeing to take on the role of Interim Chief Executive in Frances's absence and thanked the other Executives who would also need to shoulder some additional responsibility over this period.
1.1.3	Apologies had been received from Dr Alpesh Patel.
1.2	**Declarations of Interest relating to the items on the Agenda**
1.2.1	Mike Cooke invited Members to declare any interests relating to items on the agenda.
1.2.2	Dr Jonathan Levy and Dr Simon Caplan declared an interest for the sake of transparency with regards to Item 2.1 as they both practice as GPs in NCL. There were no additional declarations of interests or gifts and hospitality.
1.2.3	The Board of Members: • **NOTED** the requirement to declare any interests relating to the agenda; • **NOTED** the Declaration of Interests Register and the requirement to inspect their entry and advise the Board Secretary of any changes; • **NOTED** the requirement to record any relevant gifts and hospitality on the ICB Gifts and Hospitality Register.
1.3	**Minutes of the NCL ICB Board of Members Meeting on 25 July 2023**
1.3.1	The Board of Members **APPROVED t**he minutes as an accurate record.
1.4	**Minutes of the NCL ICB Annual General Meeting 19 September 2023**
1.4.1	The Board of Members **APPROVED t**he minutes as an accurate record.
1.5	**Matters Arising**
1.5.1	The Board of Members **NOTED** the Action Log.
1.6	**Report from the Chief Executive Officer**
1.6.1	Frances O'Callaghan provided an overview of the report, highlighting the following points: • The system is currently under considerable pressure, particularly in Emergency Departments, and she expressed her gratitude to everybody working in clinical services to address this. Although the pressure is not evenly spread at any given moment, all parts of the system have been coming together to provide mutual support. • People living with sickle cell disorder (SCD) in NCL will benefit from improved access to specialist, integrated community nursing care and timely pain relief, thanks to the development of the NCL Community sickle cell, thalassaemia, and rare anaemia service and the hyperacute service based at NMUH. This represents a massive step-forward for a group of patients who have previously been under-served • It is important for Board Members to be kept abreast of discussions at the Integrated Care Partnership (ICP) around population health and the report highlights productive conversations which took place at the recent ICP meeting on 3 October 2023 around the delivery of the Population Health and Integrated Care Strategy, special educational needs and disability (SEND), adults with SMI (serious mental illness) and early years/school readiness • The NCL Long Term Conditions model, which aims to keep people well and avoid having to return to hospital, is the epitome of the population health work which the ICB is promoting as a new statutory organisation and the scaling up of this model will be key to the ICB's success • The proposed new ICB structure has now been finalised following feedback from staff through the Organisation Change Programme, although it is recognised that there are still some outstanding issues to progress, including understanding the impact of voluntary redundancy. The focus will now move into the various implementation phases. This has been a huge piece of work which will enable the ICB to move forward as a new and different organisation with an absolute focus on population health.

1.6.2	The Board then discussed the paper, making the following comments: • Members paid tribute to Frances O'Callaghan's leadership over a critical period for the NHS and wished her well in her sabbatical • It was noted that the impact of industrial action continues to be challenging for providers. Each new strike makes it increasingly difficult for Trusts to maintain safe patient care on the day, without taking into account any longer-term consequences and this represents a significant system risk • The renewed focus on Sickle Cell and Frances O'Callaghan's role in driving this were commended • The dual focus in the report on immediate priorities, such as the impact of the industrial action, and the longer-term pro-active work was welcomed, as was the sight of planning beginning to come to fruition after the first year of the ICB's existence, as demonstrated by the Sickle Cell and SEND updates • It was confirmed that the system has a number of priorities set out through CORE20 and CORE20PLUS, as well as other national priorities. The ICP has had a particular focus on mental health and CAMHS, as well as school readiness through a partnership between the NHS, local authorities and the voluntary sector.
1.6.3	The Board of Members **NOTED** the Report.
2.	**STRATEGY AND BUSINESS**
2.1	**National Delivery Plan for Recovering Access to Primary Care – NCL approach**
2.1.1	Sarah McDonnell-Davies introduced the paper, highlighting the following points: • This is one of the three major NHS recovery plans initiated post-pandemic • The pandemic triggered rapid change over a short period to the General Practice operating model, which led to new ways of working and the implementation of technology which had been in the pipeline but had not been fully rolled out • NCL practices now offer traditional access routes as well as rapidly-scaled digital routes such as e-consult and online appointment bookings • Following a brief dip at the height of the pandemic, access and activity in general practice have recovered, surpassed and never returned to pre-pandemic levels. Despite this, patient satisfaction, particularly regarding making a GP appointment, has reduced over the same period and it is important that the Board is seen to be addressing the patient experience around access as this drives people's views of general practice which in turn drives their views of the NHS more broadly • People are still extremely satisfied with the care that is being delivered – 89% of people feel that their needs are met when they see their practice team • The ICB needs to support the 180 NCL practices to think about the shift that has taken place in the operating model and within their teams, as well as the barriers to access • The plan presented to the Board outlines the NCL approach to the national requirements which will be implemented over the next two years in a stratified way, concentrating initially on those practices which need the greatest support. Key focuses will be on technology, reducing workload, the role that partners such as community pharmacy can play, increased self-management and self-referral and wider work to support the workforce • An update on progress will be brought to the next Board meeting in March 2024.
2.1.2	The Board then discussed the paper, making the following comments: • The primary care team was commended for making the national plan more bespoke for NCL, as was the wider primary care community for its willingness to embrace the challenge. This will ultimately act as an important foundation for the wider population health work taking place

	• It was cautioned that the system needs to be realistic about the fact that although the number of avenues to access primary care have increased, there is nevertheless a limited number of medical decision-makers in primary care, which is compounded by the recruitment challenge and there is therefore a need to rationalise what is handled by primary care as there is finite capacity – this means distinguishing between demand and need. • Recovering access is the fulcrum which a number of programmes are orientated around. Alongside the focus on recovery there is a range of other work which needs to be tackled together as an integrated care system, including the focus on long term conditions (LTC) and proactive care and secondary prevention, to systemically reduce inequalities. The training involved with the locally commissioned service (LCS) has an undeniable impact on primary care capacity but the LTC LCS will enable the system to focus its capacity and capability on genuine need. However, this cannot be done by general practice alone – working with wider partnerships will enable collective focus on population health. Better proactive care (such as optimising blood pressure and cholesterol) will also make it possible to rapidly reduce some of the need in non-elective care • It was noted that the combination of a 33% increase in activity and a 4% drop in patient satisfaction needed to be kept in perspective when considering the pressure that the system is under • However, although the response to the national plan set out in the paper is very comprehensive, it is unclear if there is an understanding of what is driving the increased demand and what conditions people are presenting with in primary care and what can be done proactively to address this. Quantifying locally what constitutes this 33% increase would facilitate local tailoring of the national suggestions to enable them to be more appropriately delivered in an impactful way • In light of the fact that the population is not homogenous, it was also questioned to what extent the ICB can tailor the available options in each primary care area in order to make the offers more accessible to the various communities in NCL • The plan and the significant amount of work to date were welcomed. However, the ICB needs to be mindful that there is a risk that it could further exclude different communities where English is not the first language • It was questioned what differential support can be offered to areas with high health inequalities and the most challenged practices • It was noted that deprivation is often another common factor and therefore access to Councils' support services would potentially have a stronger benefit for somebody repeatedly seeking medical support for debt-related anxieties, for example. It would therefore be helpful for the data to be broken down to highlight which conditions are generating repeated high demand and where this is happening and in which communities. The voluntary sector has an important role to play in the solution, over and above being an amplifier of messaging from General Practice • The tension between demand and need is a challenge for the whole system, not just primary care. It was queried how the ICB proposes to communicate the scale of the problem to the local population and enable them to understand the potential solutions • It is also important to factor in the extent to which the huge demand at A&E is being driven by the perception that people cannot access primary care. More work needs to be done to disaggregate the causes of this and potentially provide alternative forms of access • It is undeniable that people find it frustrating to access general practice and the level of demand compounds this. It is important to understand what can be done to influence the way that this is handled. Technology will play a significant role in the way that general practice works, alongside telephony and face to face care, but this needs to be implemented effectively. The ICB needs to work with all practices to ensure that the systems in place are properly implemented and it is taking a supportive multi-disciplinary approach to offer a holistic package of support to practices

	• Assurance was given that the ICB recognises that demand is a challenge – work is taking place to understand the presentations and think about how we might work differently to triage some of the demand. It would be helpful for the Board to have a longer discussion at a future date about the demand/capacity challenge and potentially promoting more of a focus on pro-active care and need rather than demand • Work is underway on developing the ambitions for primary care in NCL and this piece of work is being tied into a London-wide deliberation where some of these tensions and challenges will be presented and the public will be asked to wrestle with these. The NCL work will inform what is put on the table for discussion.
2.1.3	Mike Cooke observed that the paper provided a set of actions and plans in place to deal with a specific issue. While this work is a good thing in itself, there is more which needs to be done and there is a strong appetite among the Board to deal with the wider issues that the paper touches on, including workforce, needs versus demand and working in partnership with the voluntary sector, community groups and local authorities to develop a more holistic approach. He therefore asked Usman Khan as Chair of the Primary Care Committee (PCC) to take this conversation back to the PCC for a more in-depth discussion with the support of executive colleagues before bringing something back to the Board in due course.
2.1.4	The Board of Members **NOTED** the North Central London ICB response to the National Delivery Plan for Recovering Primary Care Access.
2.1.5	Action: Usman Khan to arrange for an in-depth discussion of the issues raised to take place at a future PCC meeting before a follow-up paper is brought back to the Board in due course.
2.2	**Mental Health Update**
2.2.1	Sarah Mansuralli and Jinjer Kandola introduced the paper, highlighting the following points: • The report highlighted the successes following the Board's earlier approval of the Mental Health Core Offer, as well as the challenges against a backdrop of rising demand and significant workforce issues • There has been good progress in delivering the Core Offer, particularly in addressing issues around access and inequalities in Adult Mental Health Services and Eating Disorder Services • As part of the implementation of the Core Offer, a gap analysis was conducted to facilitate a targeted approach to where funding needed to be directed and what services needed to be improved in different parts of NCL • NCL has also delivered against a set of nationally-mandated targets as part of the Long Term Plan which both reflects population needs but also some of the wider work programmes in NCL, such as Start Well • As part of improvements in quality and timeliness of care, NCL is now meeting Core 24 Mental Health Liaison Service Standards • NCL also benefits from its Mental Health Crisis Assessment Centres, an innovative model which service ambulance conveyances, direct referrals and walk-in patients • There has been a significant increase in demand for Child and Adolescent Mental Health Services (CAMHS) where there is also a number of infrastructure challenges, including providers using different systems and having different waiting list approaches and variations in the model of care – this is complicating progress • Workforce issues are impacting on the pace of delivering service improvements, particularly around having the appropriate qualified specialist staff • There is a lot of work taking place to use the VCSE sector to deliver things such as talking therapies and providing peer support • The CAMHS Thrive model has a lot of interdependencies with some of the early intervention and prevention services that the ICB is seeking to implement in the community. In order to do this effectively, collaborative work will be required with local authorities. Constructive conversations have taken place around this at the ICP but there is still much more to be done

	• Increasing demand and unmet need in CAMHS is particularly concerning and more work is needed around this • An increased number of people have signed up for Mental Health Nurse training but it will take three-four years for them to be in post. The attrition rate for Mental Health staff is also challenging so it is clear that something different is needed. This will include a greater focus on the use of digital and AI support as the workforce cannot be grown fast enough • The North London Mental Health Partnership is also working with the ICB People Board and Capital Nursing to identify any stop-gap solutions, while also looking at bursaries and apprenticeships. The Partnership is seeking to increase the number of staff living locally as this improves retention rates and is also working on ethical overseas recruitment • The Partnership has also experienced 28 days of industrial action over the year, which has resulted in more individuals presenting at ED, more people being admitted who are acutely unwell and lengths of stays going up which is impeding patient flow, leading to increased out of area placements • The Partnership is in a significantly better position than it was two years ago, as demonstrated by some of its performance compared to other parts of London but this is not where it wants to be and there is more work to do.
2.2.2	The Board then discussed the paper, making the following comments: • It was suggested that it might be worth considering whether Mental Health access and workforce should be recorded as strategic system risks • The balance of the report is currently more on the here and now rather than population health for understandable reasons, bearing in mind the immediate pressures, but it would be helpful to understand the ambition around a prevention concordat and hear more about Tier 1 services • It was noted that although the level of adult mental health illness in the population has largely remained stable, there has been a significant increase in its prevalence among young people and this is a global issue. As the provision of service has been sub-optimal for all age groups, the work that is being undertaken is absolutely essential but without a focus on the preventive element among young people the level of illness will rise even higher and training more staff will not be sufficient to manage this. These societal changes pre-date the pandemic, although the pandemic also exacerbated them. This will require work outside the health service, particularly in schools and communities, as a more lateral approach is the only way to reduce the burden in the future • It was agreed that Mental Health access and workforce represent a systemic risk. There has been a huge increase in demand since the pandemic, particularly in CAMHS, and at a national level the system is on the verge of a 'silent' crisis which may not grab national headlines but nevertheless tends to impact the most vulnerable in society, so it is vital that it receives the correct level of attention at regional and system level • The specific interventions taking place to get even better at what is currently being done were welcomed, as were inspiring initiatives such as the one supporting rough sleepers • It was noted that as part of the shift to a more preventive approach, it would be helpful for the Board to be more sighted on the number of people waiting to access Community Mental Health Services. Given that the drivers of increased demand include the cost of living and the pandemic, it was questioned whether there is more that can be done to help at a system level, such as drop-ins to discuss anxieties about personal finances, and whether there are other collaborative approaches which might assist • The fact that the paper looks from primary care upwards was welcomed but it was suggested that it lacks an analysis of where things are across the five Boroughs and what is needed in terms of people's outcomes. It would also have been helpful to have had more illustrations of Thrive in the paper

	• It was noted that it was important to recognise what has been achieved to date. For instance, the innovative Mental Health Assessment Service (MHAS) is a pioneering service which is not currently replicated in most of the country. NCL has also rolled out core mental health teams which work collaboratively between statutory services, peer support and the third sector. However, although there is good support for acute need, the availability of support at the 'lower' level, such as waiting months for a psychology appointment, needs to be strengthened but there also needs to be an emphasis on community support to avoid people feeling isolated • In response it was noted that the system needs to recognise pockets of excellence and make them standard. The development of core teams, building on good practice in one area in Camden, was cited as a good example of this • It was acknowledged that there is now a need to focus on early intervention and prevention. A large amount of time is devoted to supporting people in crisis but people need more help with maintaining mental health in a good state. There are examples of good practice, such as the service user-led Thumb networks, which warrant further attention • In response to the challenge to think more radically it was suggested that there is a need to think differently about CAMHS, which has the highest vacancy rates across the five boroughs and growing demand. More thought is needed about the best model to help young people and their families with prompt access to diagnostics and then getting people into treatment • Mental Health Trusts are often not good at articulating their 'waits' and outcomes, so the focus on the Patient Tracking List and getting accurate data will help in this regard.
2.2.3	Mike Cooke observed that there was a clear consensus among the Board that the paper describes significant progress from where things stood two years ago but there is also a real appetite for thinking about the challenges in a much more rounded way, with partnership and preventative working at its heart. He asked Jinjer Kandola to take away these reflections for consideration at a future Board Seminar. It is important that CAMHS forms part of this discussion due to its criticality. He also observed, based on this paper and the preceding one, that it feels as if the ICB has reached a point in its development where all papers of this nature need to be considered in this more rounded way. It would therefore be helpful for Frances O'Callaghan and Phill Wells to lead a discussion among the Executive team around what this might mean for the preparation of papers so that this preventative perspective is established in the papers before the meeting.
2.2.4	The Board of Members **NOTED** the report.
2.2.5	Action: Jinjer Kandola to lead a discussion on Mental Health at a future Board Seminar, building on the discussion at today's meeting.
3.	**OVERVIEW REPORTS**
3.1	**Integrated Performance and Quality Escalation Report**
3.1.1	Chris Caldwell and Richard Dale introduced the paper, highlighting the following points: • NMUH had been officially moved out of Tier 1 oversight by NHS England since the Board last met, in recognition for reducing their 62-day Cancer pathway backlog and improving Faster Diagnosis Standard (FDS) performance • NCL is the best-performing ICB around the number of people waiting six months for diagnostic tests but further improvement is still needed • The industrial action is continuing to have a cumulative impact on the elective recovery programmes, with providers needing to recalibrate how theatres are used to ensure that cancer pathways are prioritised • NCL is slightly below trajectory to achieve its 76% target for A&E 4-hour waits by the end of the financial year. The ICB is working with sites to look at winter plans and consider whether anything needs to be brought forward to ease pressure • Work is also underway to understand the reason for the large number of patients spending more than 12 hours in ED as this was not experienced before the pandemic and is probably linked to issues around patient flow • Trusts are working to quantify the impact of the aforementioned challenges on patient outcomes

	• The ICB is beginning to triangulate staffing, safety and performance in ED to understand the impact on staff of having to frequently make difficult decisions • All NCL maternity units have undergone post-Ockenden visits by the CQC and outcome reports will be published in due course. In the meantime, maternity will continue to be a major focus as the system moves into the three-year maternity and neonatal delivery plan • NCL has been the best performing ICB in London and also one of the best in the country for the delivery of the Covid and flu vaccination programme targeting people who are housebound and in residential care.
3.1.2	The Board then discussed the paper. It was noted that some of the increased demand is caused by the inability of the system to manage pro-active care as highlighted earlier, leading to a deterioration in people's conditions and resulting pressures on acute pathways. Focusing on different ends of the pathway in the medium to longer term will help the system to intervene, especially in secondary prevention, in order to reduce some of this demand.
3.1.3	Mike Cooke noted that the paper and comments reflect good progress in some key performance areas but the overall position remains extremely challenging. It is nevertheless encouraging to see the strength of the ongoing partnership working across a complex system.
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 Month 6 Finance Report, 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: • At Month 6 the ICS reported a deficit of £87.6m, against a planned deficit of almost £57m • The second half of the year will be particularly important, both in terms of the phased recovery of this position and the planned non-recurrent support • The industrial action is continuing to have a financial and operation impact on the ICS. If the direct costs of the industrial action were stripped out, as well as the resulting 'lost' Elective Recovery Fund (ERF), NCL would actually be ahead of the challenging plan it set itself at the start of the year • The ICS is continuing to forecast a break-even position at the end of the financial year. However, this is dependent on three important assumptions: there will be a national remedy for the impact of the cost of the industrial action; providers and the ICB will continue to deliver their efficiency programmes; and the planned non-recurrent support is delivered by providers and the ICB • The report also highlights the underlying impact of prescribing costs being higher than expected due to inflation. Complex healthcare packages post-discharge are also proving more expensive than anticipated. The national team is aware of this cost pressure • The expected system risks are now starting to crystalise, as a number of organisations have begun to report emerging issues which they had not taken account of. These risks will need to be managed in line with provider plans as there is no scope for movement against the financial positions that were originally set • The ICB is still on target to deliver its £10.6m surplus – this will be used to support the ICS to deliver a break-even position. The organisation's design work will provide a structure to help the ICB to meet its running cost allowance for 2024/25 and also help in the tail-end of 2023/24 • A constructive discussion was held recently with the Finance Committee about the overall level of financial risk and a number of these risks will be carried into the planning for 2024/25. .
3.2.2	The Board of Members discussed the paper, making the following comments: • The Finance Committee has welcomed the assurance from the increased ability to track the figures presented and the system is now better able to model and predict, which helps with medium term strategic financial planning

	• The second half of the financial year will be particularly challenging, so it is important to avoid complacency.
3.2.3	The Board of Members **NOTED** the Finance Report.
3.3	**Board Assurance Framework (BAF)**
3.3.1	Ian Porter introduced the paper, noting that a refresh had been undertaken with Executives and Board Committees since the previous meeting, and he thanked all concerned for their input. He then highlighted the following points: • Four risk scores had been reduced since the previous meeting and two risks had been closed • Three new risks have been opened relating to the delivery of the financial plan, meeting the running cost allowance in future years and the costs of Continuing Healthcare/Complex Individualised Commissioning packages of care • Further thought will be given to the opening of a mental health risk in the context of the risk deep dives, building on the comments earlier in the meeting • The support of the Audit Committee, as the ICB's approach to risk management continues to evolve, was welcomed. PWC have recently undertaken a national benchmarking exercise of BAFs and overall the ICB's approach compared extremely well.
3.3.2	The Board of Members discussed the paper, making the following comments: • The huge amount of work by Executives and Committees on the refresh was acknowledged. This will provide a strong platform for the planned risk deep dives • The risk around mental health could potentially be framed as the risk around people not being able to access the treatment they need in a timely way or the fact that there is an increasing number of young people with mental health conditions which, if not helped, will lead to a deterioration in population health.
3.3.3	The Board of Members **NOTED** the Board Assurance Framework.
4.	**GOVERNANCE**
4.1	**Update to Governance Arrangements**
4.1.1	Ian Porter highlighted that the proposed changes to the Primary Care Committee Terms of Reference will provide the Committee with increased capacity to undertake more strategic work and undertake deep dives. The changes to the Procurement Oversight Group Terms of Reference will provide extra strength in governance to oversee the new Provider Selection Regime arrangements. The Board will receive a briefing on this in due course.
4.1.2	The Board of Members then discussed the paper. It was questioned how the ICB uses its procurement leverage to promote social value, such as supporting local businesses, good employment practice and the green agenda, as this was not explicitly referenced in the Procurement Oversight Group (POG) Terms of Reference. It was clarified in response that the Procurement Policy sets out some of these principles. The ICB has developed a pre-procurement checklist and the POG ensures that procurements are enacted in line with the policy. The policy is currently being refreshed to incorporate recent internal audit recommendations and also to align it with the Commissioning Handbook. It was agreed that Sarah Mansuralli would circulate to Board Members a summary of the policy and the ICB approach to procurement
4.1.3	The Board of Members: • **APPROVED** the Primary Care Committee Terms of Reference; • **APPROVED** the Procurement Oversight Group Terms of Reference; • **APPROVED** the Quality and Safety Committee Terms of Reference; • **APPROVED** the Integrated Medicines Optimisation Committee Terms of Reference; • **APPROVED** the amendments to the Standing Financial Instructions; • **APPROVED** the amendments to the Functions and Decisions Map and to other governance documentation.

4.1.4	Action: Sarah Mansuralli to circulate to Board Members a summary of the ICB Procurement Policy and its approach to procurement.
5.	**ITEMS FOR INFORMATION AND ASSURANCE**
5.1	**Update on the Delegation of Commissioning of Specialised Services**
5.1.1	The Board of Members **NOTED** the update on the Delegation of Commissioning of Specialised Services.
5.2	**Minutes of the Audit Committee Meeting on 6 June 2023**
5.2.1	The Board of Members **NOTED** the minutes of the Audit Committee.
5.3	**Minutes of the Finance Committee Meetings on 13 June and 5 September 2023**
5.3.1	The Board of Members **NOTED** the minutes of the Finance Committee.
5.4	**Minutes of the Integrated Medicines Optimisation Committee Meeting on 6 June 2023**
5.4.1	The Board of Members **NOTED** the minutes of the Integrated Medicines Optimisation Committee.
5.5	**Minutes of the People Board Meeting on 15 May 2023**
5.5.1	The Board of Members **NOTED** the minutes of the People Board.
5.6	**Minutes of the Procurement Oversight Group Meetings on 21 March and 19 July 2023**
5.6.1	The Board of Members **NOTED** the minutes of the Procurement Oversight Group**.**
5.7	**Minutes of the Quality and Safety Committee Meeting on 23 May 2023**
5.7.1	The Board of Members **NOTED** the minutes of the Quality and Safety Committee.
5.8	**Minutes of the Strategy and Development Committee Meeting on 5 July 2023**
5.8.1	The Board of Members **NOTED** the minutes of the Strategy and Development Committee.
6.	**ANY OTHER BUSINESS**
6.1	There was no other business.
7.	**DATE OF NEXT MEETING**
7.1	The Chair noted that the date of the next formal Board Meeting was 26 March 2024. However, Executive colleagues had informed him of the need to make a small segment of the Board Seminar on 7 December 2023 a Board Meeting in public.
8.	**PART 2 MEETING**
8.1	The Board of Members **RESOLVED** 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.

North Central London
Integrated Care Board

Draft Minutes
Meeting of NHS North Central London ICB Board of Members
5 December 2023 between 2.20pm and 3.05pm
Clerkenwell Room

Present:	
Mike Cooke	Chair, NCL Integrated Care Board
Phill Wells	Interim Chief Executive Officer
Ibrahim Abubakar	Non-Executive Member
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
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
Mark Lam*	Chair, Royal Free Hospitals and NMUH
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Sarah Mansuralli*	Chief Strategy and Population Health Officer/Interim Deputy CEO
Sarah McDonnell-Davies*	Executive Director of Place
Sarah Morgan*	Chief People Officer
Liz Sayce	Non-Executive Member
Gary Sired	Interim Chief Finance Officer
In Attendance:	
Michelle Johnson	Clinical Lead, Start Well Programme
Anna Stewart	Start Well Programme Director
Apologies:	
Dr Alpesh Patel*	Acting Chair, GP Provider Alliance
Ian Porter*	Executive Director of Corporate Affairs
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
Dr Jo Sauvage	Chief Medical Officer
Minutes:	
Steve Beeho	Senior Board Secretary

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	Mike Cooke welcomed attendees to the Meeting. Apologies had been received from Dr Alpesh Patel, Julia Neuberger, Ian Porter and Jo Sauvage.
1.2	**Declarations of Interest relating to the items on the Agenda**

* Standing Participant

1.2.1	Mike Cooke invited Members to declare any interests relating to items on the agenda. Simon Caplan noted in the interests of transparency that he is a member of the Start Well Clinical Review Group.
1.2.2	The Board of Members: • **NOTED** the requirement to declare any interests relating to the agenda; • **NOTED** the Declaration of Interests Register and the requirement to inspect their entry and advise the Board Secretary of any changes; • **NOTED** the requirement to record any relevant gifts and hospitality on the ICB Gifts and Hospitality Register.
2.	**STRATEGY AND BUSINESS**
2.1	**Start Well Pre-Consultation Business Case**
2.1.1	Mike Cooke noted that the Board was being asked to approve an approach to a public consultation, rather than take a decision at this stage about the future of services. Sarah Mansuralli then introduced the paper, highlighting the following points: • The Board has received a number of updates on the Start Well programme since it began in 2021. The ICB has benefitted from extensive clinical and resident involvement in developing the proposals which are before the Board today, seeking a decision about testing these proposals with the public through a consultation exercise. • This piece of work is rooted in the NCL Population Health and Integrated Care Strategy which has identified Start Well as a clear priority, recognising the huge impact it will have on improving children and young people's life-chances • Although the consultation will be around a number of reconfiguration proposals, the Case for Change also highlighted some improvement opportunities that did not require any changes to the way that services are organised and work on these improvement initiatives has already commenced across NCL • There has been a focus on the drivers identified in the Case for Change which pointed to the need to review the way that services are organised. These include a declining birthrate yet an increasing complexity of both babies and the women and people giving birth; high vacancy rates, often leading to an inability to recruit across the current five delivery units; an imbalance between demand and capacity across certain units; the fabric of NCL estates often not being in accordance with best practice building standards and the number of deliveries at the Edgware Birthing Centre declining year on year, largely due to the growing complexity of births meaning that women do not meet the criteria for delivering at this site. • The new care models set out in the paper address the clinical drivers for change. Approval was being sought to consult with the public on reducing the number of units providing maternity and neo-natal care from five to four. This would mean having three Level Two units plus the specialist Neo-natal Intensive Care Unit at ULCH, while also no longer having a Level One neonatal unit or a stand-alone birthing centre. • The two options described in the paper are both considered deliverable, subject to the outcome of the public consultation o Option A will develop the services at the Whittington to offer additional Level Two capacity, as well as improving the physical environment and infrastructure of the services o Option B will result in the Level One service currently provided at the Royal Free ceasing and the establishment of a Level Two unit in its place o Either option will require significant capital and revenue investment • The ICB is proposing to go to public consultation with Option A as its preferred option, The Start Well Clinical Reference Group has recommended this option as being much stronger clinically due to it necessitating far fewer workforce moves and would only require the expansion of two sites, compared to four under Option B

	• Additionally, North East London (NEL) ICB/ICS has advised that it will be challenging to accommodate the inflow of births to the Homerton associated with Option A but NCL will work with NEL on the implications of how they would smooth demand and capacity across the system if this is the outcome of the consultation. In contrast, North West London ICB/ICS has confirmed that they will be able to accommodate the additional inflows into their system within existing capacity. This would also help their units to become more sustainable, improve continuity of care and strengthen integration with other local services • The ICB is proposing to streamline pathways for children (predominantly very young children under the age of 3) requiring paediatric surgical care by creating centres of expertise through consolidating some daycase activity for very young children at UCLH and consolidating some emergency and inpatient surgical care for very young children at Great Ormond Street Hospital (GOSH), recognising that there is specialist paediatric surgical and anesthetic provision at these sites that can accommodate the relatively small amount of activity transfers that this would result in. • Maintaining the status quo is not an option – the current models of care are not sustainable and compromise the ability to achieve the ICB's ambitions to deliver high quality and accessible care which meets the needs of the population and improves outcomes.
2.1.2	Michelle Johnson noted that the programme had been clinically-led from the outset. Clinicians across all the professions and organisations have regularly attended meetings of the Start Well Clinical Reference Group (CRG), demonstrating their commitment to the programme. This commitment reflects the compelling nature of the Case for Change as the inequitable access to services is something the clinicians witness daily. The CRG has developed the model of care, working through what would be the most sustainable way for maternity, neonatal and paediatric services to be delivered across NCL. The proposal will also improve maternity and neonatal outcomes by eliminating the existing disparities. The clinical workforce is dedicated but they are also extremely stretched. This proposal will enable the workforce across NCL to be used as 'one workforce', delivering quality maternity and neonatal care across the patch.
2.1.3	The Board then discussed the paper, making the following comments: • The amount of work of work that had taken place in response to a complex challenge and the health inequalities drivers was commended, as was the thoroughness of the CRG's work and the commitment of the participants • It was acknowledged that there will be public concern about perceived service cuts and poor services and therefore the narrative should be strengthened to allay these concerns, while also ensuring that partners are providing a consistent message around the importance of sustainability. It was questioned whether there might be a role for the Non- Executive Members to support any stakeholder engagement • The ICB was urged to begin the consultation as soon as possible to avoid potential future delay, bearing in mind the upcoming Mayoral election and the possibility of a General Election in the coming months • The background provided on the clinical leadership and engagement with service users and the wider public was welcomed, as was the link with national good practice to enhance quality and address health inequalities across the five Boroughs • The detailed interim Integrated Impact Assessment was welcomed. It will be helpful to hear more about the mitigations during the consultation, especially around travel times and costs • It was noted that the Royal Free Board supports the need for consultation and the urgency around this as the current configuration is unsustainable in the longer term. However, it is important not to underestimate how impactful this will be on the local population and the staff affected, which will be amplified by the local communities if it is agreed to go to consultation. If this does go ahead, it will be imperative to keep listening and engage respectfully, ensuring we go into the consultation with an open mind

	• The Royal Free has three specific concerns for consideration:
	  ○ While acknowledging that following the clinically-led process Option A is the preferred option, it is important to highlight that Option B (i.e. retaining and growing services at the Royal Free) is both viable and attractive in its own right and it is therefore imperative that the ICB is seen to reach an objective and fair decision.
	  ○ Irrespective of the final decision that is taken, the Royal Free is concerned about the length of the predicted timescale for the transition of services. Taking into account potential slippage, the full delivery of the programme could eventually take the best part of a decade. This is a long period to sustain services when the very act of going to consultation and making a decision could exacerbate a staff exodus to find greater job security
	  ○ It is therefore recommended that the timeframes for both options are revisited during the consultation period and we challenge ourselves to reduce them or alternatively look at phased delivery. Either option will require significant reconfiguration capital at a time of capital constraints, so there will need to be transparency about trade-offs and ensure that capital goes where need is greatest.
	• It was acknowledged that these points were entirely reasonable and it is vital that the ICB keeps listening, with an open-minded evaluation at the end of the process. The consultation process provides the opportunity for new evidence and information to emerge which might alter the balance of the argument but it would be disingenuous to proceed at present without a preferred option, given the existing weight of evidence. The need to challenge the long timeframe was supported. It is also hoped that the 'one workforce' proposal would provide assurance to whichever staff groups are ultimately affected
	• The careful, thoughtful and collaborative construction of the proposals across a range of professions was welcomed. The clear focus on quality comes through strongly in the pre-consultation business case document and shows the system working together at its best. Nevertheless there are some difficult trade-offs to work through and choosing one option over another will not be straightforward. Work has begun with the Chief Finance Officer community to work through the capital expenditure pipeline to start to build these proposals into it and begin to show the trade-offs.
	• It will be important to ensure that conversations take place with staff about redeployment and other practical mitigations, while also ensuring that everybody is clear on the narrative and the key messages. Going forward, it will be helpful to have more detail about what form the consultation will take, as well as issues such as the impact on adjoining boroughs.
	• It was noted that this represents one of the first significant tests for the ICB around how it takes decisions forward. Sarah Mansuralli and the team were to be commended for the way that they have developed this case
	• It was suggested that a co-ordinated change management approach across providers will be needed once the consultation commences to ensure that staff feel supported. To this end, it will be beneficial to brief trade union colleagues about the consultation
	• The CQC is in the process of reviewing all maternity services nationwide and to date 60% have been found wanting. NCL is not an outlier in this respect, so it will need to think about the implications of this for staff and service users as it moves into a more sustainable future. The excellent work to date on Start Well has generated a wealth of information about the current position which might potentially unsettle people, so it is important to be clear that NCL is on a journey of improvement but this cannot be done by merely patching up what is already in place.
	• Real changes are needed to get to a better future for this generation of staff and service users, which will in turn enable things to be made even better for the next generation, so a narrative is needed around short-term pain leading to long-term gain
	• It was confirmed that UCLH is supportive of the proposal and the Royal Free's position. UCLH recognises that it will have a substantial leadership role from the moment that a decision is made all the way to full implementation to work with and support colleagues systemwide and will engage positively with the consultation.

2.1.4	In response to Board members' comments, Sarah Mansuralli made the following points: • The ICB is acutely aware of the anxiety that the proposed changes are likely to provoke, so the Programme Team and Carnall Farrar have been actively involving staff at every step of the journey. In addition, they have been working closely with Communications leads in each trust and also holding discussions with Chief People Officers, looking at putting mitigations in place to provide comfort and assurance. It is vital not to lose any staff during this process – on the contrary, it is anticipated that moving to four units will strengthen workforce resilience and sustain critical skills and competencies • The ICB will be reviewing the intelligence and feedback gathered during the consultation to see how issues can be mitigated. Where appropriate this will be done in collaboration with other ICBs. This will also enable NCL to offer more meaningful patient choice • Residents are often not aware of the existing forms of transport support and it is anticipated that the consultation will help to promote support which is already available • The appetite among Board Members to accelerate the process was acknowledged.
2.1.5	The Board of Members: • **APPROVED** the pre-consultation business cases • **AGREED** to launch a consultation on the proposed options for consultation contained within the pre consultation business cases on 11 December 2023 for 14 weeks, noting the consultation plan within the pre-consultation business cases.
3.	**ANY OTHER BUSINESS**
3.1	There was no other business.
4.	**DATE OF NEXT MEETING**
4.1	26 March 2024.

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
26 March 2024 - Action Log

On Agenda	
Needs Urgent Update	
In Progress	
Completed	

Meeting Date	Action Number	Action	Lead	Deadline	Update
25 July 2023	17	**Governance Report Paragraph 4.1.6** To meet to discuss how best to map Committee responsibilities to minimise any overlap.	Committee Chairs	November 2023	The Committee Chairs met on 14 November 2023 to discuss this.
Met 7 November 2023	18	**National Delivery Plan for Recovering Access to Primary Care – NCL approach Paragraph 2.1.5** To arrange for an in-depth discussion of the issues raised to take place at a future Primary Care Committee meeting before a follow-up paper is brought back to the Board in due course.	Usman Khan	March 2024	The Primary Care Committee discussed the progress against the National Delivery Plan for Recovering Access to Primary Care at its meeting on 20 February 2024, building on the previous discussion at the November Board Meeting. Areas flagged by the Board have been embedded in the NCL programme of work. An update on progress against the Delivery Plan is on today's agenda.

7 November 2023	19	**Mental Health Update Paragraph 2.1.5** To lead a discussion on Mental Health at a future Board Seminar, building on the discussion at today's meeting.	Jinjer Kandola	December 2024	This will form part of the discussion around the progress made in the system to implement both the Mental Health and Community Services core offers at our Board Seminar in December 2024.
7 November 2023	20	**Update to Governance Arrangements Paragraph 4.1.4** To circulate to Board Members a summary of the ICB Procurement Policy and its approach to procurement.	Sarah Mansuralli	May 2024	The Procurement Policy is in the process of being reviewed. Once it has been finalised and approved, the updated policy will be circulated to Board members, along with a summary of the ICB's approach to procurement.

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
26 March 2024

Report Title	Chief Executive's Report	**Date of report**	11 March 2024	**Agenda Item**	1.6
Lead Director / Manager	Not applicable.	**Email / Tel**		Not applicable.	
Board Member Sponsor	Phill Wells Interim Chief Executive, NCL ICB				
Report Author	Phill Wells Interim Chief Executive, NCL ICB	**Email / Tel**		Phill.wells@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Not applicable.			
Report Summary	The Chief Executive's Report shares highlights from the work of the ICB and its partners and key issues for the Board of Members' consideration that are not covered elsewhere on the agenda.				
Recommendation	The Board of Members is asked to **NOTE** the Report.				
Identified Risks and Risk Management Actions	Where applicable, any risks are identified within the report.				
Conflicts of Interest	There are no conflicts of interest arising from this report.				
Resource Implications	There are no direct resource implications arising from this report, although areas described have resource implications for the ICB.				
Engagement	Engagement activities are highlighted as appropriate.				
Equality Impact Analysis	There are no equality impacts arising from this report.				
Report History and Key Decisions	This report is a standing item on the agenda of Board of Members meetings.				
Next Steps	None.				
Appendices	None.				

1. Introduction

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

2. Start Well public consultation

2.1 The 14-week Start Well consultation which was jointly run by NHS North Central London (NCL) Integrated Care Board, and NHS England (London) Specialised Commissioning closed on Sunday 17 March 2024. The Start Well programme aims to improve experience, access, and outcomes in maternity, neonatal and children's services provided across North Central London hospitals.

2.2 The proposals for consultation have been developed over the past two years and informed by doctors, midwives, nurses, and other health professionals, working together with families with experience of maternity, neonatal, and children's surgical services. The consultation sought feedback on proposals relating to how and where maternity, neonatal, and children's surgical services could be provided in North Central London.

2.3 I want to emphasise that no decision has been made as yet and we have undertaken this consultation with an open mind. If the Board is asked to take a decision on a preferred way forward through a decision-making business case (DMBC), it will be much later this year, and it would be some years beyond that before any agreed changes would be implemented. In the meantime, all services will continue to run as normal.

2.4 I would like to thank the hundreds of staff, stakeholders and local residents who have taken the time to share their views with us about how the proposals could impact local families, services and staff. The Start Well team have attended over one hundred and fifty meetings and events, including detailed focus groups, and we have reached many more people through activity on social media, local papers and through community and via community groups. During the consultation we have heard from thousands of people across North Central London and beyond.

2.5 We are going to publish a full activity report that sets out the range of ways we have engaged with staff patients and residents. We will share this with the Board and over the summer with the JHOSC to help inform their response to the consultation.

2.6 All the responses are now being analysed by an independent research provider, ORS, and we will then – with system partners across the ICS – need to think through how to respond to the feedback and themes we have heard from our residents.

3. Launch of North Central London Outcomes Framework Dashboard

3.1 On 9 February 2024 North Central London (NCL) launched an online dashboard for the Integrated Care System's (ICS) Outcomes Framework. The dashboard is hosted on the NCL ICS website and can be found here.

3.2 The NCL Outcomes Framework sets out an agreed set of outcomes the ICS wants to achieve for patients and residents in NCL. The outcomes were selected in consultation with system and borough partners and based on needs identified within borough Joint Strategic Needs Assessments and priorities in Joint Health and Wellbeing Strategies, alongside a high-level NCL-wide needs assessment.

3.3 The NCL Outcomes Framework supports delivery of the NCL Population Health and Integrated Care Strategy . It is designed as a tool to help understand opportunities to improve, and reduce variation in outcomes across NCL. The framework can also help identify areas where greater focus and investment may be required and will be used to monitor progress in achievement against these outcomes over time.

3.4 Each outcome is linked to a set of indicators across the life course domains of 'start well, live well and age well'. The dashboard provides the most recent data for each of these indicators at borough and NCL level, compared to London and England, along with recent historic data.

3.5 The data on the dashboard will be updated at regular intervals, with a full review and insights report produced on an annual basis to inform service planning and priority setting.

4. System Financial Position Update

4.1 NCL ICS reported a Year to Date (YTD) deficit of £71.7m at Month 10 which is adverse to plan by £35.7m. £15.5m of this is driven by industrial action and the remainder relates to under-delivery of efficiency programmes which is likely to impact on the underlying positions of Trusts.

4.2 The forecast out-turn (FOT) for the NCL system at month 10 is a deficit of £15.5m, all driven by industrial action. This is fully funded in month 11 and the risk around industrial action is therefore mitigated. The two remaining risks to achieving a breakeven are around providers being able to offset their current deficits with the non-recurrent items and there being no further cost pressures or under delivery of Elective Recovery Fund (ERF). The ICB will continue to work closely with partners to manage this.

4.3 NCL are one of only two systems in London to report a forecast breakeven position. The delivery of this forecast means that the previous CCG debt will be written off.

5. ICB Organisational Change Programme

5.1 The ICB continues to manage our Organisational Change Programme and the majority of roles in the new structure have now been filled via internal processes in accordance with the ICB's Change Management Policy.

5.2 As part of the Organisational Change Programme, we were pleased to be able to offer staff the option of voluntary redundancy following approval from NHS England and by the end of March, all colleagues who had opted to leave under this Scheme will have left the ICB. We thank everyone who has opted to leave for their hard work and commitment during their time working for the ICB. At this stage, c90% of staff know their future position in the organisation. We are currently in stage 3 of suitable alternative employment (SAE) with most staff applying for roles within the ICB. Our aim is to minimise compulsory redundancy as far as possible, and to support those staff who are at risk of redundancy to secure suitable alternative employment in the ICB or with another NHS organisation.

5.3 The ICB will be moving to our new organisational structure from 1 April. The new structure will enable the delivery of four key outcomes:

- successful delivery of our Population Health Improvement Strategy
- a system that is high performing and leverages individual and extraordinary strengths of our people, providers, and partners across NCL
- an environment where everyone can thrive at work, through fulfilling roles, career progression opportunities, and a supportive and effective working environment
- a streamlined and efficient organisation with resources focused on those areas that matter the most.

We are also on track to deliver on the RCA reduction for both 2024/25 and 2025/26.

5.4 Our transition to the new structure involves a focus on the implementation of the two remaining workstreams within the change programme - OD and Ways of Working. These workstreams will start to develop the culture, values and behaviours that will go some way to improving the staff experience of working in our organisation. One of our key principles is high performing teams are the building blocks of the organisation. From mid-March through to the summer, each of our c55 teams will be going through our high performing teams programme as intact teams, including bringing interdependent teams together where possible. We will also be launching our leadership development programme for our senior leadership team (direct reports to the Executive Team) at the end of March. This is to enable and equip our leaders for our collective leadership challenge at a personal, organisational and system level. At the end of April, we will bring all staff together

at our first all staff away day since before we launched the change programme, to focus on the vision, our priorities, and the way we need to work together both within our organisation and the system to deliver our ambitions for our residents and patients. The Ways of Working programme is well underway, introducing more automation for routine processes, and developing an annual business cycle. Taken together, we anticipate these elements will accelerate our progress towards making NCL a great place to live and work.

6. Wood Green Community Diagnostic Centre – expanded range of services

6.1 Community Diagnostic Centres (CDCs) help people to access diagnostic tests in the community, closer to where they live, rather than needing to go to an acute hospital site. They have been set up to provide much needed additional capacity and are strategically located so as to have the biggest possible impact on health outcomes and inequalities, while providing a more efficient and better patient experience.

6.2 NCL's Wood Green CDC is an entirely new NHS centre, based in converted shop units in The Mall, a busy shopping centre in Haringey. It is closer than neighbouring acute hospitals for 30 out of 40 GP practices in the borough.

6.3 The centre opened in August 2022, offering blood tests, x-ray, ultrasound, and ophthalmology services. In December 2023, an additional floor was opened, enabling the centre to also provide MRI and CT diagnostic testing.

6.4 As of end January 2024, Wood Green CDC has delivered nearly 77,000 tests. Through engagement with local communities and GPs, the centre has achieved its core ambition of improving access for our most deprived communities: 77% of people seen live in the three areas of greatest deprivation in Haringey.

7. Special Educational Needs (SEND) Update

7.1 Between 29 January and 2 February 2024 there was an area inspection for Haringey of Special Educational Needs and/or Disability (SEND) arrangements. This is part of a comprehensive review being undertaken jointly by the Care Quality Commission (CQC) and OFSTED exploring how the area meets the needs of children with SEND. Through the process, the inspectors engage with a wide range of parents, children and young people and professionals. The inspection experience was positive and constructive and the ICB would like to extend its thanks to both the health professionals and to the range of parents, carers and young people who took part. We look forward to updating on the outcome in the next CEO Report, by which time the report will be published.

8. Dental Services Update

8.1 NCL ICB took on responsibility from NHS England for Dental Services in April 2023 as part of the overall delegation of responsibility of the DOP Services (Dental, Community Optometry and Community Pharmacy). The commissioning responsibility for Dental Services includes Primary Dental Services as well as Community and Secondary (Hospital Based) dental care for patients. Key responsibilities were retained by NHS England with regard to the General Dental Contract (GDC), which limits the changes we can introduce locally.

8.2 Since delegation to the ICB in April, we have undertaken a deep dive into dental services and identified areas for improvement as well as key strategic initiatives already in place that we would want to continue to support given the transference of commissioning responsibility. This has led to securing additional funding to invest in key areas that will benefit our population, such as:

- increasing investment in supporting those experiencing homelessness (including rough sleepers and asylum seekers) and ensuring there is a consistent offer across North Central London

- reducing waiting times for children and young people who need more intense support than can be provided in primary dental services, providing access to support for those within care settings (focusing initially on those in residential care)
- seeking to expand the work already undertaken to grow the skills of primary dental clinicians to enable them to undertake more complex care for patients
- targeted investments to increase the capacity for patients to be seen within primary dental services as well as incentivising general dental practitioners to hit and exceed their activity targets.

8.3 Alongside this, we have continued our commitment to ensuring everyone in London who is in acute dental pain has access to support via 111, often being seen the same day. We have also committed to continue the work already underway to expand the number of child friendly dental practices. To progress our shared commitment with Local Authority partners, we have restarted initiatives aimed at providing all parents and children with access to advice and support to improve oral health, while increasing the investment made into oral health promotion.

8.4 Plans for 2024/25 include embedding the transformational changes we have committed to already and seeking to expand the support for those in care settings, In the short time we have been responsible for delegated services, we have made positive progress in addressing some of the known challenges and inequalities of access with regard to dental services in North Central London.

9. AT Medics Update

9.1 On 30 November 2023, AT Medics Ltd wrote to London ICBs advising that Centene Corporation are proposing to sell their UK General Practice business to T20 Osprey Midco Limited (HCRG Care Group). AT Medics Ltd provides General Practice services across London and England. In NCL, AT Medics holds 8 GP contracts (across Camden, Haringey and Islington) including the Camden Extended Access Hubs. AT Medics Ltd was acquired by Operose Health Ltd in 2021, who are ultimately owned by Centene Corporation. Due to a clause in the Alternative Provider of Medical Services (APMS) contract, the contract holder must first obtain consent from the commissioner before undergoing a change of control.

9.2 There are clear procedures and governance processes to follow and a robust due diligence and assurance process is being undertaken. This covers areas such as financial standing, ownership model, company structures and governance, handling of patient data, proposed staffing and management changes and evidence of engagement with patients. When considering whether or not to grant consent, NHS NCL ICB is required to act reasonably, fairly and in accordance with its legal duties.

9.3 We have communicated this request to patients, stakeholders and the wider public. We held a Webinar on 29 February and there is a live survey and FAQs on the ICB website. Information is being shared via multiple channels to give people the opportunity to ask questions and inform the due diligence and assurance process. The decision whether or not to consent to the change of control will be made at a meeting in public of the ICB's Primary Care Committee which provides oversight, scrutiny and decision making for primary medical services. We expect to take this decision in Summer.

9.4 Irrespective of the outcome, we will monitor the quality and performance of services on an ongoing basis. The ICB monitors primary medical services via appointment data, workforce data, clinical quality data, patient feedback and a range of other indicators. We ensure services meet NHS standards and regulations using the levers we have as commissioner and working closely with NHS England and the Care Quality Commission as the regulator.

9.5 We will keep the Board appraised of progress.

Phill Wells
Interim Chief Executive

11 March 2024

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
26 March 2024

Report Title	NCL Delivery Planning (Population Health & Integrated Care Strategy)	**Date of report**	8 March 2024	**Agenda Item**	2.1
Lead Director / Manager	Sarah Mansuralli – Deputy Chief Executive and Chief Strategy & Population Health Officer	**Email / Tel**		sarah.mansuralli@nhs.net	
Board Member Sponsor	Sarah Mansuralli – Deputy Chief Executive and Chief Strategy & Population Health Officer				
Report Author	Penny Mitchell Ruth Donaldson Sarah D'Souza	**Email / Tel**		penny.mitchell3@nhs.net ruth.donaldson1@nhs.net sarahd'souza@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Not applicable.			
Report Summary	The NCL Population Health & Integrated Care (PH & IC) Strategy was endorsed by system partners in April 2023 following a significant programme of engagement and co-production. Since April, significant work has been undertaken: • Engaging and socialising • Building the action plans for system transformation programmes • Developing and mapping local priorities in Borough Partnerships • Developing the NCL Outcomes Framework Population health improvement is embedded in everything we will do so this Delivery Plan sets out our critical path to achieve this. This document, following final design input, will serve as our Joint Forward Plan submission to NHS England. Work is also ongoing to progress development of other resident-friendly products to support the communication of work the ICB and partners are doing to improve population health				
Recommendation	The Board of Members is asked to: • **ENDORSE** the NCL Delivery Plan which will act as our Joint Forward Plan • **NOTE** the development of other resident-friendly products to support the communication of work the ICB and partners are doing to improve population health				

	• **SUPPORT** the prioritisation of the work set out in the NCL Delivery Plan through 2024/25.
Identified Risks and Risk Management Actions	There are risks associated with not developing a sustainable approach to population health improvement and a long term planning focus on improved outcomes for residents. This strategy and delivery plan seek to address future sustainability of health and care services through more integrated, preventative and proactive care.
Conflicts of Interest	Not applicable.
Resource Implications	This document outlines priorities in order to focus on population health improvement therefore this will have implications on how we work across all directorates and areas.
Engagement	In line with the system-ownership of the strategy, engagement has been central to progressing delivery planning since endorsement. This includes engaging with: • Integrated Care Partnership Board • Health and Wellbeing Boards • Borough Partnership Boards • Provider Boards • VCSE Alliance • Programme leads across NCL (E.g. Cancer Alliance, Inequalities Fund, Start Well) • Community Partnership Forum.
Equality Impact Analysis	Not applicable.
Report History and Key Decisions	The Population Health and Integrated Care Strategy was taken to the NCL ICB Board of Members meeting on 28 March 2023 asking members to note content and provide feedback. The Population Health and Integrated Care Strategy was taken to the NCL ICP meeting on 18 April 2023 asking members to endorse the strategy and discuss the proposed approach to delivery. Significant content and updates regarding elements of the plan, such as system transformation programmes plans and BP plans, have been discussed at system forums including the PHI Steering Group, PHI Committee, ICP Board, and a discussion with BP Chairs.
Next Steps	• Finalise content and work with a design agency to finalise presentation of the plan. • Continue development of other resident-friendly products to support the communication of work the ICB and partners are doing to improve population health • Work will continue regarding monitoring arrangements via the **NCL Outcomes Framework,** including development of the insight report.
Appendices	Not applicable.

North Central London Integrated Care System

North Central London Delivery Plan – implementing the NCL Population Health & Integrated Care Strategy

Reflecting on the last 12 months and looking 18 months ahead

March 2024

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North Central London Integrated Care System

North Central London Integrated Care System

Context

About this document

North Central London Integrated Care System

‘Our ambition is to work with residents of all ages of North Central London so they can have the best start in life, live more years in good physical and mental health in a sustainable environment, to age within a connected and supportive community and to have a dignified death.’

Photo to be added by designer

About this document

North Central London Integrated Care System

- The NCL Population Health & Integrated Care (PH & IC) Strategy was endorsed by system partners in April 2023 following a significant programme of engagement and co-production. The Strategy can be found here.

- Since April, significant work has been undertaken:

    - **Engaging and socialising**
    - **Building the action plans for system transformation programmes**
    - **Developing and mapping local priorities in Borough Partnerships**
    - **Developing the NCL Outcomes Framework and launching the online dashboard to support monitoring –** *the dashboard can be found here.*

- Population health improvement is embedded in everything we will do so – this document sets out our critical path to achieve this. It is a live document that will change over time as we refine our ambitions.

Photo to be added by designer

Strategy Delivery Areas

North Central London Integrated Care System

Our five key health risk areas where we can create the biggest impact in NCL.

The 20% most deprived communities in NCL.

Our adult NCL communities who experience greater health inequalities and poorest outcomes.

Our child and young people (CYP) NCL communities who experience greater health inequalities and poorest outcomes.

Focusing on the root causes of poor health.

- Inclusion Health Groups
- Select Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities
- Adults with severe mental illness and adults with learning disabilities
- Family carers
- Older adults with care and support needs
- Supporting residents at risk of hospital admission
- Supporting residents to recover following hospital admissions

- Children with Special Educational Needs and Disabilities (SEND)
- Children Looked After (CLA) and care leavers.
- Select Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities
- Continuing Care for Children and Young People
- Safeguarding arrangements for designated doctors and nurses for Children and Young

- Childhood immunisations
- Heart Health
- Cancer
- Lung Health
- Mental Health and Wellbeing across all ages

North Central London Integrated Care System

Progress to date

Delivery since April 2023

Key Communities Progress – Adults and Children

North Central London Integrated Care System

- £5m investment to address inequalities experienced by 20% most **deprived communities** working with communities and VCSE focused on areas of greatest disparity in outcomes
- £1m system investment in multi-agency, integrated support for people experiencing **homelessness**
- **Inclusion Health** needs assessment completed which has been identified as an example of good practice in national guidance
- 14,000 adults with **Severe Mental Illness** will have a specified physical health check in 23/24
- Equitable expansion of community **chronic kidney disease** service now offered by all practices in NCL
- Supporting care home staff through **staff wellbeing bus** where high levels of hypertension and diabetes risk identified and navigated to right care setting.

- Improved **vaccination** uptake (1 year) by 5% between January 22 and January 24
- Free prescriptions for NCL **care leavers** launching in spring 2024.
- Inequalities funding directed to **Children & Young People in most deprived areas** for empowerment, mentoring and reduction in serious youth violence schemes.
- Additional **Mental Health Support** Teams - 257 schools supported by 14 teams in 2024/25.
- Invested in capacity in **eating disorders** services to meet an increase in demand improving performance significantly.
- Over £1m invested in **Children's Therapies** backlog so that 5,591 initial assessments provided in SLT and OT, reducing the number waiting for initial assessment
- **Parentcraft** courses contributing to a 24% reduction in ED attendances for under 5s in one local hospital.

**Slide 26 of our PH & IC Strategy introduces our Delivery Areas which are areas we want to focus on and where we can make the greatest impact.*

Population Health Risks Progress

North Central London Integrated Care System

- **Tobacco** dependence teams established in all acute and mental health trusts leading to an increase in number of staff members in the trust trained regarding having conversations on smoking cessation and an increase in referrals to the community stop smoking services
- Improved the uptake of Targeted **Lung Health** Checks from 30% to 55%. Over 20,000 people have now had a lung health check
- Across three NCL trusts in Q3 2023/24, 942 people were identified as being at high risk of **liver cancer** and of those, 397 received a routine ultrasound
- Worked with the Voluntary, Community and Social Enterprise (VCSE) sector, including those representing the Bangladeshi, Jewish and Somali populations to improve uptake of **childhood immunisations** in those groups.
- Invested in a range of hyperlocal schemes to encourage **healthy weight** informed by Community Participatory Research [insert link to EVA film]

Photo to be added by designer

**Slide 26 of our PH & IC Strategy introduces our Delivery Areas which are areas we want to focus on and where we can make the greatest impact.*

System Transformation Programmes Progress

North Central London Integrated Care System

NCL has a number of system transformation programmes, which have a strong focus on population health improvement and which use core population health approaches. This includes risk stratification and targeting support using our population health management platform HealthEintent, co-production with most impacted communities, alignment with **Core20plus5** priorities and ensuring services are equitable.

- **Long Term Conditions Locally Commissioned Service** rolled out with resource aligned to need through additional deprivation weighting
- **Community Services** – shifted resource to areas of highest need – including recruitment of 60 additional front-line staff and 48% increase in virtual ward capacity
- **Mental Health -** increased workforce by 6.4% in 22/23 with a further 4% increase in 2023/24. Over 21,000 people will access our transformed adult community mental health services in 2023/24
- **Diagnostics** – established two Community Diagnostic Hubs in areas of high need, with best diagnostic waiting times in the country in Dec 2023
- **Start Well** – clinically developed proposals to improve access, experience and outcomes associated with maternity and neonatal care as well as emergency surgical pathways for very small babies that has benefited from a comprehensive consultation programme with >150 community events

We are also working across our wider system programmes to ensure that a population health approach is embedded within each and maximising impact on health, inequalities, integration and the shift toward prevention. This includes **Digital Strategy** focus on digital inclusion, **Urgent and Emergency Care** utilisation linked to deprivation, improving end to end pathway outcomes through **Specialist Commissioning**, equitable **Elective Recovery**, hyperlocal care through **Primary Care Transformation,** and addressing outcomes, our work on the **Women's health strategy** and considering in reports such as **Child Death Oversight.**

Photo to be added by designer

**Slide 27 of our PH & IC Strategy flags that our inflight programmes of work in NCL are the foundations for population health improvement.*

Levers for Change Progress

North Central London Integrated Care System

- **Making population health everyone's business**
- **Strengthening integrated delivery**
- **Collaborating to tackle the root causes of poor health**
- **Aligning resources to need**
- **Becoming a learning system**
- **Creating 'one workforce'**

- Supported system partners to launch the **NCL Health and Social Care Academy**, supporting over 150 residents into work with a focus on supporting those with barriers to employment.
- Secured national funding to establish a **Research Engagement Network** (REN) which has developed relationships between the ICB and academic and VCSE partners. Delivered 20 community engagement events working with our black and Gypsy Roma Traveller communities to co-ordinate research and improve diversity in research.
- Launched the **ethnicity dashboard** and refined data system to focus on most underserved communities.
- Met the reduction target in **inhaler emissions** in Q3 as part of our Green NHS plan.
- Delivered our **Communities and VCSE strategies** – community voice now key part of governance structures and service delivery
- Began implementing the year 1 delivery plan of our **People Strategy**, 'Laying the foundations'
- Collaboration across system to address impact of **cost of living** through provision of advice and support to staff, patients and residents.
- Development of the Outcomes Framework and launching the online dashboard to support monitoring

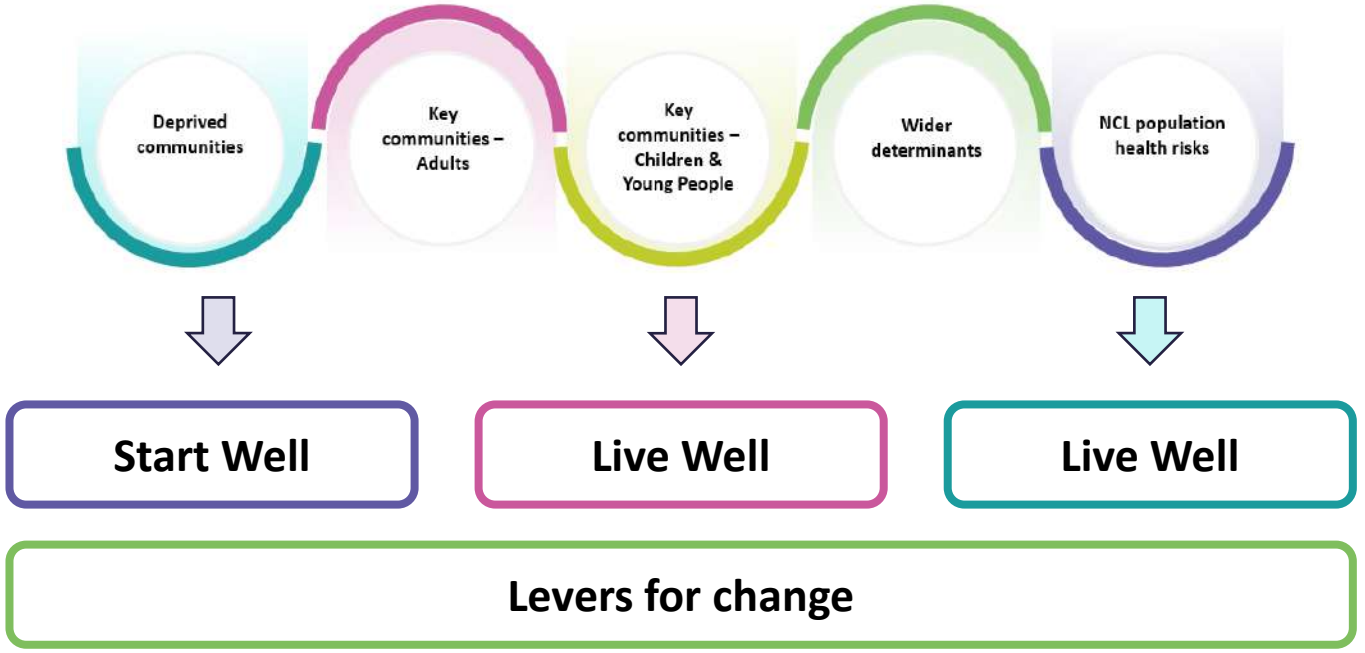
**As outlined in slide 36 of our PH & IC Strategy, in order to drive progress on our delivery areas, we have identified ICS levers for change which will create the context and conditions for sustainable delivery.*

North Central London Integrated Care System

Our next 18 months

Headline plans for further progress

In our delivery plan we have combined our focus on key communities and population health risks with improving health outcomes across the life course. Levers for change are enablers which underpin our programme of work over the coming months



Next Steps – Start Well

Area of focus is shaded to demonstrate alignment to key communities and pop health risks

North Central London Integrated Care System

Area of focus	Starting position – April 2024	Priorities for the next 18 months	Where we are aiming to get to
Start Well	• Challenges associated with outcomes for deprived populations, location, declining birthrate and increasing complexity & specialist staffing in maternity and neonatal care	• Finalising the proposals for maternity and neonatal services, and children's surgical services following public consultation • Delivery of maternity and neonatal equity and equality plan via LMNS and key focus on service use experience	• Ensure equity in access and outcomes from hospital based maternity, neonatal and CYP care.
Children Looked After (CLA) and care leavers.	• Care leavers experience poorer health outcomes than other young people. • The homeless population has significant levels of people with experience of care.	• Understanding delivery of key areas identified through the London Care Leavers Compact. • Work with NCL Directors of Children's services to improve access to effective emotional, psychological, and physical health and wellbeing support for care leavers	• Implementation of free prescriptions programme • Scoping further support to address health needs such as dental care • Internship opportunities
Special Educational Needs and Disabilities (SEND)*	• High levels of need and delays on assessments • CYP wait much longer than NICE guidance for CYP Autism diagnosis.	• Develop a network of learning across Special Educational Needs & Disability and Alternative Provision programme • Improvement of care pathway for Children & Young People with neuro-developmental needs	• Significant reduction in waiting times for therapy and NDD assessments
Childhood immunisations*	• Entrenched health inequalities, and impact of post-pandemic on immunisation rates in NCL. Particular challenges re MMR uptake.	• Increase routine childhood immunisation vaccine uptake with a focus on most deprived communities and communities with lowest uptake.	• Target 3-5% increase in childhood vaccination by focusing on areas of greatest disparity.
Family help in early years*	• Identified as an ICP priority	• ICP consideration of priorities in April 2024	• Aspiration in line with ICP recommendations
Children's Mental Health	• Significant differences in early help and prevention in NCL for CYP MH • High levels of need and delays in assessments	• Serious Youth Violence Vanguard • Implementing the THRIVE model • Enhancing support for Children & Young People by development of our online CAMHS waiting room	• Reduction in variation of provision between boroughs • Improvements in waiting times for assessment

**ICP Priority Area*

Next Steps – Live Well

Area of focus is shaded to demonstrate alignment to key communities and pop health risks

North Central London

Area of focus	Starting position – April 2024	Priorities for the next 18 months	Where we are aiming to get to
Inclusion Health	• Differential community health services, lack of integration with wider services and lack of skills in mainstream	• Develop equitable integrated MDT physical and mental health community offer for people experiencing homelessness in all boroughs in line with needs. • Improve mainstream offer that is trauma informed	• Improve healthcare equity, access, experience and outcomes for people in inclusion health groups across boroughs.
Community Services	• Limited access to diagnostics in some geographies/some conditions • Inequitable community service offer across boroughs.	• Community Services Review implementation 2024/25 • Reduce growth of liver disease diagnosis through Community Diagnostics Centres • Increased capacity of diagnostics at Wood Green	• Increased investment according to need • Increased Diagnostic Capacity whilst tackling health inequalities including through rapid cancer diagnostics and new Fibroscan
Prevention and wider determinants	• Differential prevention offer across NCL • Lack of employment impacting health	• Develop sustainable and equitable core offer across smoking cessation , alcohol and weight management services. • Implement work well programme	• Long Term Plan tobacco offer fully implemented • Enhanced employment opportunities
Heart Health*	• Challenges in case-finding, treatment and management of lifestyle risk factors for high blood pressure, but also from an inequalities lens when looking across communities.	• Develop borough-based action plans to support identification and management of high blood pressure	• Close our high blood pressure prevalence gap and to treat people with high blood pressure to target, while tackling inequalities in NCL.
Mental Health/Learning Disability & Autism*	• Residents who have an SMI die on average 14.9 years earlier if they are female, 18.4 years if they are male. • Inequitable community mental health service offer	• Longer Lives – supporting better physical health for residents with SMI • Improving home treatment for people in crisis and strengthening proactive community support at home • Strengthen diagnostic and support services for residents with LD & Autism	• Reduce premature death of NCL residents with SMI due to preventable conditions. • Ensure there is an equitable, consistent and high-quality service offer available to all NCL residents. • Further reduce reliance on inpatient care for LD & A residents
Cancer	• Participation in screening varies across boroughs and communities	• Promote and enable engagement with primary care, focussing on actions that support earlier diagnosis plan	• Contribute towards achieving the diagnosis of 75% of cancers at stage 1 and 2.
MSK Live Well Review	• Rising demand that outstrips current capacity alongside increasingly complex patient needs and inequity in funding across our services.	• A minimum MSK community services offer, including digital self-management and self-referral	• Ensure quality MSK care for all, best possible MSK outcomes for all, and sustainable, continuously improving care

**ICP Priority Area*

Next Steps – Age Well

Area of focus is shaded to demonstrate alignment to key communities and pop health risks

North Central London Integrated Care System

Area of focus	Starting position – April 2024	Priorities for the next 18 months	Where we are aiming to get to
Long Term Conditions	• Launched with 100% of GP Practices signed up	• Embedding outcomes incentivisation and case finding to reduce prevalence gap	• A single Locally Commissioned Service for Long Term Conditions focussed on proactive and personalised care.
Proactive Care	• Commitment to developing the ICB's approach to and functionality around Proactive Care and LTCs	• Develop the vision, aims and case for a proactive care function and design an approach to this function that optimises resources, skills and assets in NCL	• Patients and Residents diagnosed earlier, treated to target in a biopsychosocial model with coordination, continuity and digital support to be more empowered and active in their care
Carers	• Family carers have poorer health and wellbeing outcomes and are disproportionately impacted by the cost of living crisis	• Borough based development and delivery of carer strategies.	• Ensure carers receive proportional support required to improve outcomes
Older adults with care and support needs	• Reducing numbers of care providers, variations in care and the need to support digital and tech infrastructure	• Continue to implement Enhanced Health in Care Homes programme • Progress joint market management arrangements for care homes, drawing on the particular strengths the NHS and Councils can bring.	• Equitable offer across care provision • Joint working to stabilise and develop care market offer in NCL
Supporting residents at risk of hospital admission*	• Significant challenges on hospital flow with focus on downstream activities • Our most deprived communities experience increased admission levels of 20-30% than the general population	• Further develop the admissions avoidance framework and utilise as tool to develop system and place plans/build admission avoidance approaches across key programmes	• Improve join up and effectiveness of downstream activities whilst shifting focus upstream and on prevention
Supporting residents to recover following hospital admissions	• Broad range of services in NCL ICS which help people to recover from hospital admission • Opportunities for further integration and consistency across the ICS	• Embedding a shared core offer of discharge services and pathways between partners • Improved understanding of outcomes, with particular focus on population health • Focus on 'home first' – helping people recover at home	• Proactive, recovery oriented, services between partners, aligned to need • Shared evidence of improving long term outcomes • Helping more people get 'home first'

**ICP Priority Area*

Next steps – Levers for Change

North Central London Integrated Care System

- **Making population health everyone's business**
- **Strengthening integrated delivery**
- **Collaborating to tackle the root causes of poor health**
- **Aligning resources to need**
- **Becoming a learning system**
- **Creating 'one workforce'**

- Incorporate plans into ICB business planning processes and those of wider system partners so this is a **golden thread** throughout all that we do.
- Develop and implement **population health and health inequalities training programme**, building on training already delivered and hold system wide Equity Summit.
- Develop **Neighbourhood Teams** as core integrated population health management delivery vehicles.
- Extend the impact of **Inequalities Fund** schemes in areas of greatest deprivation using this as a vehicle for attracting shared investment funding and building evidence base.
- Embed approach to **aligning resource to need** across investment activity and decision making.
- Implement **VCSE Strategy** developing a shared approach to investment in this sector across Council and ICB commissioning, supporting **prevention** agenda.
- Strong and ongoing engagement of Borough Partnerships in the identification of local gaps against the **Community and Mental Health Services core offer** and design and prioritisation of investment recommendations to address these.
- Develop **NCL Research Strategy** with the aim of increasing quality, quantity and depth of research undertaken across NCL. Evaluate **Research Engagement Network** (REN)
- Take forward **People Strategy** and **Work Well programme** (subject to outcome of bid)
- Revise **Population Health governance** to reflect focus on delivery phase.

**As outlined in slide 36 of our PH & IC Strategy, in order to drive progress on our delivery areas, we have identified ICS levers for change which will create the context and conditions for sustainable delivery.*

Next Steps – Borough Partnerships

North Central London Integrated Care System

Borough Partnerships and integrated working are core to the successful implementation of our delivery plan. Significant focus will be on supporting and enabling that delivery building on significant work to date.

Next steps for Borough Partnerships include:

- Refine plans and priorities for the coming 18 months so that each borough has a **clear focused local programme of work** aligned with the Delivery Plan.
- Align project monitoring to indicators and outcomes in the NCL Outcomes Framework and develop and embed use of **borough dashboards.**
- Agree how to drive systematic **cross-borough learning**.
- Deepen work to drive impact and align resources to 'supercharge' on a **tighter set of priorities**.

**As outlined in slide 19 of our PH & IC Strategy, we will deliver on our vision for NCL by working across three levels of the system.*

North Central London Integrated Care System

Monitoring and oversight

Our Outcomes Framework

Our NCL Outcomes Framework

North Central London Integrated Care System

Vision

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

Start well

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

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

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

- Early identification and proactive support for mental health conditions
- Reduced prevalence of children and young people who are overweight or obese
- Improved outcomes for children with long term conditions
- Children have improved oral health

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

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

Live well

Early identification and improved care for people with mental health conditions

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

Reduced early deaths from cancer, cardiovascular disease and respiratory disease

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

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

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

Age well

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

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

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

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

**Slide 16 of the PH & IC Strategy outlines that we have developed a population health outcomes framework that reflects where we have significant local disparities across the life course.*

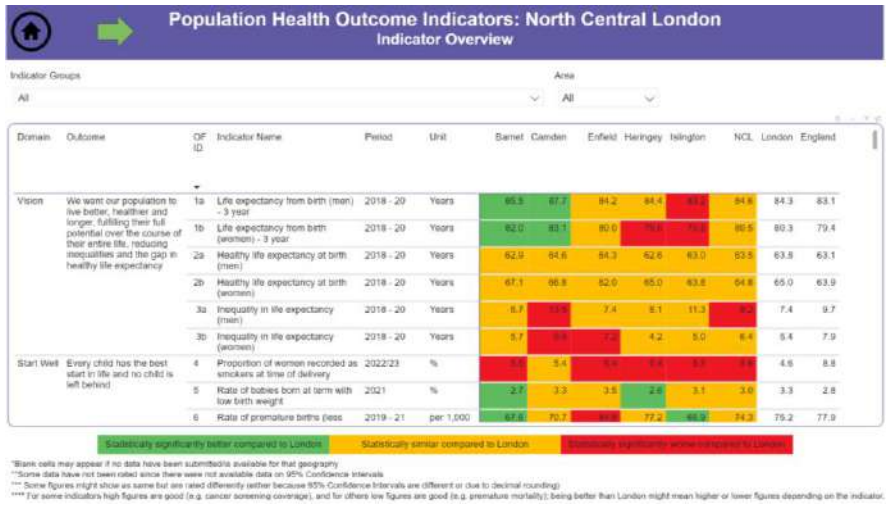
Developing the NCL Outcomes Framework

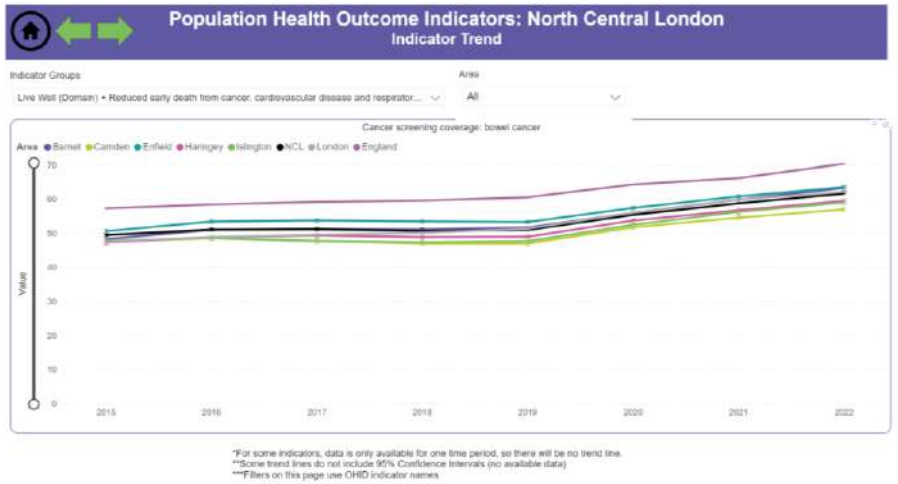
North Central London Integrated Care System

Further development of the NCL Outcomes Framework planned for the next 18 months:

- Review and refresh the full data across all indicators in the Outcomes Framework on an annual basis and produce an insight report to go alongside this
- Update data in the dashboard at more regular intervals (where available)
- Work with Borough Partnerships to design and develop borough-level outcome and performance dashboards
- Embed awareness and use of the framework across teams within the ICB, and the wider system, through training and communications
- Continue to review the range of indicators to ensure it remains relevant and aligned to emerging priorities
- **Ensure improving equity remains at the heart of everything we do**

Views of the NCL Outcomes Framework online dashboard





North Central London Integrated Care System

Appendices

- Financial monitoring
- Glossary

Work is ongoing to ensure we are discharging NHS financial duties

North Central London Integrated Care System

- We are currently working on the NHS system financial plan for 24/25 and we are aiming to set a plan that meets all the financial standards expected of us.
- With regard to the revenue plan, we are working towards a system break-even plan for 24/25, but we know that this will be challenging to agree and to deliver.
- We will set a 24/25 capital expenditure plan within the capital resource limit. This will also be a challenge to agree with NHS system partners, as the local requirement will exceed the available funding.
- We also recognise there are financial challenges for non-NHS partners such as Local Authorities and VCSE, therefore working together will be important.

NHS Rule	Meaning for our NHS system	23/24	24/25
Duties to break even / achieve financial balance	Objective to breakeven - i.e. duty to seek to achieve objective of system financial balance.	We are expecting to achieve all of these financial targets in 2023/24.	Work in progress towards a break-even plan for revenue.
Capital resource limit	Collective duty to act with a view to ensuring that the capital resource use limit set by NHS England is not exceeded.		We are expecting to achieve all of these financial targets in 2024/25.
Mental Health Investment Standard	Comply with standard as set out in relevant planning guidance.		
Better Care Fund	Comply with minimum contribution as set out in relevant planning guidance.		

Glossary

North Central London Integrated Care System

To be added at end

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
26 March 2024

Report Title	Sustainable Healthcare: Green Plan Annual Report	**Date of report**	6 March 2024	**Agenda Item**	2.2
Lead Director / Manager	Sarah D'Souza / Ruth Donaldson	**Email / Tel**		sarahd'souza@nhs.net	
Board Member Sponsor	Sarah McDonnell-Davies, Executive Director of Place Dr Jo Sauvage, Chief Medical Officer				
Report Author	Paul Allen, Assistant Director for Strategy Communities, and Inequalities	**Email / Tel**		paul.allen14@nhs.net	
Name of Authorising Finance Lead	Anthony Browne	**Summary of Financial Implications** The NCL Green Plan has no national or local dedicated funding. Targets have been set nationally but the plan and programme has largely been designed and delivered to date within existing resources. Workstreams and schemes within the NCL Green Plan do have resource implications and small amounts of non-recurrent investment have been found. The cost and benefit of any scheme within the plan is assessed on a case-by-case basis at provider and system level. There is a health economic case and there are benefits to be leveraged; some can be realised short term (for example energy efficiency) others will not be seen for a generation.			
Report Summary	Our purpose in NCL is to improve outcomes and wellbeing, through delivering equality in health and care services for local people. As an ICS we have a duty to consider the wider determinants of health. Climate change poses a major threat to our health as well as our planet. The NHS is responsible for around 4% of the country's carbon emissions. In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero with two clear targets: • The NHS Carbon Footprint: for the emissions we control directly, net zero by 2040				

	• The NHS Carbon Footprint Plus: for the emissions we can influence, net zero by 2045. In July 2022, net zero was embedded in legislation through the Health and Care Act with the *Delivering a Net Zero National Health Service* report issued as statutory guidance. The Green Plan complements the NCL Population Health & Inequalities Strategy. Widening inequalities and growing pressures on the health and care system prompt questions about the role of large public sector organisations, in tackling the wider determinants of health. The population most impacted by health inequalities are also those most impacted by climate breakdown and poor air quality. The NCL Green Plan has been coproduced locally and outlines how we will deliver national and local commitments. This Annual Report details NCL's progress made in a number of key areas: • Governance and building a social movement • Working with local authorities. • Early progress on desflurane use and emissions from inhalers. Our priority areas in 2024/25 are: • Medicines - inhaler emissions, use of nitrous oxide • Reusable PPE – roll out trials across organisations • Travel & transport – completing staff surveys and associated plans • Procurement – 10% social value. NHS London recently provided cross-London ICB information on a range of priority metrics. The results suggest NCL ICB and its NHS Trusts are doing well in some areas (notably renewable energy), but could learn from other London ICSs progress in others, including low/zero-emission vehicle purchase/lease, and in incorporating social value and green agenda requirements in individual organisations' procurements. The results indicate NCL is making positive progress on inhaler emissions, use of nitrous oxide and renewable energy but there is further work to do on travel and transport and social value procurement by Trusts to bring us in line with progress in other areas. These areas align with our planning priorities for 24/25 and the Programme Oversight Board will be reviewing plans in light of this data at its next meeting and refining the 24/25 plan. As indicated in the report there are a number of challenges in taking forward some elements of work in particular around estates and changes to fleet vehicles. We know we have more still to do but believe we are targeting the areas in the short term which have the biggest impact; while acknowledging that to achieve Net Zero to timescales we will need to continue to develop, refine and target our actions over the coming years. The report details specific challenges to our further progress, in particular associated with estates, clinical leadership/incentivisation to support medicines work in primary care and. It also notes a number of areas where regional and national changes are needed to enable progress. Delivering sustainable healthcare and improving the local environment for residents will improve outcomes, improve lives and reduce demand for services. A focus on sustainability directly delivers the core objectives of the population health improvement strategy. To deliver good clinical care is to deliver more sustainable healthcare. Volatile weather (extreme heat or cold) also causes death and makes delivering care harder, so we must also focus on adaptation and climate resilience.

	The ICB is accountable for our system wide Green Plan and NHS England requires the Board to consider progress at least annually. Responding to the discussion at the Board Seminar in December, the following specific support is requested. Board members to use their positions within ICB, in partner organisations and more broadly to champion and embed sustainability across all NHS and system activities. This could include: • Routine consideration of sustainability in all reports/business cases to ICB Board and Committee meetings. • Support to enable involvement of all Trusts in inhaler switching work. • Specific focus on reducing carbon footprint in capital allocations, operational planning cycle and as key priority in addressing population health and tackling inequalities. • Advocating on behalf of initiatives such as anti-idling on NHS and partner sites in support of Mayor's Clean Air and Health programme. • Supporting decisions that can be made as an ICS to speed up pace of change e.g. address barriers to reusables (infection prevention control) & support for community energy projects.
Recommendation	The Board of Members is asked to: • **NOTE** the progress made to deliver our Green Plan in 2023/24 and the work planned for 2024/25. and the further support required to deliver our ambitions. • **NOTE** challenges identified to making greater progress in 2024/25, the scaling back of plans in line with resource/capacity and the raised risk to achieving net zero targets. • **COMMIT** to actions identified to champion sustainability as Board members and system partners.
Identified Risks and Risk Management Actions	On the Corporate Risk Register: Failure to implement ICS Green Plan (Threat). CAUSE: If the ICS fails to prioritise and resource our green plan aims & actions, EFFECT: There is a risk that the System will be unable to co-ordinate a response to the ongoing Climate breakdown, and individual responses will not result in their full potential, and be a non-optimal use of financial and other resources. IMPACT: This will result in NHSE targets being missed, climate impacts on health worsening (e.g. air quality) and reputational damage, and workforce fatigue.
Conflicts of Interest	Conflicts of interest are managed in line with our Conflict of Interest policy.
Resource Implications	The report recognises the ambitious national objective with local teams delivering what they can without additional resource. The report highlights areas where support is needed from all in the NHS and partner organisations locally to deliver the scale of change required.
Engagement	The Greener NCL programme is a social movement and has taken an inclusive approach recognising that the success of this programme depends on

	collaboration and everyone being signed up to the same goal. Examples of work with communities include: • Commissioning Enfield Climate Action Network & Enfield Racial Equality council to deliver focus groups and community hub discussions with residents in Enfield in 2022. Insights informed plan delivery, partnerships were strengthened and the group is focusing on food growing, green space and community energy (amongst other things) • VCS organisations invited and engage with Partnership Board • All Local Authority climate action plan teams engaged, presenting at Partnership Board and joint work being undertaken.
Equality Impact Analysis	Completed and signed off when the plan was developed in 2022. The plan focuses on improvements to quality of care, patients' outcomes, prioritise actions that improvement resident wellbeing and address health inequalities.
Report History and Key Decisions	• NCL Green Plan signed off by EMT and SMB in March 2022. • Presentation at EMT in May 2023: discussion about the alignment of sustainable healthcare with population health improvement • Discussion at ICB Seminar in December 2023.
Next Steps	Further work to address resourcing gap with system partners. Monitoring of delivery will continue with the quarterly Greener NCL Programme Oversight Board. A further benchmarking analysis comparing NCL ICS with other London ICSs will be the subject of a further report.
Appendices	Slides attached. Green Plan can be found here: https://nclhealthandcare.org.uk/about/our-plans/ncl-green-plan/

North Central London Integrated Care System

Green Plan Annual Update for NCL 23/24

Incorporating sustainable healthcare to deliver our net-zero targets *and* improve health and wellbeing

March 2024

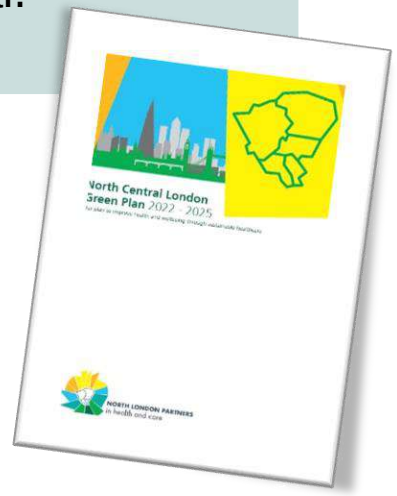
Key messages

ICB is accountable for the delivery of our system wide Green Plan. NHS England requires the Board considers progress of our Green Plan at least annually

NCL has developed a social movement with projects being delivered via framework of dispersed leadership. Some positive progress in 23/24 informing priorities in 24/25.

Delivering sustainable healthcare in line with our Population Health Improvement strategy, cost effective & requires sustained strategic change & use of all levers available to affect change.

One key ask to Board to use all levers to make progress towards our net-zero goal.



Improving population health

North Central London Integrated Care System

Our purpose in NCL is to improve outcomes and wellbeing, through delivering equality in health and care services for local people. **Our Green Plan helps us to do this.**

Widening inequalities and growing pressures on the health and care system have prompted questions about the role and responsibility of large public sector organisations in tackling the wider determinants of health.

The population most impacted by health inequalities are often those most impacted by climate breakdown and poor air quality. Delivering sustainable healthcare and improving the local environment for residents will improve outcomes, improve lives and reduce demand for services.

A focus on sustainability directly delivers the core objectives of the population health improvement strategy. Sustainable behaviours can be a catalyst for workforce engagement and are complementary rather than standalone or conflicting.

We are seeing increases of volatile weather – we know that in extreme heat or cold, there are deaths. The extreme weather makes delivering care harder so we must also focus on adaptation and climate resilience.

Deliver more environmentally sustainable health and care services

Principle in our Population Health Improvement Strategy

Good clinical care = more sustainable care

North Central London Integrated Care System

We cannot have a healthy population without a healthy environment. Sustainability is a core pillar of our anchor system approach. It should be considered in all decision making alongside financial and social considerations (triple bottom line). The same principles to improve people's health, are also principles of sustainable healthcare delivery.

Min. service use e.g. air quality & resp. health

1. PREVENTION

Promoting health and preventing disease by tackling the causes of illnesses and inequalities

2. PATIENT SELF-CARE

Empowering patients to take a greater role in managing their own health and healthcare

Community-led services; remote care; personalised approaches

Active focus on appropriate use & waste; clear care pathways

3. LEAN SERVICE DELIVERY

Streamlining care systems to minimise wasteful activities

4. LOW CARBON ALTERNATIVES

Prioritising treatments and technologies with a lower environmental impact

Alternative medicines (i.e. inhalers) & care delivery

Mortimer, F. The Sustainable Physician. Clin Med 10(2). April 1, 2010. D110-111.

CENTRE for SUSTAINABLE HEALTHCARE

NHS and the climate emergency

North Central London Integrated Care System

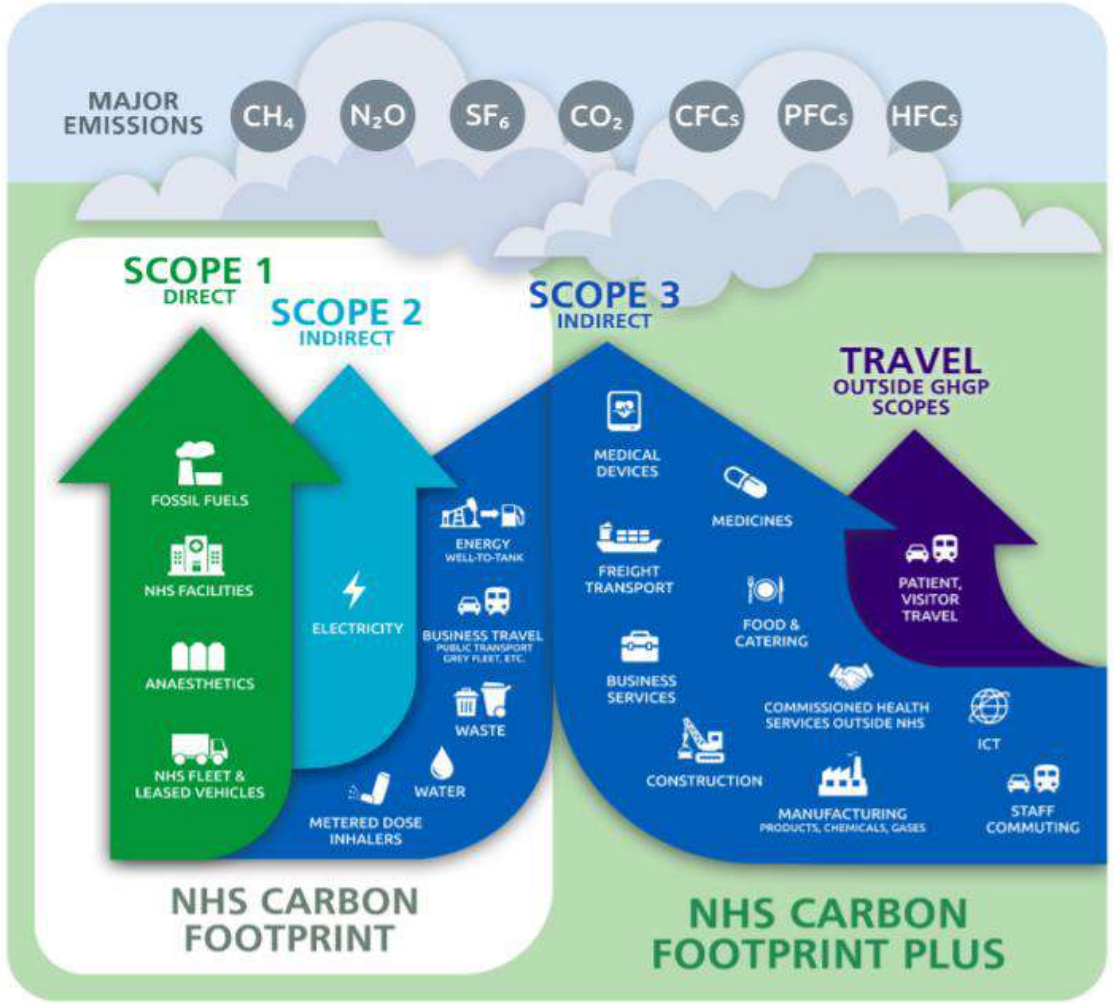
The NHS is currently responsible for **4%** of England's carbon footprint.

National Greener NHS plan launched October 2020:

- For emissions **controlled directly** by the NHS (NHS Carbon Footprint), **net-zero will be reached by 2040**, with an ambition to reach an 80% reduction by 2028 to 2032;
- For the emissions that the **NHS can influence** (NHS Carbon Footprint Plus), we will **reach net zero by 2045**, with an ambition to reach an 80% reduction by 2036 to 2039

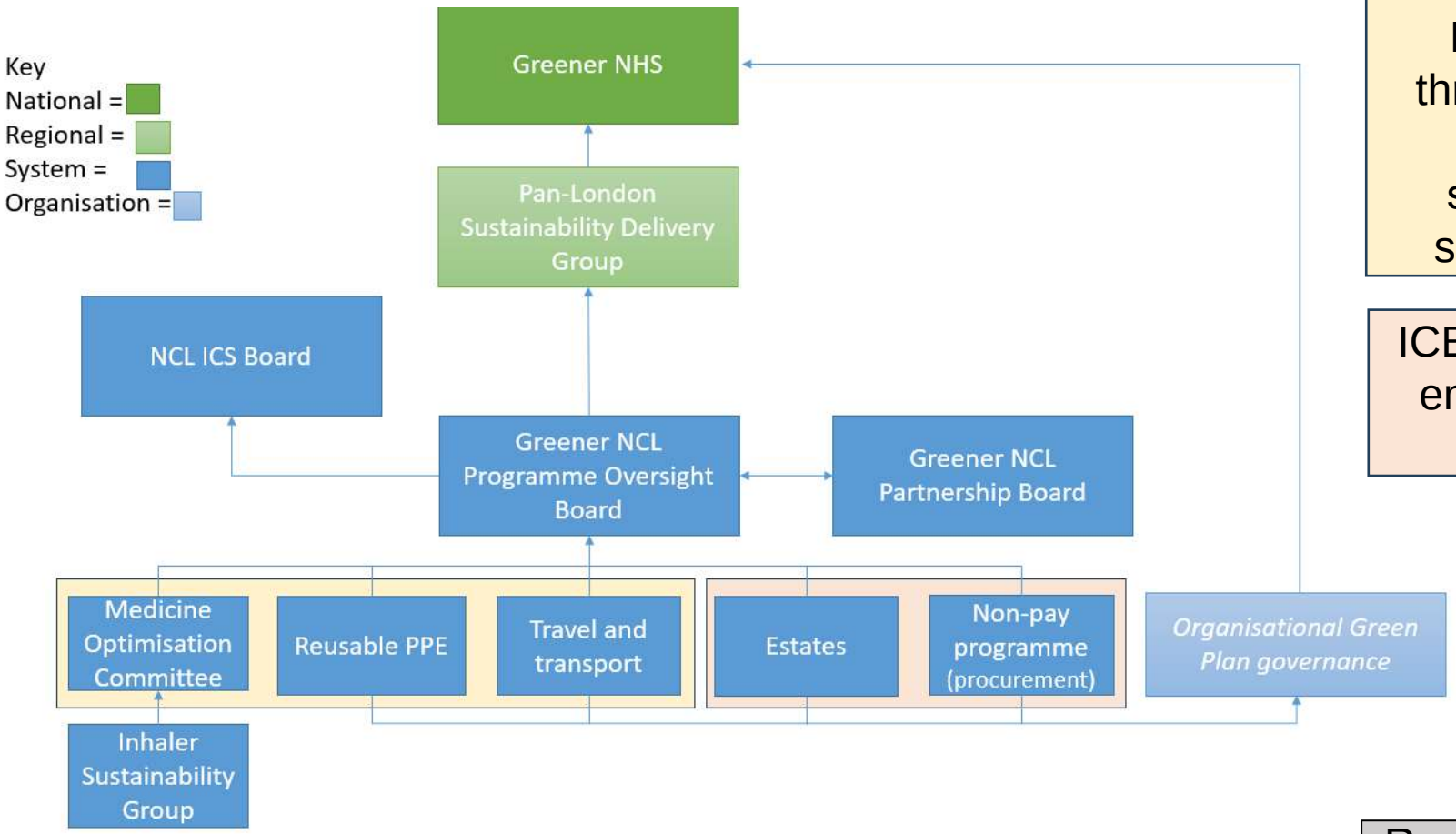
Trusts signed off Green Plans in January 2022
ICSs signed off the system Green Plan in March 2022

NHS England require that the Board considers progress of our Green Plan at least annually



Governance & oversight

North Central London Integrated Care System



Priorities agreed at Greener NCL Partnership Board. Trust led through distributed leadership – authority to set direction for system, innovate, 'fail fast' & support other trusts to deliver.

ICB led programmes – with green embedded through social value responsibilities

Corporate Risk: Failure to implement ICS Green Plan overseen by Strategy and Development Committee. Next step to strengthen committee involvement.

Regional working with ICB leads & Greener NHS

Green Plan delivery 22/23 and priorities 24/25

North Central London Integrated Care System

Achievements 23/24

- NCL has met 2 NHSE indicators re **inhaler emissions** ahead of schedule in Q3
- NCL has ended the use of **Desflurane** gas in its hospitals.
- Two **supply chain vehicles** off the road per day due to distribution centre at Chalk Mill Drive
- Improved opportunities for **cycling for NHS staff,** eg e-bike trial at CLCH.
- GOSH has integrated **air quality alerts** based on a patient's home postcode and has provided guidance to staff to engage with MPs and councillors
- **Strong leadership** from SRO (Chief Exec, RNOH) and network of sustainability leads across trusts. Creating a social movement.
- Refreshed targets for 23/24 in line with available resource and capacity
- Considering **sustainable transformation** in LTC LCS, surgical hubs redesign & start well transformation
- **Greener NCL ICB Staff network** – changes in the office (recycled paper, reusable crockery)

Priorities 24/25

Medicines (GOSH led)
- Ongoing work to reduce emissions from inhalers against a 2019/20 baseline,
- Review oral nutritional supplement prescribing to improve quality & reduce plastic bottle use/waste
- Reduce medicines waste (target TBC)

Reusable PPE (ULCH led)
- 2 x reusable PPE trials in UCLH + supporting another Trust

Travel and Transport (NMUH & CLCH led)
- All Trusts to complete Travel Surveys & have 2 – 3 interventions supporting modal shift

Plus
- 10% social value in all procurements
- Plan for net-zero primary care estate
- 65% Trusts with walking aid reuse scheme
- Data to understand relative position to other areas and against overall green net zero targets

Medicines focused targets

North Central London Integrated Care System

Inhalers

Led by the NCL IPMO Inhaler Sustainability Group

Targets:

- Increase DPI/reduce pMDI use;
- Reduce over-prescribing of SABAs;
- Increase 'greener' disposal;
- Use of fixed combination devices

KPI	Target	NCL Q3 position
CO2 savings monitoring	25% reduction in 2023/24 (12m) Baseline 2019/20	**25.8%**
DPIs vs pMDIs (excl salbutamol)	25% of all non-saba inhalers dispensed as DPI/SMI	**28%**

Anaesthetic gases

Led by individual Trust departments

Target: Reduce desflurane to less than 5% of total volatile anaesthetic gas use

Progress

Desflurane use stopped.

Nitrous oxide

Led by NHS England (London Region)

Target: To reduce nitrous oxide use by 40%

Progress

- RNOH has stopped all piped gas
- Successful bid with UCL Partners to provide guidance on stopping

Work with Local Authorities

North Central London Integrated Care System

Work to date

Corporately
- Work with each borough Climate Action Team
- Each Greener NCL Partnership Board has a presentation from a borough – learning, partnership

Politically
- Communities Team Director and SRO (Chief Exec of RNOH) presented the Green Plan at Barnet HOSC

Practically
- Enfield council supporting BEHMT cycle training for staff
- Camden & RFL delivering heat network
- Training for Barnet adult joint commissioners (delivered by ICB & Council)
- Enfield Collaborative through Enfield Climate Action Council
- Camden council & GOSH street improvements

Work to do

- Mainstreaming this agenda
- Changing our approach to the delivery of care by looking at specific care pathways and how green can be embedded & priorities (we've seen some examples in LTC, Start Well)
- Community engagement and resident voice
- Hyper-local solutions to improve the environment e.g. air quality
- Public realm improvements following trusts completing staff travel surveys.

North Central London Integrated Care System

NCL Progress against Green Targets

- NHS London has recently provided comparative benchmarking information for each London ICB and its associated NHS Trusts against London Greener NHS Deliverables focused on Travel and Transport, Medicines, Procurement and Supply Chain and Estates and Facilities

- The results indicate NCL is making positive progress on inhaler emissions, use of nitrous oxide and renewable energy but there is further work to do on travel and transport and social value procurement by Trusts to bring us in line with progress in other areas.

- These areas align with our planning priorities for 24/25 and the Programme Oversight Board will be reviewing plans in light of this data at its next meeting and refining the 24/25 plan. As indicated in the report there are a number of challenges in taking forward some elements of work in particular around estates and changes to fleet vehicles.

- We know we have more still to do but believe we are targeting the areas in the short term which have the biggest impact; while acknowledging that to achieve Net Zero to timescales we will need to continue to develop, refine and target our actions over the coming years.

Areas where support needed

North Central London Integrated Care System

Resources to support faster delivery

- Capacity needed to deliver our programme and the commitments in our plan
- Clinical capacity and leadership e.g., for medicines

Use of wider system levers to deliver change

- Position sustainable healthcare as integral to delivering our population health management goals
- All staff carbon literate - including Board members - considering business through sustainability lens
- Embedding sustainability within the operational planning cycle and in business cases
- ICS decisions to speed up pace of change e.g., address barriers to reusables (infection prevention control) & CAG support for sustainable care pathways
- **Regional and national green team**
- Funding available for estate improvement (mitigation & adaptation)
- Guidance from national on how to tackle some areas e.g. adaptation
- Making salary sacrifice & other schemes easier to access for Primary Care
- Free TfL travel for NHS staff – to be informed by trust travel surveys, supported by other ICBs.

Recommendations

North Central London Integrated Care System

To **NOTE** the progress made to deliver NCL Green Plan in 23/24, the work planned for 24/25 and the further support required to deliver these ambitions.

To **NOTE** challenges identified to making greater progress in 24/25, the scaling back of plans in line with resource/capacity and the risk to achieving net zero targets.

To **COMMIT** to actions identified to champion sustainability as Board members and system partners including:

- Routine consideration of sustainability in all reports/business cases to ICB Board and Committee meetings.
- Specific focus on reducing carbon footprint in capital allocations, operational planning cycle and as key priority in addressing population health and tackling inequalities.
- Advocating on behalf of initiatives such as anti-idling on NHS and partner sites in support of Mayor's Clean Air and Health programme.
- Supporting decisions that can be made as an ICS to speed up pace of change e.g. address barriers to reusables (infection prevention control) & support for community energy projects

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
26 March 2024

Report Title	Primary Care Access Recovery Plan – update on progress	**Date of report**	1 March 2024	**Agenda Item**	2.3
Lead Director / Manager	Sarah McDonnell-Davies, Executive Director of Place	**Email / Tel**		sarah.mcdonnell1@nhs.net	
Board Member Sponsor	Sarah McDonnell-Davies, Executive Director of Place Jo Sauvage, Chief Medical Officer				
Report Author	Rebecca Kingsnorth and Adam Backhouse	**Email / Tel**		rebeccakingsnorth@nhs.net adam.backhouse@nhs.net	
Name of Authorising Finance Lead	Sarah Rothenberg, Director of Finance, Primary Care	**Summary of Financial Implications** Three forms of national funding support delivery: • System Development Funding – held by the ICB • PCN Capacity and Access funding • Practice Transition and Transformation funding Investment of each line is on track against plan.			
Report Summary	The National Delivery Plan for Recovering Primary Care Access was published in May 2023. In November 2023 the Board received its first formal report on our approach to national requirements and local priorities. This report summarises progress since November. The full detail (required to meet National assurance requirements) is available via a public report to the NCL ICB Primary Care Committee (PCC) published in February 2024. As noted previously 'access recovery' is not about recovery of activity (given activity levels are significantly higher than they were pre-pandemic). It is focused on recovery of patient experience and satisfaction with access. Interventions are designed to improve systems, processes and ways of working, improve patient information and communications, reduce workload and ensure other areas of primary care (in particular community pharmacy) are being optimally deployed. We have 180 practices in NCL and have developed data and a support offer that is flexible and can be adapted to the needs of the practice team. Delivery is on track and we are confident we will achieve positive changes for patients and practice teams over the course of the programme. This will vary at practice level and our quantitative and qualitative information will provide the insight we need to understand variation during the programme and ongoing.				

	The paper covers key points of assurance and outlines how we have evolved the programme in line with Board feedback. Specifically we have strengthened communication and engagement, enhanced work on digital inclusion and further developed our approach to benefits realisation and evaluation of impact. Some areas of the programme – in particular self-referral pathways and the Primary-Secondary Care Interface are challenging, but this is the case nationally. We are going beyond national requirements as we understand the breadth and depth of work needed to generate the intended outcomes – but are doing so mindful of the volume of work and transformation we are asking practices and ICB colleagues to manage. So our approach to change support is targeted, coherent and streamlined, with clear roles for the ICB and for providers. It offers a model for sustained quality improvement and change management activity as the ICB and ICS evolves. In February the ICB Strategy and Development Committee endorsed development of NCL *Ambitions* for General Practice. This wider work will consider access priorities but also tackle key choices and tensions, for example the sustained increase in demand on finite general practice capacity, the balance needed between on the day access and proactive care, variation at practice level, the need for sustainable general practice estate and infrastructure, the impact of multidisciplinary teams and changing practice leadership models and the need for dialogue with the public around general practice.
Recommendation	The Board of Members is asked to **APPROVE** this report.
Identified Risks and Risk Management Actions	Delivering the Access Recovery Plan will contribute to mitigation of the ICB's Corporate risks related to addressing variation in primary care quality and performance. The overall risk profile for the programme has reduced since the November update. Specific programme risk updates: **Risk:** the ICB will deliver the individual actions described in the plan but fail to support a consistent transition to the Modern General Practice Access operating model. **Mitigation:** described in section 4. **Risk**: recurrent funding is not available to support sustained work on digital inclusion. **Mitigation:** currently under review with analysis of this issue led by the ICB Communities and Digital teams. **Risk:** the programme is a whole ICB approach with critical support from across Directorates. **Mitigation:** EMT sponsor as a priority programme during transition of our own structures and operating model.
Conflicts of Interest	The Clinical Director for Primary Care for North Central London ICB is a Board member of the General Practice Provider Alliance which has coordinated the response by primary care providers to change support requirements. This has been managed in line with the ICB Conflicts of Interest Policy with governance and procurement advice.

Resource Implications	Delivery of this plan requires allocation of national funding as described above, and significant allocation of ICB staff time and resources.
Engagement	To date engagement of practices has been via discussions with Primary Care Operations Group (attended by a range of primary care clinicians) and Londonwide Local Medical Committees. Communications have been issued to all practices about national change support offers, transition and transformation funding, and upcoming local change support. A subset of 66 practices have received communications about Support Level Framework conversations. Practice communications will be ongoing throughout the delivery period. Engagement with patients and the public forms part of our local change support offer for a subset of practices, to ensure that changes to individual practice models are communicated effectively and shaped with patients. A full communications plan for primary care access is in development which will build on existing work to engage with patients and the public on changes to primary care, national comms campaigns and London-wide patient and public involvement work. North Central London ICB has also jointly commissioned, with other London ICBs, some Deliberative Engagement with frontline staff, patients and the public about primary care more broadly. This is being commissioned across London. We plan to focus the engagement on key areas like access and use this to inform our current work and future ambitions.
Equality Impact Analysis	A national Equality and Health Impact Assessment was produced in relation to the national Plan. A local Equality Impact Initial Screening Assessment has been produced to supplement, focusing on our local implementation approach. Both are available on request. Neither document has identified any equality concerns related to the PCARP work, but they do underline the importance of the interdependency between this programme and the ICB's digital inclusion programme which is being led by the digital and communities teams. This work will inform our ambitions for General Practice.
Report History and Key Decisions	NCL ICB Executive Management Team received a report on this work in August 2023, October 2023, and February 2024. The Primary Care Committee has received a report on this work in October 2023 and February 2024. The ICB Board received a report on this work November 2023.
Next Steps	Implementation against this plan will continue to March 2025.
Appendices	Appendix 1: Patient journey under Modern General Practice Operating Model Appendix 2: Image - scale of work undertaken by General Practice teams

1 Introduction

The national Delivery Plan for Recovering Primary Care Access was published in May 2023. In November 2023 the Board received the NCL plan, reflecting national requirements and local priorities. The national and NCL plans are designed to support Practice transition to the *Modern General Practice* operating model (appendix 1).

This report summarises progress since November and our approach to delivery and evaluation of impact. In February 2024 a more detailed report was received by the NCL ICB Primary Care Committee (PCC). This covered all national assurance requirements and is publicly available. Delivery is on track across all areas of the plan, with slower progress around self-referral pathways and the Primary-Secondary Care Interface, but this is the case nationally.

This summary paper supports Board review of progress against plan, describes steps the ICB has taken to maximise impact and positions this work in the wider context of challenges and areas of focus for General Practice.

2 Background and context

2.1 Scale of contribution of General Practice

General practice in North Central London now provides on average 680,000 appointments every month[1], for a registered population of 1.78 million people[2]. These activity levels are 15% higher than before the COVID pandemic – for some practices as much as 30% higher[3]. It means we are offering and around 50,000 more appointments per month, or 600,000 appointments per year, than we did in 2022/23. Appointment numbers have risen year on year. Face to face appointments now make up ~62% of all appointments[4], the rest being largely telephone appointments.

Demand for appointments has outpaced growth in practice list sizes. There is variation at practice level but all sites are under considerable pressure and the extraordinary workload is impacting patient experience, staff retention and wellbeing. The activity picture is incongruent with declining levels of patient satisfaction with access.

Major transformation of the practice operating model has taken place over the last 3 years – new staffing models, new access routes and rapid digitisation with new technology for access, consulting and communication. The access recovery plan assumes practice systems and processes, people's understanding of them, and the overall efficacy of the practice operating model can be improved and in doing so, patient satisfaction with access will improve. Patient satisfaction with the care provided and outcomes in primary care have dipped in some cases, but overall remain high.

Access to General Practice is a major priority nationally and locally and continues to be a focus in political debate. Appointment numbers do not convey the full scale of work undertaken on behalf of patients by General Practice. Changes to Acute services in particular – changes to their operating model, backlog from the pandemic and the impact of frequent industrial action – impact General Practice. Appendix 2 has been prepared by General Practice providers to show the scale and type of 'behind the scenes' work undertaken in general practice on top of appointment activity.

[1] National GP Appointment Data
[2] Raw list size January 2023
[3] Source: NHS England: appointments in General Practice dataset 2019 - 2023
[4] Average for London, slightly below average for England

2.2 Patient satisfaction with General Practice

Practices are providing more appointments than ever before, but there is an overall drop in satisfaction with access and significant variation in national and local GP Patient survey results. A negative perception of general practice is also prominent in national media coverage, and practice staff have seen an increase in verbal and physical abuse.

In response to the pandemic, and to help practices handle increasing demand, new routes into General Practice and new tools for triage and consultation have been introduced at pace over the last four years. Digital tools play a dominant role in access (online bookings, online consultations e.g. e-consult, NHS app usage) and patient list management (supporting risk stratification for proactive care, call / recall etc). However, there is variation between Practices in the way changes have been implemented and the extent to which different tools are used or used effectively. Some tools are not yet intuitive for practices or patients and considerable development work is needed by those who own the products.

Work to communicate changes to patients and to support them to use digital channels has sometimes lagged behind their introduction or been sufficiently broad and deep to effect understanding. Digital exclusion and language barriers also remain a risk.

2.3 Policy context

Delivery of the Primary Care Access Recovery Plan is taking place in the context of a heightened national focus on General Practice more broadly:

- The Fuller stocktake Next steps for Integrating Primary Care articulated well *why* General Practice needs to change and at a high level *what* needs to change, with the proposed introduction of Integrated Neighbourhood teams, a streamlining of access and segmentation of episodic demand and proactive, personalised care, development of end to end urgent care pathways, and a focus on prevention. Work continues on *how* these changes should be achieved;
- The Hewitt Review made recommendations for a new framework for GP primary care contracts, an outcomes focus, a new approach to incentive schemes; support to primary care at scale;
- NHS England are consulting on the future of national incentive schemes – the Quality and Outcomes Framework and the Investment and Impact Fund;
- The current national GP contract ends in March 2024, with a one-year contract in negotiation for 2024/25, and significant change expected from 2025/25;
- The Academy of Medical Royal Colleges reviewed action needed at the interface between primary and secondary care – recommendations from this have been incorporated into the Primary Care Access Recovery Plan; and
- We know that challenges related to workforce, primary and secondary care interface, primary care estate, patient safety, access and proactive care are part of current discussions at many levels.

In London:

- a Londonwide Strategy for Health is in development, with a goal related to patient access to care;
- Deliberative Engagement with patients and the public about the future of primary care has been jointly commissioned by London ICBs with NHSE (London) – this is focusing on choices, implications and 'trade-offs' to be considered in future developments (see section 5)
- Londonwide LMCs has published a report focused on retention in London General Practice, with Key Lines of Enquiry for ICBs to consider in supporting retention.

In NCL the ICB is leading the development of local Ambitions for General Practice, through extended local dialogue. These ambitions will underpin our decisions and actions and articulate shared aims to frontline teams and patients. Whilst focused on General Practice they will be set in the context of integrated working and population health, and consider interfaces with other sectors and partnership working, in particular at Neighbourhood level.

3 Programme overview

The National Access Recovery Plan has four key aims and fourteen areas for action. These are outlined in Figure 1 below. The detail of NCL progress against each area was recorded in the full PCC report. There is a national practice and PCN support offer and an expectation that ICBs provide and arrange for local hands-on change support.

It is expected that the overall impact of the programme will be *improved patient experience of accessing general practice* – as measured through the national GP Patient Survey. A related aim is reducing pressure on General Practice by increasing capacity elsewhere in the system (community pharmacy) or reducing administrative workload (self-referral into community services, reduction of bureaucracy at the interface). Effective access – for urgent, planned and proactive care – is essential to population health improvement and this programme of work has been shaped to support progress against three key NCL population health outcomes:

- The care navigation and triage elements of modern general practice allow practices to better direct people to the *local services that can best meet their needs*;
- Digital General Practice access routes allow people to take *greater control of their healthcare and keep themselves well*;
- Strengthening the interface and between General Practice and Community Pharmacy creates opportunities for collaboration on *preventative care* such as vaccinations, and development of better *integrated care for patients with complex needs*.

Since the last report we have mobilised the practice change support offer, shaped and commissioned a communications and engagement programme, seen significant shifts in key KPIs related to digitisation and the practice operating model and undertaken a significant amount of work with local Community Pharmacies to mobilise Pharmacy First (which enables community pharmacies to complete episodes of care for 7 common conditions following defined clinical pathways). The detail and impact to date is described in section 4.

We will continue to develop the link between the programme and NCL outcomes framework to demonstrate these impacts more clearly. We have described briefly in this report (see section 4.3 and full detail in the PCC paper) how we expect to track impact of the programme using structure, process and outcome measures.

1	**Empower patients**	• Improving NHS App functionality	• Increasing self-referral pathways	• Expanding community pharmacy		**Intended effect:** a diversion of demand away from general practice
2	**Implement new Modern General Practice Access approach**	• Roll-out of digital telephony	• Easier digital access to help tackle 8am rush	• Care navigation and continuity	• Rapid assessment and response	**Intended effect:** improved experience for patients in seeking and accessing care
3	**Build capacity**	• Growing multi-disciplinary teams	• More new doctors	• Retention and return of experienced GPs	• Priority of primary care in new housing developments	**Intended effect:** increased capacity in general practice
4	**Cut bureaucracy**	• Improving the primary-secondary care interface	• Building on the 'Bureaucracy Busting Concordat'	• Reducing IIF indicators and freeing up resources		**Intended effect:** increased capacity in general practice

Figure 1 – key aims, actions and intended effect

4 Programme delivery

4.1 Progress since November 2023

We are on track with programme delivery against each major area above and have made significant progress since November. Highlights are:

1. Empowering patients – supporting a diversion of demand away from general practice when appropriate	• 95% of NCL practices are now correctly configured to enable online records access for patients • 80% of NCL practices are now offering prospective online access as default in the NHS app (a 58% increase from November 2023). • 54% of NCL patients are registered with the NHS app with 36% of patients logging in to the app in January 2024 (significantly up from previous months). Viewing records is the most popular feature, followed by ordering repeat prescriptions, viewing test results and managing appointments. • We are on track to meet targets for increasing self-referral activity into Community services, allowing patients to self-direct across a range of pathways. • 96% of Community Pharmacies in NCL have signed up to deliver *Pharmacy First* services, the vast majority of which will be offering services by the end of March 2024.
2. Implementing new Modern General Practice Access approach – improving the experience for patients in seeking and accessing care	• 92% of practices are using digital telephony. 100% of practices have signed agreements for digital telephony systems, supporting transition to these systems by the national deadline of March 2024. • 100% of practices have digital access and online consultations enabled. • We are on track to release our full 23/24 practice transition and transformation funding by March 2024. This has supported 36% of practices to plan transition to the modern General Practice operating model to date. All practices will be covered during the programme. • Using data and insight we identified 65 practices for a structured diagnostic conversation with a clinical facilitator. We are on track to complete 40 by March 2023, informing understanding of practice support needs. • We have commissioned a local GP Federation to provide leadership, expertise and hands-on change support to practices from March 2024 (see section 4.2).

3. Building capacity – growing and strengthening the multi-disciplinary general practice team	• Work with practices includes:
	  • support for recruitment, induction and supervision of ARRS staff. We have seen data that suggests we are now the ICB with the highest GP retention rate in the country.
	  • delivery of GP retention initiatives via the Training Hub (mentoring, fellowships, coaching and leadership development)
	  • appointment of joint PCN and Training Hub workforce and education leads
	  • development of multi-professional education
	  • introduction of a flexible staffing pool (to develop an NCL pool of locums)
	  • initiatives to support primary care staff wellbeing.
	• We are funding a deep dive into the supervision of ARRS staff and designing training for ARRS Supervisors to support high quality supervision and the retention of the ARRS workforce.

4. Cutting bureaucracy – freeing up capacity in general practice	• The NCL Clinical Advisory Group has approved a *Consensus Document* detailing how primary and secondary care will work together to reduce bureaucracy at the interface of these two key sectors. • Relationships are good in NCL supported by local interface groups around each Trust. • We are reviewing the work programme and thinking about how we support buy in to operational changes from primary and acute providers, focused on 'win-wins' and evidence of the positive impact streamlining this interface could have for staff and patients.

4.2 Optimising impact

The transformation effort under this programme – from practices / providers and the ICB - is significant, and we want to optimise the impact of the programme. As an ICB we are going beyond the nationally proscribed change support offer for practices.

We have scoped individual practice support needs through practice engagement and desktop review of data held by ICB teams. 'MDT' meetings brought together leads from Primary Care, GP IT, Digital, Workforce and Estates to share insight and develop bespoke practice support offers to optimise impact. Through this process we identified our own priorities:

- Telephone access processes
- Practice website quality
- Demand and capacity management
- Engagement and communication with patients
- Digital maturity amongst practice teams
- Supporting practice managers and reception teams

We have appointed a lead provider and the offer will include subject matter experts working in practices to effect change. Technical support will come from ICB GP IT and Digital First teams, who will support practices to implement the "must-do" requirements of the access recovery plan. GP IT are working with digital telephony suppliers to offer training and support to leverage the full benefits of the telephony systems. We have shaped a Digital Change Facilitator role and commissioned this additional capacity to provide hands-on support at practice level. Dedicated resource packs are in development to ensure practices have high-quality information and guidance. The team will take an agile approach and continuously adapt in response to practice and facilitator feedback, aligning support where required from external suppliers.

Acknowledging the risk that increased digitisation will exclude people who do not have access to – or are not confident using – technology, we have focused on over the last few months on digital exclusion / inclusion. We are funding pilot projects in each borough. These will connect practice teams to voluntary sector organisations with expertise in digital inclusion. Leads will work in General Practice settings to help patients engage with tools like online consultations and the NHS app. We will use the learning from pilots to develop a longer-term digital inclusion plan for General Practice based around interventions with proven impact.

The success of the programme rests on our ability to help practice teams create the space to engage, shape and embed change at practice level. Given the number of asks on practices, and the multiple elements under this programme alone, we have worked with the GP Alliance and Federation providers to agree shape a Joint Oversight Group. Convened by the lead provider, this will coordinate all offers of support and ensure a coherent package and logical sequence of interventions for each practice.

4.3 Measuring impact

We want to ensure the programme delivers meaningful and demonstrable change for patients. Building on Board feedback from November, we have developed an impact monitoring approach - tracking several indicators that would as a whole represent improved patient experience. We will use a three-stage approach measuring structural, process and outcome measures for each area of the programme. The framework is shown in appendix 3 with a detailed description in the PCC report.

The primary outcome measure for the programme is improved *patient experience of access* as measured through the national GP Patient Survey. We are looking for and working towards:

- an overall increase in NCL average scores
- a reduction in the variation between the highest and lowest scoring practices
- a reduction in the number of NCL practices who appear in the lowest 20% of practices nationally for each of the questions.

As the survey reports annually, with data collection in Winter and publication of results in July, it is unlikely that we will see the full impact of the work until summer 2025. We will work in the meantime with qualitative feedback from patients and other stakeholders and monitor complaints trends, online reviews. Local surveys are undertaken with patients where there may be formal concerns about a practice and/or it is subject to a formal Performance Review. This is taken via PCC.

In some cases, increased digitisation has correlated with a reduction in patient satisfaction with making an appointment as measured by the GP Patient survey. Our change support offer includes work with practices where this may have happened, but we note the potential for survey results to decline before they get better. We will benchmark against National data to isolate local issues and use local case studies and the GP Friends & Family Test (once firmly established) as interim measures of satisfaction.

An important aim of the wider programme of work is reducing pressure on General Practice by increasing capacity elsewhere in the system (community pharmacy) or reducing administrative workload (self-referral into community services, reduction of bureaucracy at the interface). Outcome measures require further development but will focus on reduction in pressure on practice staff and patient satisfaction with alternative pathways.

4.4 Programme challenges and risks

Delivery will contribute to mitigation of key corporate risks.[5] At programme level the overall risk profile has reduced since November and several risks will be closed as we near the end of the first year of the programme. The most significant programme risks are:

- that we deliver the plan but do not significantly impact key outcomes like patient satisfaction and staff morale. This is mitigated in part by our approach to optimising impact, but also relates to general practice challenges that we are seeking to progress beyond the scope of this programme – see section 5.
- that variation persists at practice and PCN level. Locally we have developed an approach to mitigate this risk - using data to baseline, target change capacity and track impact in a formative and summative way.
- practice engagement with the plan. We have reduced the risk-rating since November due to positive responses to date, but practice funding and capacity for change is limited at a time when practices are also focusing on implementation of the long-term conditions locally commissioned service (LTC LCS). We have identified specific risks around engagement with the NHS App and the Support Level Framework which we will continue to monitor.

[5] Risks PERF 15, 18, 28

- varying levels of engagement from acute trusts with implementing the recommendations in the plan about improving the primary / secondary care interface and reducing the administrative burden on practices, which will in turn free practice staff up to focus on other areas of delivery.

We are identifying critical success factors not prominent in the National plan. Digital inclusion is key - closing the gap between the presence of technology and digital channels and patient use and satisfaction with them. The lack of recurrent funding and capacity to support sustained work on digital inclusion has been highlighted as a risk by National and NCL Equality Impact Assessments. The ICB Primary Care, Communities and Digital teams are developing plans to address this, within scope of ICB remit and influence.

5 Wider considerations

Whilst the Access Recovery Plan is a significant programme of work for NCL ICB, it is somewhat narrowly focused on patient experience of access to general practice. As an ICB we are aware of, and actively seeking to address a much broader set of challenges for general practice. The NCL ICB Ambitions are key to this. We are also influencing at London and National level to shape the future of primary care. Considerations for the Board include:

Continued increases in demand for primary care

We anticipate demand for general practice services will continue to outstrip capacity and resources. The 2024/25 GP Contract was released at the end of February, positioned as a 'stepping stone' to a longer term deal, however national messaging emphasises financial challenges. ICBs and ICS need to consider discretionary investment locally, with some national evidence suggesting the relative proportion of investment into general practice has reduced over the last few years.

New pathways (self-referral to community services, and use of community pharmacy) will have a small benefit if they can contain the activity (avoiding multiple contacts for the same presentations), however the capacity will not make a significant dent. We hope to access better data on demand (met and unmet) from telephony systems. We believe action is needed around staying well, self-care and self-management and standardised triage to analyse need and navigate patients. Technology and AI offer opportunities in this space. This will require significant work to build public understanding of new models as they emerge.

Trends in patient expectation

Rapidly changing patient expectations might impact work to improve patient satisfaction. The five London ICBs, together with NHSE (London), have commissioned a London-wide programme of deliberative engagement to support deeper conversation and choices around the future of primary care in London. Topics for deliberative engagement include the role of digitalisation, how patients may be better navigated to meet need, and multi-agency ways of working. There will also be a focus on the knotty question of standardisation of service vs local flexibility across London. We will also consider 'trade-offs' that accompany change, for example having need met more swiftly, may mean that patients are not able to see their clinician of choice.

Balancing on-the-day demand with capacity for proactive and preventative care

We have noted a significant increase in appointment numbers since before the pandemic; however we need to acknowledge that with a finite workforce this may be at the expense of capacity for prevention and proactive care. In North Central London we have recently commissioned a model for proactive management of care for patients with long term conditions. We have worked closely with General Practice and partners to design this, thinking about how we deploy population health management tools to increase the efficacy of the interventions, the role of the GP and wider practice team and how general practice and partners such as the VCS and Trusts might integrate their approaches. If we continue to prioritise this – and there is no significant investment into general practice or growth in workforce – we

would expect appointment numbers to remain relatively static and would not expect the rapid growth we have seen over recent years. We will need to monitor patient satisfaction and outcomes for key population groups closely to ensure we get the balance right.

Improving general practice premises

The ICB is responsible for strategic estates planning and support to develop the General Practice estate. This covers approximately 200 buildings in NCL. We must work with providers to ensure there is sufficient space to deliver commissioned models of care, secure a fit for purpose estate that meets standards, secure value for public money and support redevelopment. Revenue costs for the General Practice estate are managed via PCC.

Just under half the NCL general practice estate was built before 1948. There are declining numbers of 'owner occupied' premises (GP Partners as landlords) and as Partners retire and release premises we see an increase in Leasehold which increases cost to the NHS and impacts the General Practice business model. The current General Practice estate is not sufficient – nationally or locally - to support and sustain the *Modern General Practice* model. National changes are also needed to reflect in estates guidelines the significant growth in the workforce, the PCN model and integrated working and changes to the practice operating model.

The ICB is reviewing estates needs – triangulating contract, estates, finance and other information to understand current and future patterns in the estate. We are taking proactive action on capital allocations for the general practice estate, securing 5% of the Capital envelope per annum (one of the only ICBs in the country to do so). We are also digitising patient records and converting record rooms to clinical to optimise space. We are influencing at a National level with local lessons shared to inform the anticipated national Infrastructure Strategy.

Securing recurrent investment for digital developments

We are seeing an acceleration in the development of new digital tools and approaches that may support the sustainability of general practice. However with this comes both development costs and the recurrent costs of licences and kit. Currently this tends to be supported with non-recurrent funding which enables pilots of new approaches, however to be able to embrace, test, evaluate, roll-out and sustain the use of new digital tools, we will require recurrent investment. This forms part of the ICS Capital envelope and we need to achieve a balance between estate and digital investment.

Maintaining and strengthening the multi-disciplinary team

The introduction of a wider multi-disciplinary team in general practice is changing the nature of work for senior GPs, who now spend a larger proportion of their time supervising the wider team. In developing our Ambitions for General Practice, we will consider how the growth of the MDT is changing the nature of practice leadership and supervision models, and how we can support practices to make this shift safely and consistently. There is also some risk to retention of staff recruited under the additional roles reimbursement scheme (ARRS) as national investment is set to level out in 2024/25 after five years of growth.

Supporting change and a quality improvement approach

Through our System Access Improvement Plan we are exceeding national requirements for change support to practices, because we understand the level and pace of change required. This offers a prototype approach to change support which could be built upon to embed a consistent model, similar to the Clinical Effectiveness Group approach used in other ICBs. We are keen to explore this as part of our ambitions and approach to financial planning for general practice in NCL.

6 Communications and engagement

In November the Board noted the importance of communication and engagement to support patients to effectively self-manage, access support when it is needed and understand the challenges and choices faced by general practice teams. The previous section makes clear the scale of change that may be experienced, beyond the delivery of the System Access Improvement Plan. This in turn underlines the need for sustained communications, engagement and dialogue with patients, the public, and stakeholders locally, aligned to the outputs of the Londonwide deliberative engagement and our general practice ambitions.

The national access recovery campaign launched in January 2024. Building on previous campaigns, activity focuses on three key themes - digital access, the wider practice team and wider care available. There are also national communications on the launch of Pharmacy First to supplement our local approach to increasing patient awareness of new access routes into services.

National materials linked to the recovery plan are relatively high level so we are supplementing this with a full communications plan locally. We will message via partner and stakeholder channels, traditional local media and digital platforms such as newsletters, websites and social media. Working closely with our local voluntary and community sector groups we will use trusted voices to help share our message. We will also draw on ICB clinicians and primary care staff to enhance the impact of the campaign. Materials to be developed include profile pieces, template materials that partners and stakeholders can adapt, video content and images. We will use paid for social media activity to extend the campaign's reach, targeting materials by borough, location and language.

We have developed a practice-facing Directory of Services web page available via the NCL GP Website to support practice staff with care navigation.

7 Next steps

North Central London has developed its programme of work, has clear plans and is making progress against national deadlines. It is a whole-ICB approach with critical support from across our Directorates.

This will need to be maintained as a priority during transition of our own structures and operating model. We are enhancing the work as necessary and considering all key success factors.

Beyond this work we are seeking to develop, through local dialogue, our *Ambitions* for general practice in NCL which will seek to address the wider considerations outlined in this paper.

Appendix 1 – The patient journey under the modern General Practice operating model

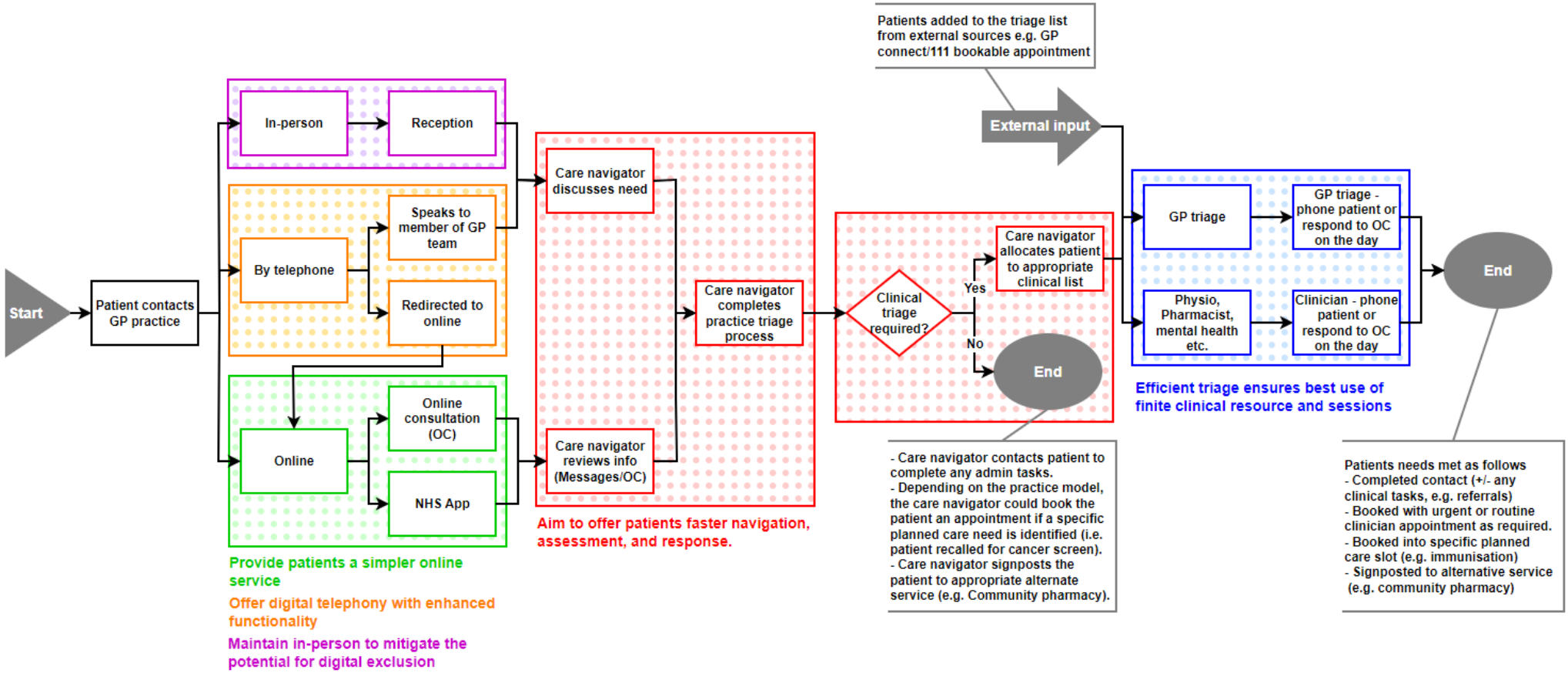
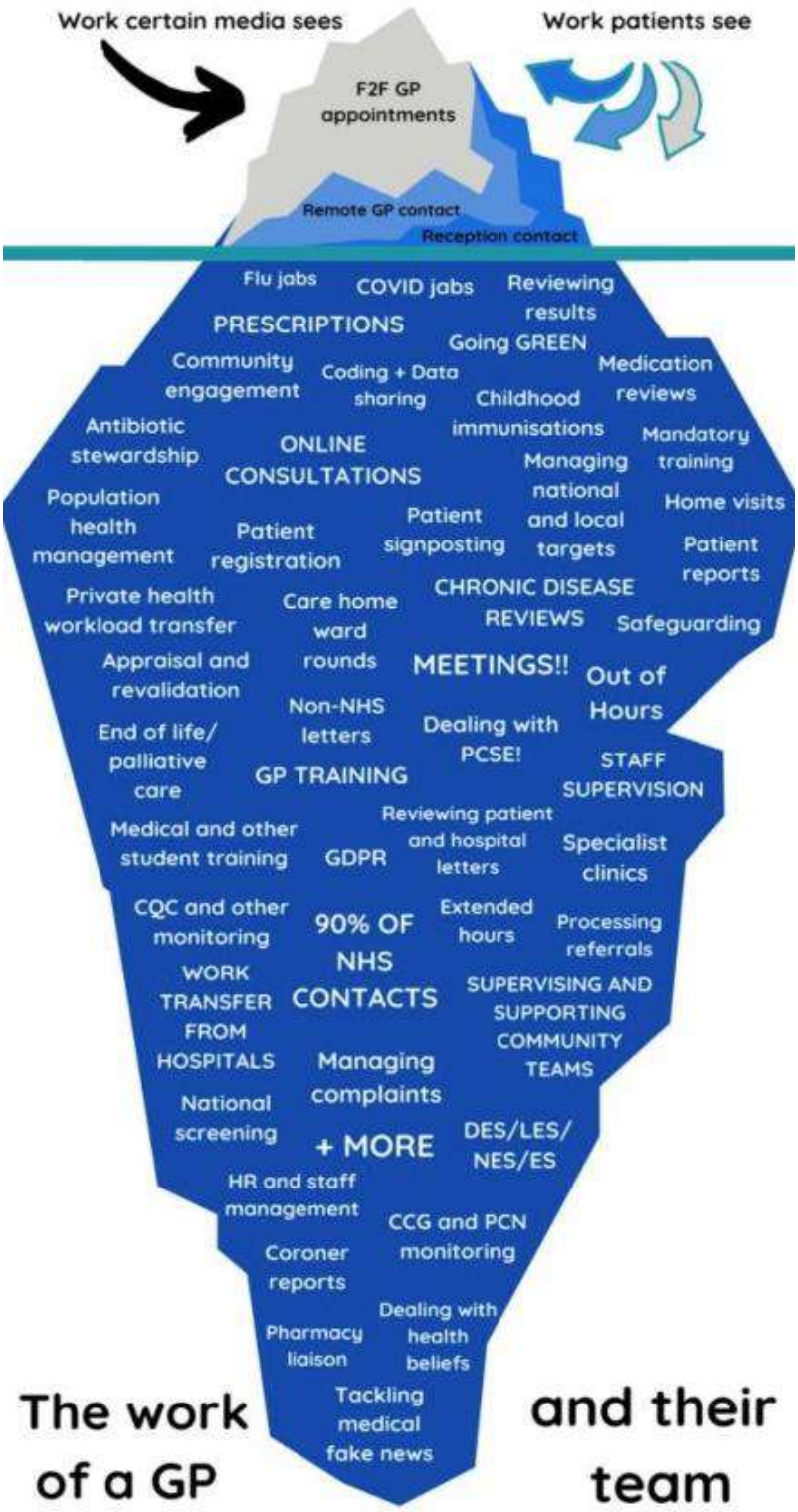


Figure 2 – visualisation of the modern General Practice operating model

Appendix 2 – the work of a GP and their team (source: Londonwide LMCs)



Appendix 3 – Measuring impact – sequence of work

		2023/24				2024/25				2024/25	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Practice-level change	Patient experience of GP access		**2023 GP survey** (baseline)				**2024 GP survey** (interim)				**2025 GP survey** (final)
		Ongoing qualitative feedback from patients and other stakeholders									
	PCN capacity and access improvement	**Structure:** PCNs write improvement plans	**Process:** PCNs track progress against the deliverables in their improvement plans			**Outcome:** PCNs demonstrate improved patient outcomes					
	Transition to modern General Practice		**Structure:** Practice survey measures readiness for change			**Process:** practice uptake and use of transition funding is monitored against NCL schedule and practice plans					
							Outcome: impact of practice use of their transition funding to move to modern general practice				
	Hands-on change support			**Structure:** MDT meetings agree support needs		**Structure:** SLF conversations develop understanding of need					
							Process: practice uptake of hands-on change offers				
								Outcome: impact of hands-on change offer			
Digital& IT	Digital and IT change		**Structure:** implementation and switch-on of key digital tools / features								
						Process: reducing variation in levels of digital activity					
			Structure: telephony upgrades in place								
				Process: reducing variation in telephony activity							
								Outcome: impact of digital and IT change on patients			
Wider programme	Pharmacy First			**Structure:** pharmacy sign-up to deliver the service							
							Process: Pharmacy First activity				
	Self-referral		**Structure:** provider uptake of self-referral pathways								
						Process: Patient self-referral activity					
	Interface			**Structure:** Interface infrastructure baseline		**Process:** Ongoing interface measures to demonstrate achievement of 4 priorities (details TBC)					

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
26 March 2024

Report Title	Integrated Performance and Quality Report	**Date of report**	6 March 2024	**Agenda Item**	3.1
Lead Director / Manager	Richard Dale, Executive Director of Performance and Transformation Dr Chris Caldwell, Chief Nurse	**Email / Tel**		richard.dale@nhs.net chris.caldwell@nhs.net	
Board Member Sponsor	Liz Sayce, Non-Executive Member Dr Chris Caldwell, Chief Nurse				
Report Author	Alex Cox, Director of Performance Deirdre Malone, Director for Quality	**Email / Tel**		alex.cox2@nhs.net deirdre.malone@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** The report does not set out specific financial requests, but some of the improvement programmes do have financial implications. Within the System Oversight Framework, finance is a key aspect of oversight. The detail of this is contained in the separate finance report.			
Report Summary	The NCL ICB Integrated Performance and Quality Report presents the latest analyses of key system operational performance and quality indicators against national and locally agreed targets relating to primary care, mental health, community and acute services. Areas of progress: • The proportion of patients waiting over 6 weeks for a diagnostic test has improved and stabilised in recent months, the net impact of increasing capacity, improving productivity, and stable demand. Based on the latest published data for December 2023, NCL remains the top-performing system in England, with 9.2% of patients waiting over 6 weeks for a diagnostic test. Further work is underway to ensure the system remains on track to achieve the national backlog ceiling of 5% by March 2025. NCL ICB is planning to execute the NHS ambition to reduce the cohort of				

	patients waiting over 13 weeks by the end of March 2024 - work is underway across the system to identify modality hotspots where the highest volumes are recorded and focus actions to help achieve this target. • NCL have seen improvements in patient flow and the reduction of the number of inappropriately placed mental health out of area patients (OAP) when compared to the same period last year. There are several programmes underway, such as the use of integrated discharge teams, that are reducing reliance on this bed provision. The latest data for Q3 2023/24 shows 1,042 OAPs recorded, which is a significant reduction on the Q3 2022/23 value of 1,847. • NCL general practice continues to deliver significant appointment volumes, and at an aggregate level, practices are consistently meeting the national expectation that 90% of primary care appointments are booked within 2 weeks. Further to this, 53% of NCL patients received a same day appointment, which is above the national average of 46% recorded for December 2023. Ongoing challenges and further work: • The number of patients on an open referral to treatment pathway waiting longer than 78 weeks remains a key challenge for the System. Sustained Industrial Action has inhibited long waiting patient clearance rates across NCL Providers throughout 23/24, with NCL forecasting a year end total of 209 patients waiting for treatment. The highest proportion of these patients are awaiting treatment in T&O, Urology & Plastics at The Royal Free London. A collaborative system approach to backlog clearance is being led by the ICB, through mutual aid & equitable demand management initiatives. • The number of patients on an open referral to treatment pathway waiting longer than 104 weeks in Paediatric Dentistry remains a key challenge for the System. There are 21 patients, 16 of which are awaiting specialist paediatric treatment at Great Ormond Street Hospital. A collaborative system approach to backlog clearance is being led by the ICB, through mutual aid establishment with UCLH in March and into Quarter 1 of 24/25. • At NMUH, an audit of Vascular completed RTT pathways identified that a number of patient pathways had been inappropriately stopped. The Trust. Following the implementation of the National NHSE Guidance, the Trust is forecasting 8 patients waiting longer than 78 weeks, and five patients waiting beyond 104 weeks for treatment at year end. Weekly escalation meetings are being held between the ICB & NMUH covering pathway management, clinical harm and quality engagement. • Access to community mental health services for Children & Young People (CYP) in NCL fell short of the Q3 2023/24 target (19,327) by 7.8% due to staff shortages in services. With 2023/24 investment in community services including plans to recruit additional staff, improvements in performance are expected before year end. • Cancer performance is challenged across NCL for both Operating Plan metrics (62-day backlog and the Faster Diagnosis Standard) – ongoing industrial action has continued to impact services adversely. The NCL Cancer Alliance continues to support a number of innovations led by

	Trusts across NCL. These help to deliver faster diagnosis, improve timely access to treatment, and enhance patient experience. • Aggregate NCL performance against the A&E 4-hour had been above trajectory for the beginning of 2023 but has dipped since August 2023 due to flow pressures and ongoing industrial action - the latest position for January 2024 shows performance of 67.9% against a plan of 75.7%. Work in the NCL System continues to deliver the step change towards the national performance ambition of 76.0% of patients seen within 4 hours, by March 2024. • The number of patients spending more than 12 hours in EDs remains high, reflecting high occupancy and constraints relating to patient flow through hospitals. Demand for social and community care resources continues to exceed supply, resulting in delayed discharges. Providers are focussing on increasing the use of Same Day Emergency Care and Urgent Community Response services in a bid to reduce demand on EDs. They are also looking to increase virtual ward capacity to improve flow, and subsequently reduce waiting times to be seen. In addition, work is being undertaken to improve supported discharges and bed flow.
Recommendation	The Board of Members is asked to **NOTE** the key issues set out in the paper for escalation and the actions in place to support improvement.
Identified Risks and Risk Management Actions	Key risks identified are detailed in the BAF and listed below: • STR9: Failure to Deliver the 2023/24 ICB CIP (Cost Improvement Plan including elements of Transformation Programmes) (Threat). • PERF5: Failure to deliver Cancer 62-day waiting time standard (Threat). • PERF7: Failure to manage patient flow during heightened periods of pressure, including winter, Easter and other Bank Holidays (Threat). • PERF8: Failure to Deliver Referral-To-Treatment ('RTT') Waiting Time Standard (Threat). • PERF29: Failure to deliver timely urgent and emergency care for the residents of NCL (Threat).
Conflicts of Interest	Not applicable.
Resource Implications	The report does not set out specific resource requests, but some of the improvement programmes do have resourcing implications.
Engagement	Not applicable.
Equality Impact Analysis	Not applicable – although quality processes do take account of equity when reviewing specific incidents.
Report History and Key Decisions	This report is underpinned by the Quality Report to the Quality and Safety Committee and the Performance Report shared across the organisation and system.

Next Steps	The report will continue to iterate based on board and stakeholder feedback, as well as develop alongside the NCL Outcomes Framework.
Appendices	Full dashboards for measures are set out in the appendix for reference.

NHS
North Central London
Integrated Care Board

NCL ICB Integrated Performance & Quality Report

February 2023

Authors: NCL ICB Performance and Quality Teams

Overview of this Report

North Central London
Integrated Care Board

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

The report focusses on the following key areas:

- NCL system response to industrial action (slides 3 and 4)
- Primary Care (slide 5)
- Mental Health Services (slide 7)
- Community Health Services (slide 8)
- Urgent and Emergency Care (UEC) (slides 9 and 10)
- Electives (slide 11)
- Diagnostics (slide 12)
- Cancer Services (slide 13)

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

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

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

The report incorporates aspects of the 2023/24 NHS Priorities and Operational Plan - NCL ICB are monitoring activity against trajectories taking into account the risks posed by ongoing industrial action. This also includes the further collaborative work with providers to deliver compliance against elective activity targets, to improve bed capacity to secure A&E performance improvement trajectories, and the efficient use of mental health beds to reduce the reliance on out of area placements. Planning for 2024/25 is already underway in the NCL System, ahead of forthcoming national guidance.

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

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

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

NCL System Response to Industrial Action (1/2)

North Central London
Integrated Care Board

Overview

Industrial action has continued across the NHS throughout 2023 and into 2024, with recent junior doctors' strikes taking place for 4 consecutive days in December 2023 (20th to 23rd) followed by a 6-day strike from January 3rd to the 9th 2024. Further action by the junior doctors occurred from February 24th to the 28th, 2024. As with previous strike action, this encompassed stoppage of non-emergency activity and on-call duties, with the only scenarios excluded from the action being a potential major incident or a mass casualty event. Junior doctors in GP training practices have also been part of the industrial action, although GPs were expected to maintain patient access on strike days.

Key NCL System & Provider Actions

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

Elective activity was stood down ahead of the strikes, with a focus on prioritising the provision of critical services including EDs. Multi Agency Discharge Events (MADE) continued in the lead up to strike action, focusing on reducing occupancy and facilitating discharges, with the overall aim of halving the number of beds occupied by medically optimised patients. ICU transfer services remained, but heralded bookings from NHS 111 to EDs were suspended. This will remain the same for the upcoming strike action.

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

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

NCL System Response to Industrial Action (2/2)

North Central London
Integrated Care Board

Primary Care and NHS 111

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

Community Providers

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

Impact of Industrial Action on Quality

To reduce the impact caused by industrial action on patients, NCL providers continued to take a risk-based approach when cancelling and rescheduling appointments to minimise the effect on quality and experience of care, and also to reduce the risk of clinical harm, recognising the impact of physiological harm associated with delays.

While NCL providers continue to undertake harm reviews on patients affected by continued strikes resulting in delays to their diagnosis and treatment, it is widely recognised by NHSE and the system that there may be resultant psychological harm experienced by patients and their families of repeated delays to scheduled care.

Overview of Primary Care

North Central London
Integrated Care Board

General Practice activity levels are at least 15% up on pre-pandemic levels, and for some practices activity has increased by as much as 30%. Appointment activity continues to increase and NCL now averages 680,000 appointments per month, which is an increase of 50,000 a month on 2022/23 activity levels. For December 2023 published data, face to face appointments made up 60% of all appointments, with the rest being largely telephone appointments. Overall core appointments recorded are lower than in preceding months, as would be expected due to the Christmas and New Year period. In response to the pandemic and to help practices handle demand since, new routes into General Practice and new tools for triage and consultation have been introduced at pace over the last four years.

Digital tools play a dominant role in access with online bookings, e-consultations, app usage, and also with patient list management via risk stratification for proactive care. NCL ICB monitors the uptake of digital tools, and supports practices with switch-on, and the embedding of these new ways of working as required. This offers patients more ways to contact their practices, though traditional access routes are maintained to support digital inclusion.

Through delivery of the requirements of the national Primary Care Access Recovery Plan (PCARP), practices are actively working on reducing variation in patient experience of accessing General Practice, noting that whilst practices are providing more appointments than ever before, there is an overall drop in satisfaction with access, alongside significant variation in national GP Patient survey results.

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

The NCL-wide locally commissioned service focuses on the identification and management of long-term conditions and launched on October 1st, 2023. The service has an emphasis on personalised care planning and continuity of care for those who will most benefit. The service launch has been accompanied by ongoing mobilisation support and training for practices, and in the first 6 months, practices are asked to target improvements in key outcomes for people with hypertension or diabetes. This new service will ensure that the focus on access to general practice is balanced by a commitment to protecting capacity for planned work, and proactive care for people with long term conditions to help them stay well.

	Oct '23	Nov '23	Dec '23
Core primary care appointments	738,995	716,137	578,058
% same day appointments	49%	51%	53%
% appointments within 2 weeks	91%	92%	92%

Primary care reporting

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

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

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

Overview of CNST - Maternity Incentive Scheme

North Central London Integrated Care Board

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST, and incentivises ten safety actions.

Trusts that can demonstrate they have achieved all ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Ten safety actions:

1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
3. Can you demonstrate that you have transitional care services in place to minimise separation of mother and their babies?
4. Can you demonstrate an effective system of clinical workforce planning to the required standard?
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6. Can you demonstrate that you are on track to meet compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?
7. Listen to women, parents and families using maternity and neonatal services and coproduce services with users.
8. Can you evidence the listed 3 elements of local training plans and 'in-house', one day multi-professional training?
9. Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
10. Have you reported 100% of qualifying cases to the Healthcare Safety Investigation Branch (HSIB), (known as Maternity and Newborn SAFETY Investigations Special Health Authority (NMSI) from October 2023), and to NHS Resolution's Early Notification (EN) Scheme from 06 December 2022 to 07 December 2023?

NCL position against the MIS safety actions:

UCLH	Full compliance
RFL	Full compliance
WH	Full compliance
NMUH	Noncompliance – actions 1 and 9

NMUH are developing an action plan to address the non-compliance issues with safety actions 1 and 9. Progress against this will be overseen by the ICBs Local Maternity and Neonatal System (LMNS).

Overview of Mental Health Services

North Central London
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Overall access to **Talking Therapies (TT)** remains challenged against the reduced 2023/24 LTP target of 44,350. Mitigating actions include the expansion of outreach sessions to underserved community groups, ahead of undertaking a wider promotion of the offer via primary care. In addition, to improve access pathways and referral management, NCL TT services are implementing digital systems to automate patients' reminder notifications to reduce DNAs. The TT waiting list has increased to 2,546 in February 2024 from 2,338 in January 2024. In December 2023, NCL are achieving targets for 6 and 18 week waits, but the recovery rate is just under the 50% target at 49%.

During 2023/34 there has been a notable reduction in the number of **Out of Area Placements (OAP)**. The North London Mental Health Partnership has been working with system colleagues to achieve zero OAPs by year-end, and to reach this ambitious target, a ten-step discharge plan based on the Quality Improvement approach has been implemented. The aim is to reduce patients' mean length of stay and improve flow by focusing on three key processes: pre-admission, inpatients, and discharge. In Q3 of 2023/24, the target was not achieved due to a surge in demand for inpatient services, which resulted in increased admissions.

The NCL **CYP Access +1** target for 2023/24 is 20,579, with underperformance driven by service vacancies. NCL ICB continues to monitor recruitment to 2023/24 investment schemes via a monthly sitrep to capture the status of funded posts in respect of progress against delivery milestones, alongside associated risks and issues. Access to CAMHS has increased for CYP at schools who are supported by Mental Health Support Teams (MHST) – as NCL sees an increase from 16 to 19 MHST from 2024/25, this will likely support achievement of next year's target.

Memory services in NCL are developing plans to ensure delivery of the **Dementia** diagnosis rate ambition of 67% is maintained throughout 2023/24. These cover streamlining referrals into the service and commencing pre-assessment checks at an earlier phase, alongside a pilot initiative to implement a more concise assessment procedure to reduce the duration of face-to-face evaluations.

As of October 2023, NCL is meeting one of the three measures relating to the use of inpatient facilities for patients with **Learning Disability/Autism.** NCL has 12 patients above 9 months length of stay (LOS), so requiring borough escalation to ensure that there are clear plans to optimise treatment and discharge to the community. Delays occur where patients have complex needs meaning it takes considerably longer to identify and secure suitable placements. Camden has the longest LOS at 56 months for ICB funded beds. There continues to be delays in discharge with CYP inpatients due to suitable social care placements not being available. The average LOS has reduced to 4.5 months, currently under the national target of 6 months

	Oct '23	Nov '23	Dec '23
TT Access (YTD) *[Dec YTD Target: 33,263; 23/24 Y/E Target: 44,350]*	20,080	23,151	25,421
OAPs (in month) *[23/24 Target: 0]*	420	198	424
CYP Access (12MR) *[Dec Target:19,327; 23/24 Y/E Target: 20,579]*	17,325	17,620	17,865
Dementia Rate *[Diagnosis Target: 67%]*	68%	68%	68%

	Aug '23	Sept '23	Oct '23
LD/Autism Inpatients (ICS) *[23/24 Y/E Target: 22]*	23	21	17
LD/Autism Inpatients (NHSE) *[23/24 Y/E Target: 16]*	31	14	21
LD/Autism Inpatients(<18yrs) *[23/24 Y/E Target: 5]*	5	7	7

Overview of Community Health Services

North Central London
Integrated Care Board

The percentage of Children and Young People (CYP) waiting 18 weeks or less reduced to 61% in December 2023 against the locally agreed target of 66% - therapies and autism services account for 49% of the total CYP waiting list. The number of CYP waiting over 52 weeks increased by 135 to 683. NMUH immunisation services drive the growth in the long waiter cohort, and account for 54% of those waiting over 52-weeks. Part of the growth is thought to be data quality, and NMUH is undertaking a validation exercise ahead of the next submission. The validation outcome will be supported by discussion with NCL System partners, at the March 2024 CYP Transformation Board.

Demand for autism diagnosis (referrals accepted) currently outstrips the monthly supply of assessments (completed assessments) in all NCL boroughs. The autism backlog reduction has been supported by Healios (an independent provider of assessment services for children with autism), and the NCL Autism Hub, through non-recurrent funding for 2023/24, which will carry out around 1,000 additional CYP assessments on top of current core capacity. Across NCL, the ICS has established a task and finish group led by provider colleagues, to review diagnosis pathways for children under and over 5. This group is exploring systematic changes to the diagnostic pathway and is gathering refreshed demand and capacity information to allow for an equitable resource proposal to be submitted, and then gain investment from the 2024-25 Community Service Review funding pool. This process is expected to be finalised in March 2024.

To finalise the financial envelope alongside the Project Delivery Plan (PDP) by April 2024, work is underway for the NCL 2004/25 Community Core Offer. Following a gap analysis and stocktake in January 2024, priority setting will be determined by March 2024 for NCL ICB approval. To reduce the existing CYP waiting list and enhance performance, Barnet, Enfield, and Haringey have filed their PDPs, inclusive of therapeutic service trajectories.

In December 2023, the 18-week waiting time compliance for adult community services was 80% from referral – there is not currently a locally agreed target for delivery in NCL. There was also a reduction to 8 cases waiting over 52 weeks compared to October 2023. Musculoskeletal, podiatry and physiotherapy services remain key contributors to the adult waiting list.

At Whittington, backlog reduction has been seen in MSK since October 2023 as recruitment reached full staffing establishment levels, and this will help to maintain capacity and performance in the future. In addition, extra weekend lists scheduled through February and March 2024 will see 200 new patients per weekend. With better utilisation of the self-management app ‘getUBetter’, patients will be encouraged to try this option first for physiotherapy - so far 2,000 routine patients have been contacted, and with good uptake, the app is expected to ease the demand for services.

	Oct ‘23	Nov ‘23	Dec ‘23
Waiting Times % <18 weeks (CYP) *[23/24 Target: 66%]*	66%	65%	61%
Waiting Times >52 weeks (CYP)	504	548	683
Waiting Times % <18 weeks (Adults)	83%	81%	80%
Waiting Times >52 weeks (Adults)	22	12	14

Overview of Urgent & Emergency Care Services (1/2)

North Central London
Integrated Care Board

Attendances to NCL EDs increased over the winter with 8,000 more attendances between November 2023 and January 2024, compared with the prior 3-month period. In January 2024, this was around 5,000 more attendances than January 2023. Whilst attendances have increased, so has acuity of presentations, leading to bed congestion which is further exacerbated by infection prevention and control challenges - there has been a corresponding decline in 4-hour performance, which remains below the 2023/24 Operating Plan trajectory. All NCL providers continue to work towards the national ambition of 76% 4-hour performance by March 2024, alongside improved performance re the number of patients waiting over 12 hours in ED. Actions to support EDs on these aims are detailed on the following slide.

LAS ambulance handover performance remains challenged, with deterioration seen in November and December 2023. Following the implementation of the pan-London LAS 45-minute handover protocol in summer 2023 which led to significant improvement in handovers occurring within 45 minutes, there has been a dip over the winter months, which have averaged around 80%. Although there was an increase in the number of handovers taking longer than 60 minutes in the last three months, these remain significantly fewer than the same period last year. The handover process has supported some improvement in the mean LAS ambulance response times for category 2 calls, although this remains challenged and above the 30-minute standard.

The new alliance contract (LAS and LCW) for NHS111 came into effect at the start of November 2023. Whilst the total number of calls received to the service remains within planned contract levels, performance continues to be challenged with a call answering time of over 3 minutes, and a call abandonment rate of 12.6%, both for January 2024. The Clinical Assessment Service (CAS) continues to perform well with 94% of ED dispositions being validated by a clinician.

The front-end call handling workforce remains a key service constraint in terms of recruitment, retention, and absence. A series of support and improvement initiatives are in place, including a national resilience partner (Vocare) supporting up to 25% of calls received, up to Q2 of 2024/25, as well as a series of local incentivised staff schemes based on call answering rates. Service activity and performance is monitored and managed through formal monthly contract meetings with the NCL Alliance Partnership - a requested improvement trajectory plan will be tracked for the recovery of targets.

	Nov '23	Dec '23	Jan '24
A&E 4-hour Waits *[23/24 national target – 76%]*	66.9%	65.4%	67.9%
A&E 12 Hours in Department* [From a decision to admit]	2,028	2,059	2,514
Ambulance Handover Delays (>30 minutes) *[National target – 5%]*	2,145	2,578	2,888
Ambulance Handover Delays (>60 minutes) *[National target – 0]*	156	310	418
NHS 111 – Calls Abandoned *[National target <3%]*	11.0%	18.4%	12.6%
Long Lengths of Stay (>21 days) *[23/24 Target – 455]*	605	571	589

Overview of Urgent & Emergency Care Services (2/2)

North Central London
Integrated Care Board

At the end of January 2024, NHSE sent a communication asking for providers to review their own internal systems and processes to support their ED teams, ensuring that plans are in place to address five key priority areas, so supporting their system in getting closer to achieving the two key deliverables set out in the Urgent and Emergency Care Recovery Plan, namely:

1. Patients being seen more quickly in EDs, with the ambition to improve to 76%, the proportion of patients being admitted, transferred or discharged within four hours by March 2024 and,

2. Ambulances getting to patients quicker, with improved average response time for category 2 incidents, to 30 minutes over 2023/24.

There are five key initiatives underpinning the improvement of access, and the patient experience of services:

1. Streaming and redirection,

2. Rapid Assessment and Treatment (RAT),

3. Maximising the use of Urgent Treatment Centres (UTC),

4. Improving ambulance handovers,

5. Reducing the time spent in department.

Providers are currently reviewing and embedding plans aligned to this. Providers are already focussing on increasing the use of Same Day Emergency Care (SDEC) and Urgent Community Response (UCR) services in a bid to reduce demand on EDs. They are also looking to increase virtual ward capacity to improve flow, and subsequently reduce waiting times to be seen. In addition, work is being undertaken to improve supported discharges and bed flow.

Overview of Elective Services

North Central London
Integrated Care Board

NCL acute providers have continued the focus on reducing the referral to treatment (RTT) time of the longest waiting patients, aiming to eliminate waits over 78 weeks by the end of March 2024. The loss of clinical capacity in both outpatient and inpatient programmes from industrial action (IA) has continued to impact the total numbers of patients waiting, but also the long waiting patient cohort clearance rates. Both cancer and urgent pathways have been prioritised during the strike action. In NCL, IA has reduced elective activity by 20-30% and outpatient activity by 10-20% for each strike day – this covers 36 days in 2023 and the first 6 of 2024.

Although NCL providers have shown good recovery and service resilience, the inevitable effects of the recurrent IA throughout the year has had a significant impact on elective capacity and patient waiting times. The majority of the longest waiting patients are attributed to capacity constraints across surgery and particularly affect the specialised and complex paediatric services across the sector.

Elective activity levels continue to exceed the 2019/20 baseline, and so the objective to achieve 65 week waiting compliance by the end of September 2024 remains. Key NCL interventions to reduce waiting times remain in place and cover:

- Referral optimisation – GP referrals to be managed appropriately first time.
- Improving productivity – assessing theatre utilisation data to optimise usage, and the use of consultant connect and advice and guidance to manage relevant pathways in primary care.
- Increasing capacity – additional sessions to deliver more appointments and procedures.
- Outpatient transformation – innovative delivery including digital and patient-initiated follow-ups, with a significant emphasis on reducing outpatient follow-ups in line with national guidance
- Mutual aid – reducing inequity in access through the sharing of resources, and redistribution of demand. Implementation of the National Digital Mutual Aid System (DMAS) and the Patient Initiated Mutual Aid Digital System (PIDMAS), and the local review of referral demand to balance activity and waits across providers through demand smoothing.

	Dec ’23	Jan ’24	Feb ’24
RTT Waiting List *[23/24 Target – 259,133]*	266,991	*273,429**	*277,144**
RTT 65ww *[23/24 Target – 0]*	2,495	*2,675**	*2,398**
RTT 52ww *[23/24 Target – 3,088]*	8,429	*8,947**	*8,802**

	Oct ’23	Nov ’23	Dec ’23
Electives YTD vs 19/20 baseline *[Inpatients + Day Cases]*	109.7%	110.9%	111.0%
Outpatient FU YTD vs 19/20 baseline *[Excluding OPPROC]*	106.9%	108.1%	107.5%

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

Overview of Diagnostics Services

North Central London
Integrated Care Board

Based on the latest published data for December 2023, NCL remains the top-performing system in England, with 9.2% of patients waiting over 6 weeks for a diagnostic test. NCL ICB is planning to execute the NHS ambition to reduce the cohort of patients waiting over 13 weeks by the end of March 2024 - work is underway across the system to identify modality hotspots where the highest volumes are recorded and focus actions to help achieve this target.

The latest unvalidated data for February 2024 suggests that the NCL diagnostic backlog has recovered to 8%, after the increase seen over the festive and New Year period, combined with ongoing industrial action. Recovery plans are in place to further reduce the backlog, with additional capacity at NCL providers, and more utilisation of Community Diagnostic Centres as mutual aid for imaging modalities.

February 2024 unvalidated data shows that the imaging backlog contributed to 35% of the overall NCL diagnostics value. The largest cohort within this are patients at UCLH awaiting an MRI, where capacity at Queen Square has been affected due to the decommissioning of 2 scanners and the installation of replacements. Currently, 5 MRI scanners are functioning on-site, but staffing capacity is reduced. There are additional lists being run on weekends resourced with bank and agency staff. MRI capacity has also been sought via CDC mutual aid, at the Finchley and Wood Green sites. CT performance at RFL is also challenged - discussions are ongoing to outsource CT cardiac patients to InHealth to help reduce the backlog, as mutual aid is unavailable at CDCs for this special test

RFL and NMUH have the highest proportion of the NCL total endoscopy backlog. At RFL, demand continues to exceed capacity at the Hampstead site, however the unvalidated weekly data shows a reduction since its peak in October 2023. Transnasal endoscopy procedures are due to transfer to the Finchley CDC, and this is likely to free up capacity to focus on the remaining backlog. At NMUH, the driver for the increase in the endoscopy backlog has been the ringfencing of capacity to support the colorectal cancer pathway - initial outputs have seen a reduced average booking time here from 18 days to 13 days. An insourcing company is supporting NMUH in reducing the size of its endoscopy backlog by looking at potential efficiencies. An additional endoscopy room is scheduled to open in Q1 of 2024/25, which will create additional endoscopy capacity in the future.

The NCL ICB led Planned Care Delivery Group continues to oversee NCL System diagnostic performance fortnightly, alongside monthly imaging and endoscopy boards.

	Dec '23	Jan '23	Feb '23
Diagnostic Waiting List	40,416	*42,262**	*45,432**
Diagnostic Waits > 6 weeks %	9.2%	*12.7%**	*7.8%**
Diagnostic Waits > 6 weeks	3,713	*5,354**	*3,536**
Diagnostic Waits > 13 weeks	514	TBC	TBC
Diagnostic Activity *[% of 2019/20)*	122%	*117%**	*117%**

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

Overview of Cancer Services

North Central London
Integrated Care Board

Overall, performance of NCL cancer services remains variable. Although challenges in the diagnostic phase of pathways continue to impact the number of patients waiting 62 days or longer, the 62-day backlog has reduced in Q3 and into Q4. As of February 25th 2024, the backlog stood at 608 patients, a reduction of 194 patients since September 2023. This is a current underperformance of 67 against the February 2024 plan of 541. For the same period, NMUH, RFL and WH backlogs as a percentage of total PTL, were better than the England average.

In February 2024, the FDS Tiering threshold, based on December 2023 performance, was increased from 70% to 72.5% - UCLH, Whittington and RNOH met the target, whilst RFL performance was 71.2%. An emerging area of concern is in the breast pathway as throughout 2023/24, the percentage of patients seen within 2 weeks has fallen, driven by performance at UCLH and Whittington, so impacting on FDS achievement. Whilst NCL's breast FDS performance has been maintained above the 75% target, due to services having a one-stop clinic model, UCLH and Whittington have performed below the target in recent months. The 62-day backlog has increased from 40 in July 2023, to 88 in January 2024. To mitigate this, both UCLH and Whittington are putting on additional capacity throughout Q4 2023/24, which has been funded by the NCL Cancer Alliance.

The NCL Cancer Alliance continues to support a number of innovations led by Trusts across NCL. These help to deliver faster diagnosis, improve timely access to treatment, and enhance patient experience. Innovations include:

- Skin - continuing to support implementation of teledermatology services at RFL and UCLH.
- Gynaecology - options appraisal for a sustainable, long-term model of gynaecology diagnostics.
- Breast - optimising capacity through the development of an alternative pathway for breast pain only.
- Colorectal - pathway redesign, including discharge at endoscopy, and continuing to promote the FIT <10 pathway.
- Prostate – Medical Image Merge, contouring software roll out with evaluation in Q4 2023/24 and redesign of the NMUH pathway.

Skin at UCLH was the most challenged pathway - the recovery plan included additional capacity using existing staff, the independent sector (IS) to deliver additional 2ww and procedure clinics, and a Teledermatology pilot. Subsequently, UCLH's 62-day skin backlog has reduced from 165 patients to 20.

31-day subsequent radiotherapy performance at RFL continues to improve. December 2023 performance was the highest since December 2021, at 81.5%, but further work is required to meet the standard. Mitigations include the transfer of Whittington's urology patients requiring radiotherapy, from RFL to UCLH, utilising the IS to provide additional capacity, and the development of proposals to install additional LINACs.

	Dec '23	Jan '24	Feb '24
Cancer Waits 62-Day Backlog *[23/24 Target - 515]*	675	692	*608**
Cancer Diagnosis Standard (FDS) *[23/24 Target – 75%]*	71.6%	TBC *Data is reported 6 weeks in arrears*	TBC *Data is reported 6 weeks in arrears*

NCL Providers (as of February 25th 2024)	**Cancer Backlog as % of Waiting List**
University College London	8.2%
Royal National Orthopaedic	8.1%
North Middlesex	6.9%
Royal Free London	6.7%
Whittington Health	5.6%
England Average	**8.0%**

** Based on the latest in-month data. February 2024 value to be finalised.*

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

North Central London Integrated Care Board

Royal Free London (RFL)

SOF3 arrangements continue with monthly performance meetings in place and a joint executive level quarterly meeting with RFL and NMUH led by the NCL ICB CEO. Exit criteria for 2023/24 for RFL relate to UEC, cancer and finance.

Good progress was seen up to Q2 across the 3 UEC metrics, but the latter part of the year has been more challenging - trajectories have not been achieved for Q3. While AE 4-hour targets have not been achieved in Q3, performance has incrementally improved despite increasing attendances. 12-hour performance has also been impacted by patient volumes, so focus remains on modelling re capacity and flow across sites. RFL are exploring front door alternatives to ED, and how Same Day Emergency Care pathways and virtual wards utilisation can be maximised.

Ambulance handover times have struggled during Q3, despite initial in year improvements via the cohorting of patients. The upcoming refurbishment of the ED at the Barnet site will become active during 2024/25 and this is planned to mitigate handover pressures, with more space available to look after arriving patients.

Cancer performance for the 62-day backlog has been variable during 2023 but has shown improvement into 2024. Clearance has been impacted by recent industrial action in Q3 and Q4, but the RFL position at the end of February 2024, shows a minimal variance of 4 to the NHSE 'fair shares' value of 308. The NCL Cancer Alliance will be assisting regarding the utilisation of independent sector capacity during Q4.

Faster Diagnosis Standard (FDS) improvements have been seen against the revised plan for Q3 and Q4 - performance is now above the agreed trajectory for November and December 2024. Early indications for January 2024 performance show that the position will be impacted by the recent industrial action, but this effect has also been seen across other London providers.

North Middlesex University Hospital (NMUH)

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

In respect of the NHSE National Cancer Programme, NMUH was moved out of Tier 2 oversight in Q3 2023/24, recognising the reduction in the 62-day pathway backlog and improving FDS performance. The latest cancer performance shows that NMUH are ahead of trajectory for 62 day waits (improvements in urology driven by by increased MRI capacity, enabled by Tier 2 funding), with further work required for the 104-day cohort. FDS achievement is impacted by endoscopy delays affecting overall performance, but plans are in place to open additional outpatient capacity, with 3 extra clinics during Q4 2024.

UEC performance against the exit criteria remains below agreed trajectories since Q2 of 2023/4. The NMUH 'Go for Flow' programme is focussing on 3 key areas – increasing discharges by midday, ensuring patients are streamed to the right place, and reducing delays when discharging to community services or the local authority.

Regarding timely patient discharge, NMUH are now utilising senior clinical input earlier in the day to aid with discharge, and maintaining communication with diagnostic colleagues where delays are occurring. A review of the process with social care to expediate discharges will be carried out in Q4 2024. To further aid flow though ED, NMUH are liaising with NCL colleagues to explore methods of best practice, and the possible implementation of a maximum capacity protocol on site.

Delivery on the ambulance handover target has been particularly challenged but remains a key focus into 2024/25 - physical capacity constraints and periods of high demand on ED continue to be barriers to improvement.

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

North Central London
Integrated Care Board

Tavistock & Portman (T&P)

The SOF process in place at T&P is focussed on the progress of areas aligned to revised exit criteria and agreed milestones based on 6 themes – the Gender Identity Development Service (GIDS), long term strategy, finance, leadership and governance, quality, and the Gender Identify Clinic (GIC) service. The oversight mechanisms include a monthly executive group focussed on performance and improvement chaired by the ICB Executive Director of Performance and Transformation, and an Oversight Board chaired by NHS England.

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

GIDS – commitment to demonstrating grip over the clinical and operational challenges of the GIDS service whilst it remains within T&P control. This includes the support for transferring services to the new model of care.

Longer Term Strategy – the development of strategy agreed with NCL ICB and NHSE, that is clinically, operationally, and financially sustainable. T&P will have in place a robust governance process to oversee and review delivery of the programme of work.

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

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

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

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

Improvement of GIC Productivity – productivity improvement will be driven by pathway redesign, to close the gap to the national average.

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

The trust is now undertaking a process of agreeing a future partner trust for merger, which will support delivery of the longer-term strategy of the trust.

NHS
North Central London
Integrated Care Board

Appendices

Appendix 1 – NCL Balanced Scorecard

North Central London
Integrated Care Board

NCL ICS Level Scorecard (05-03-24)

	Key Performance Indicator	Target	Reporting Period	Current Performance	Trend	Year-End Forecast	Notes
ICS Finance	Bottom line (YTD)	(£50.9m)	YTD M9	(£76.3m)		(£14.4m)	*The year end deficit FOT of £14.4m is entirely driven by industrial action pressures for M9 and M10. Excluding the impact of industrial action, the FOT is breakeven.*
	Efficiency delivery (YTD)	£180.6m	YTD M9	£152.8m		£272.4m	*Providers are currently behind on CIP delivery but forecasting to be on plan.*
	Agency Spend (YTD)	£70.8m	YTD M9	£84.0m		£107.3m	*YTD overspend on agency and a straight line extrapolation would indicate that NCL will exceed the 2023/24 NHSE agency cap.*
	Capital (YTD)	£111.8m	YTD M9	£110.3m		£187.3m	*Providers are reporting YTD overspends of £4.4m across the NCL capital programme at M8. The adverse variance is driven by RFL, RNOH, UCLH, WH and NMUH, offset by underspends at other providers.*
	Cash (YTD)	n/a	YTD M8	£740.4m		£726.7m	*The YTD cash position is a net £123m decrease in cash balances. This is equivalent to a net decrease of 9 days (16.8%) cash in hand from 56 days to 46 days*
Performance & Quality	Elective Activity (% of 19/20)		YTD M10	111.0%	Steady		*Value represents NCL provider aggregate*
	Total Waiting List Size	Feb '24 <259,249	w/e 25/02/24	277,144	Declining	off target	*The NCL waiting list has increased through Feb-24 with a post holiday dip and industrial action impacting on clearance rates. The future impacts of the junior doctor strikes will be monitored.*
	RTT 65ww	Feb '24 <2,333	w/e 25/02/24	2,398	Improving	on target	*NCL Trusts' focus is on delivering higher clearance rates over 23/24 to meet the year end H2 ambition. Escalation meetings with trusts have been set up to monitor key pressures, and the mutual aid availability across London.*
	Cancer Backlog	Feb '24 <541	w/e 25/02/24	608	Improving	off target	*The NCL backlog position is largely driven by urology (232), lower GI (88) and breast (73).*
	Cancer Backlog - % of PTL	6.4%	w/e 25/02/24	7.0%	Steady	off target	
	Cancer FDS	Dec '23 >72.5%	Dec '23	71.6%	Steady	off target	*NCL FDS performance remains challenged in recent months, but the latest data shows relatively stable achievement.*
	Diagnostic % >6 weeks	Feb '24 <9.9%	w/e 25/02/24	8.2%	Improving		*Based on validated data, NCL is the best performing system in England re 6ww performance for Dec-23 at 9.6%.*
	MH - Talking Therapies Access	M9 YTD - 33,263	YTD M9	25,421	Improving		*Underperformance seen across all NCL boroughs*
	MH - Out of Area Placements	Q2 - 155	Q2	1,042	Steady		*The numbers of Out of Area Placements is exceeding anticipated target at both BEH and C&I.*
	CAMHS Access	M9 (12MR) - 19,327	M9 (12MR)	17,865	Steady		*NCL underperformance of CYP MH access is due to lower reported levels than nationally projected, of the MHST function 1activity.*
	Never Events	0	Jan-24	2			*Represents NCL trusts' total count*
	Serious Incidents	0	Jan-24	15			*Represents NCL trusts' total count*
	HCAI - *C.Diff*	12 month rolling - 297	Dec-23	273			*Represents NCL ICB total cases*
	HCAI - MRSA	0	Dec-23	26			*Represents NCL ICB total cases*
Efficiency/ Workforce	Staff in Post v Plan	Op Plan	M10	2.8%			*Values are based on the 2023/24 Operating Plan submission*
	Vacancy Rate	n/a	M10	8.9%			*RNOH, UCLH & WH are above the NCL 8.9% average*
	Sickness Rate	c4%	M6	4.2%			*The overall NCL sickness rate has remained steady over recent reporting periods.*
	Theatre Productivity	85%	4 wks to 28/01/24	80.3%			*Value represents 'capped utilisation'.*
	Daycase as a % of Elective	85%	Dec '23	84.8%			*MEH and NMUH are currently meeting the target.*
	Outpatient FU Reduction	75%	YTD M10	107.7%			*All NCL providers are over the 75% target YTD*

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

North Central London
Integrated Care Board

North Central London ICS - Mental Health LTP/ICS Trajectories (Monthly)		TARGET 22/23 - Q4	2022/23			TARGET 23/24 - Q1	2023/24			TARGET 23/24 - Q2	2023/24			TARGET 23/24 - Q3	2023/24		
			January	February	March		April	May	June		July	August	September		October	November	December
Summary of Monthly Measures	Talking therapies access	42,600	27,740	30,515	33,715	11,088	2,990	6,055	9,045	22,175	11,915	14,665	17,310	33,263	20,080	23,151	25,421
	Talking therapies recovery rate	50.0%	50.0%	52.4%	52.0%	50.0%	47.0%	51.0%	49.0%	50.0%	47.0%	48.0%	49.0%	50.0%	46.0%	47.0%	49.1%
	Talking therapies first treatment 6 weeks finished course rate	75.0%	84.0%	83.0%	84.0%	75.0%	85.3%	85.0%	87.0%	75.0%	87.0%	86.0%	87.0%	75.0%	89.0%	90.0%	91.0%
	Talking therapies first treatment 18 weeks finished course rate	95.0%	98.0%	98.2%	98.0%	95.0%	98.0%	98.0%	99.0%	95.0%	98.0%	98.0%	99.4%	95.0%	98.0%	99.0%	99.0%
	CYP access - One contact	23,291	15,755	16,035	16,275	16,822	16,345	16,405	16,595	18,075	16,655	16,995	17,150	19,327	17,325	17,620	17,865
	Dementia diagnosis rate 65+	73.0%	TBC	TBC	TBC	67.0%	66.3%	67.2%	68.0%	67.0%	67.9%	67.9%	68.0%	67.0%	68.2%	68.2%	68.2%
	EIP entering treatment - treatment received <2wks	60.0%	75.0%	74.0%	72.0%	60.0%	69.0%	69.0%	78.0%	60.0%	77.0%	85.0%	80.0%	60.0%	75.0%	72.0%	83.0%
	Number of inappropriate OAP days (YTD by quarter)	2,270	762	1,232	1,556	578	221	390	594	392	241	377	683	155	420	618	1,042
	1 hour response time %	95.0%	92.1%	94.5%	94.7%	95.0%	96.8%	96.8%	97.2%	95.0%	95.8%	96.3%	95.3%	95.0%	94.1%	93.4%	94.6%
	24 hour response time %	95.0%	94.3%	95.5%	96.2%	95.0%	98.2%	96.8%	95.5%	95.0%	97.1%	97.5%	97.4%	95.0%	97.4%	97.3%	98.0%
	Women accessing perinatal mental health (PMH)	2,002	775	820	750	275	351	498	612	550	709	771	851	948	944	1,040	1,135

Appendix 3 – NCL Mental Health Dashboard (2/2)

North Central London
Integrated Care Board

North Central London ICS - Mental Health LTP/ICS Trajectories (Quarterly)		2022/23								2023/24					
		TARGET 22/23 - Q1	Q1	TARGET 22/23 - Q2	Q2	TARGET 22/23 - Q3	Q3	TARGET 22/23 - Q4	Q4	TARGET 23/24 - Q1	Q1	TARGET 23/24 - Q2	Q2	TARGET 23/24 - Q3	Q3
Summary of Quarterly Measures	Children and young people (CYP) eating disorders - urgent	95.0%	43.6%	95.0%	54.1%	95.0%	57.1%	95.0%	75.0%	95.0%	75.0%	95.0%	100.0%	95.0%	87.5%
	Children and young people (CYP) eating disorders - routine	95.0%	25.4%	95.0%	27.2%	95.0%	28.1%	95.0%	34.0%	95.0%	84.0%	95.0%	88.0%	95.0%	97.4%
	People accessing individual placement and support (IPS)	285	308	570	400	855	494	1,141	767	355	331	711	441	1,066	585
	Severe mental illness - physical health check (SMI-PHC)	10,142	8,567	10,909	8,949	11,677	10,342	12,445	13,322	13,498	11,388	13,674	11,008	13,851	11,343
	Adult Community Access	16,795	15,200	17,825	14,985	18,555	14,945	19,887	14,805	16,627	19,010	18,248	20,042	19,870	20,859
	Learning disabilities - annual health checks	12.4%	17.0%	29.4%	37.4%	49.2%	59.5%	75.0%	90.3%	12.4%	14.0%	29.4%	31.9%	49.2%	51.6%
	Learning disabilities - adult inpatients (ICS Commissioned)	26	27	24	20	22	18	22	22	23	25	23	21	23	TBC
	Learning disabilities - adult inpatients (NHSE Commissioned)	19	16	19	18	16	17	16	18	17	18	16	14	15	TBC
	Learning disabilities - CYP inpatients	5	6	5	8	5	9	5	5	8	5	7	7	6	TBC

Appendix 4 – NCL Acute Dashboard

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NCL - Selected Acute Services		2022/23			2023/24								
		January	February	March	April	May	June	July	August	September	October	November	December
UEC	*4-Hour AE performance target*	*95.0%*	*95.0%*	*95.0%*	*70.1%*	*70.5%*	*71.9%*	*72.7%*	*73.8%*	*74.8%*	*75.6%*	*76.0%*	*74.9%*
	4-Hour AE performance	69.8%	67.7%	68.4%	71.3%	70.6%	72.8%	73.8%	72.7%	69.7%	69.4%	66.9%	65.4%
	12 hour waits	2,031	1,653	1,586	1,054	1,614	1,343	1,078	1,493	1,387	1,924	2,028	2,059
	LAS handovers	5,993	5,648	6,451	6,589	6,381	6,111	7,099	7,082	6,892	7,086	6,678	6,917
	Ambulance handovers 30 min+	2,272	2,011	2,542	2,183	2,191	2,065	1,894	1,996	2,207	2,311	2,145	2,578
	Ambulance handovers 60 min+	837	720	889	589	753	613	210	117	124	201	156	310
RTT	*New RTT pathways (clockstarts) plan*	*55,305*	*54,398*	*54,751*	*52,262*	*60,400*	*58,575*	*58,005*	*58,678*	*57,657*	*61,019*	*59,905*	*49,061*
	New RTT pathways (clockstarts)	61,568	59,707	69,287	55,756	63,559	64,858	62,169	61,821	61,972	65,237	65,655	53,430
	RTT incompletes plan	*248,766*	*248,614*	*247,754*	*259,555*	*261,219*	*261,938*	*261,127*	*260,675*	*259,771*	*259,978*	*259,218*	*259,109*
	RTT incompletes	251,934	255,892	259,535	262,516	264,929	267,490	267,358	269,450	271,572	268,969	265,640	266,991
	52+ waits plan	*7,311*	*7,580*	*7,186*	*5,962*	*6,624*	*6,392*	*6,088*	*6,297*	*6,182*	*5,546*	*4,910*	*4,208*
	52+ waits	6,152	6,162	6,289	6,710	7,048	7,170	7,717	7,748	8,197	8,600	8,684	8,429
	65+ waits plan	*n/a*	*n/a*	*n/a*	*2,379*	*2,728*	*2,473*	*2,365*	*2,526*	*2,267*	*1,874*	*2,231*	*2,219*
	65+ waits	1,798	1,593	1,231	1,250	1,391	1,527	1,611	1,964	2,167	2,269	2,162	2,495
Diagnostics	*Imaging plan*	*58,371*	*55,206*	*57,740*	*48,306*	*54,129*	*51,967*	*52,436*	*52,435*	*55,555*	*57,582*	*58,814*	*49,800*
	Imaging activity	63,316	61,216	68,236	57,313	63,721	67,854	64,511	63,917	64,169	68,021	70,219	62,532
	Endoscopy plan	*4,210*	*4,215*	*3,966*	*4,004*	*4,481*	*4,167*	*4,604*	*4,197*	*4,206*	*4,434*	*4,577*	*3,863*
	Endoscopy activity	3,757	3,647	4,651	3,889	4,036	4,489	4,194	4,073	4,347	4,823	4,954	4,250
	Total diagnostic 6+ weeks	4,754	3,232	3,503	4,596	4,467	4,447	3,997	4,534	4,395	3,744	3,154	3,713
	Total diagnostic 6+ weeks achievement	88.1%	92.2%	91.3%	88.5%	89.4%	89.4%	90.4%	88.6%	89.6%	91.2%	92.6%	90.8%
Cancer	*62+ backlog plan*	*563*	*521*	*488*	*748*	*725*	*701*	*679*	*651*	*637*	*609*	*592*	*578*
	62+ backlog	782	656	665	752	742	723	691	763	802	788	413	675
	104+ waits plan	*n/a*	*n/a*	*n/a*	*340*	*346*	*324*	*307*	*291*	*271*	*256*	*241*	*237*
	104+ waits	340	342	345	341	330	345	355	332	313	354	197	350
	28-day FDS plan	*75.0%*	*75.0%*	*75.0%*	*69.8%*	*72.1%*	*72.2%*	*74.3%*	*75.1%*	*76.0%*	*77.6%*	*73.0%*	*72.5%*
	28-day FDS achievement	65.4%	72.6%	73.1%	69.8%	66.9%	67.9%	71.2%	69.9%	70.1%	69.0%	69.6%	71.6%
Beds	*Average G&A beds occupancy plan*	*93.5%*	*93.9%*	*93.9%*	*95.8%*	*95.4%*	*95.3%*	*95.7%*	*95.4%*	*95.7%*	*95.9%*	*96.4%*	*96.2%*
	Average adult G&A beds occupancy	95.3%	94.9%	94.6%	91.8%	92.6%	92.4%	89.5%	90.4%	90.9%	91.9%	93.5%	90.3%
	Average adult CC beds occupancy plan	*80.0%*	*80.0%*	*79.5%*	*79.8%*	*79.3%*	*79.8%*	*80.3%*	*79.7%*	*79.3%*	*79.8%*	*79.3%*	*79.7%*
	Average adult CC beds occupancy	82.5%	79.0%	80.9%	78.6%	82.4%	77.0%	79.6%	81.8%	72.9%	78.2%	82.1%	82.2%
	Length of stay 21+ plan	*n/a*	*n/a*	*n/a*	*541*	*548*	*529*	*520*	*516*	*507*	*512*	*470*	*474*
	Length of stay 21+	577	566	576	591	578	553	548	566	565	593	605	571

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North Central London ICB
Board of Members Meeting
26 March 2024

Report Title	Month 10 Finance Board Report	**Date of report**	6 March 2024	**Agenda Item**	3.2
Lead Director / Manager	Bimal Patel, Chief Finance Officer	**Email / Tel**		Bimal.Patel1@nhs.net	
Board Member Sponsor	Dr Usman Khan				
Report Author	Becky Booker, Director of Financial Management	**Email / Tel**		r.booker@nhs.net	
Name of Authorising Finance Lead	Bimal Patel, Chief Finance Officer	**Summary of Financial Implications** For Month 10 (January 2024): • NCL ICS is reporting a deficit of £71.7m (£56.2m excluding industrial action) at Month 10 representing an adverse variance of £35.7m against the YTD plan.20 • NCL ICB reports a year to date (YTD) breakeven position and a Forecast overspend of £0.1m against plan.			
Report Summary	**NCL ICS** • **YTD** - NCL ICS reported a YTD deficit of £71.7m (£56.2m excluding IA) at M10 which is adverse to plan by £35.7m. There is an overall improvement in the straight-line run rate between M9 and M10 driven by eight organisation reporting improving run rates. • **FOT** - The FOT for the NCL system at M10 is a deficit of £15.5m. This represents an adverse movement of £15.5m entirely driven by December and January Industrial Action (IA) costs. This forecast is an allowable overspend against the forecast outturn. **NCL ICB** For Month 10 (January 2024) YTD the ICB reports a forecast £0.1m adverse position against plan due to Locum cover for additional capacity as a result of Industrial Action reported within Primary Care. The Acute position forecasts an adverse variance of c£2.7m driven by increased activity within Independent Sector (IS) and over performance on the variable elements of block contracts (namely Drugs & Devices). Non-Acute forecasts pressures of c£24.0m mainly driven by;				

	• **Primary Care Co-Commissioning** pressures (**£12.5m**) due to costs for the Additional Roles Reimbursement Scheme (ARRS). The ICB is expecting ARRS costs to be fully reimbursed, • **Continuing Healthcare** pressures (**£8.2m**) driven by pressures reported within Adults Fully funded (£5.2m), Joint Funding (£1.3m), Funded Nursing care (£0.9m) and Childrens (£0.7m), • **Prescribing** pressures due to increases in price and activity, and CIP slippage (**£5.9m**), • **Mental Health** pressures (**£2.1m**) driven by increased s117 placement costs and activity within LD and Mental Health, • Increase in Audiology, Gynaecology, Termination of Pregnancy (TOPS) and Community Equipment Services reported within **Community** (**£1.3m**), • Underspends reported within **Primary Care Dental, Ophthalmic & Pharmacy** (DOP) of **£5.7m** driven by underperformance within Dental. Forecast pressures are offset by underspends reported in Other Programme Services (£24.6m) driven the recognition of expected ARRS allocations from NHSE, which will offset the pressure reported within Primary Care Delegated Commissioning, and underspends within Running Costs (£2.0m) driven by pay underspends. The ICB reports a balanced risk position at Month 10, with a risk adjusted position of £11.7m. The ICB reports a forecast CIP achievement of £27.4m against a planned target of £29.2m (94% achievement).
Recommendation	The Board of Members is asked to **NOTE** the contents of this report.
Identified Risks and Risk Management Actions	**NCL ICS** NCL organisations have reported net risks of c.£10m at M10. **NCL ICB** The report includes a fully mitigated risk position. If any other emerging risks occur in-year, further recovery actions will need to be identified to offset cost pressures. .
Conflicts of Interest	This paper was written in accordance with the Conflicts of Interest Policy.
Resource Implications	To note that any further recurrent cost pressures that materialise will impact the ICB's 2024/25 financial position.
Engagement	This report is presented to the Board.
Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	The report will be presented to the Board on a quarterly basis.
Next Steps	This report is to be reviewed by the Board.

Appendices	None.

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Month 10 Finance Board Report

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NCL ICS 2023/24 Financial Position Month 10 (Jan'24)

23/24 M10 Financial Position - Overview

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NCL ICS is reporting a deficit of £71.7m (£56.2m excluding IA) at Month 10 representing an adverse variance of £35.7m against the YTD plan. The FOT for the NCL system at M10 is a deficit of £15.5m entirely driven by the impact of Industrial Action (IA) in M9 and M10.

M10 Financial Position Overview – Revenue

	M10 Year to date			M10 Forecast Outturn		
Organisation	YTD Plan (17th May)	YTD Actual	YTD Variance	Annual Plan (17th May)	Forecast Outturn	FOT Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Trust Total	**(44,830)**	**(80,472)**	**(35,642)**	**(10,621)**	**(26,069)**	**(15,448)**
NCL ICB	8,852	8,777	(75)	10,622	10,547	(75)
System Total	**(35,978)**	**(71,695)**	**(35,717)**	**1**	**(15,522)**	**(15,523)**

Year to Date at M10

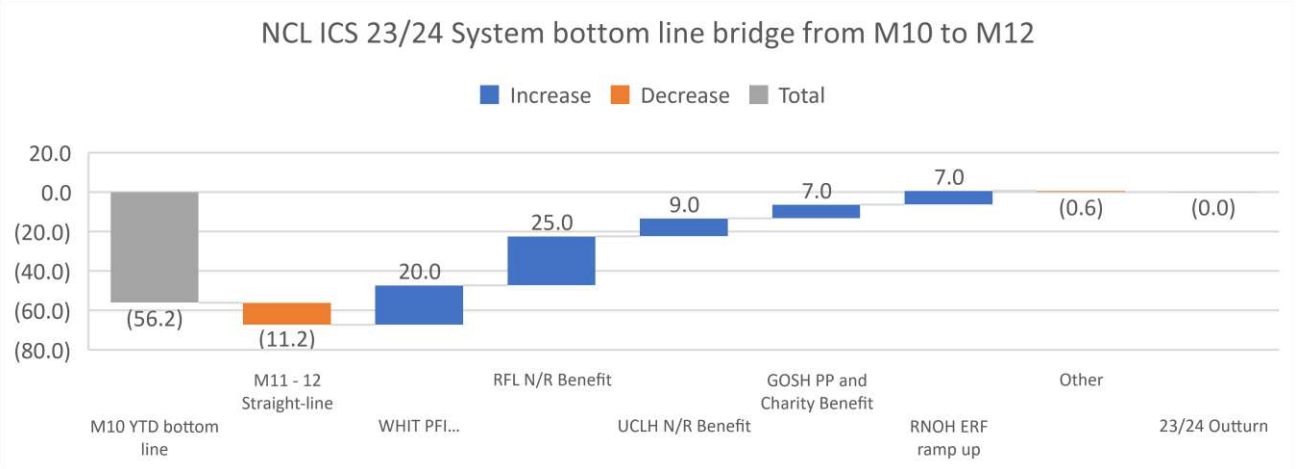
- NCL ICS reported a YTD deficit of £71.7m (£56.2m excluding IA) at M10 which is adverse to plan by £35.7m. There is an overall improvement in the straight-line run rate between M9 and M10 driven by eight organisation reporting improving run rates.

23/24 FOT at M10

- The FOT for the NCL system at M10 is a deficit of £15.5m. This represents an adverse movement of £15.5m **entirely driven by December and January IA costs.** This is an allowable overspend against the FOT.

Key movements between M9 and M10

- The variance has adversely moved by £11m since M9. Of the adverse variance adverse movement of £11m between M9 and M10:
  - Direct IA and other IA costs have worsened £5.1m due to strikes that took place in January. This was not funded as part of the N/R IA funding received.
  - Non IA related issues included CIP shortfall and other worsening by £12.7m in-month. This is driven by RFL (£5.2m), RNOH (£3m) and WHIT (£3.8m).
  - Overall ERF performance has improved by £4.8m despite M10 being impacted by strike action. Catch up in coding of elective activity from M9 has contributed towards the favourable movement in-month.



Planned key movements between M10 and FOT

- The trajectory from the M10 YTD deficit of £56.2m (excluding £15.5m of IA) extrapolated to year end coming to a £67.4m deficit to a breakeven outturn for 23/24 is as follows (See bridge above):
  - WHIT PFI provision release £20m.
  - Non-recurrent benefits of £34m at RFL (c.£25m) and UCLH (c.£9m)
  - Additional income of c.£14m including £7m at GOSH (Charity/Private patients) and £7m at RNOH (ERF run rate due to increased capacity).

23/24 M10 Financial Position – Overview (cont.)

North Central London Integrated Care System

M10 Financial Position Overview (cont.)

Capital position at M10

- Providers are reporting YTD underspends of £9.5m across the NCL capital programme at M9. Two trusts (UCLH and WHIT) are reporting material adverse variances, offset by underspends at other providers.
- **The capital allocation for 23/24 is fully utilised** with the FOT for the ICS programme is in line with the agreed control total with providers, except for BEH who are £0.9m overspend due to a timing issue with regards to receipt of £0.9m of allocation relating to RAAC works that will be reflected in M11.
- **IFRS 16** - NHSE's Capital & Cash team have confirmed NCL's IFRS1 16 allocation which is £18.8m for 23/24. The allocation has been informed by using the M6 FOT submitted by trusts, less low likelihood schemes and NCL's share of the London wide IFRS16 pressure which is £262k for NCL. London Region have confirmed that if there are underspends on the NCL IFRS 16 allocation, the first call will be on IFRS 16 pressures elsewhere in London.

Provider efficiency savings at M10

- The 23/24 plan for the NCL system assumes £211.6m of efficiency savings to be delivered by M10. As of M10, NCL were reporting YTD savings of £177.6m which represents delivery of 64.4% of the total savings requirement for 23/24.
- The NCL system is forecasting under delivery of £54.3m of recurrent savings for 23/24. This mainly comprises of mainly RFL forecasting £18.7m behind the annual target of £40m representing a shortfall of 47% and UCLH who are £15.8m adverse on their £60.3m target. A change of 20% in recurrent CIP delivery has an adverse impact of c.£55m on a full year basis, adversely affecting the opening plan position for 24/25.

Provider agency at M10

- Agency spend is adverse against plan at M10 by £13.2m.
- As of M10, all providers except NMUH and C&I are forecasting overspends totalling £11.7m on agency. The FOT represents 101.2% of NCL's agency cap.
- The agency cap has been exceeded and we believe that this has been impacted by IA and elective recovery.
- There will be a more stringent agency target in 24/25 (c.£101m) and this will be discussed with providers as part of the 24/25 planning round.

ICS Capital Programme

	YTD Plan M10	YTD Actual M10	YTD Variance M10	Control Total 23/24	FOT 23/24	Variance 23/24
	£'000	£'000	£'000	£'000	£'000	£'000
ICS Capital Programme	132,372	122,799	9,573	183,871	184,794	(923)

IFRS16

	YTD Plan M10	YTD Actual M10	YTD Variance M10	Allocation 23/24	FOT 23/24	Variance 23/24
	£'000	£'000	£'000	£'000	£'000	£'000
IFRS16	6,603	11,382	(4,779)	18,752	17,404	1,348

Efficiency Savings

	M10 Year to date				M10 FOT			
	Plan	Actual	Variance	YTD delivery as a % of total target	Plan	Actual	Variance	FOT delivery as a % of total target
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Total System efficiencies	211,603	177,569	(34,034)	64.4%	275,895	280,410	4,515	101.6%
Recurrent efficiencies	172,318	105,806	(66,512)	48.7%	217,231	162,939	(54,292)	75.0%

Agency

	M10 Year to date				M10 FOT			
	YTD Plan	YTD Actual	Variance	Variance	YTD Plan	YTD Actual	Variance	Variance
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Total Provider Agency Spend	78,916	92,116	(13,200)	(16.7%)	93,615	105,329	(11,714)	(12.5%)
System level agency cap					104,061			

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NCL ICB 2023/24 Financial Position Month 10 (Jan'24)

Month 10 Summary Position

North Central London
Integrated Care Board

Month 10 Summary Position

Background

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

However, the ICB plan is subject to the achievement of a number of challenging targets including full achievement of the ICB's efficiency target, £25.6m and additional pay vacancy and non-pay running cost efficiencies of £2.9m and £0.7m respectively. The plan also assumed full mitigation of a substantial risk profile, currently £11.7m as at Month 10 (risk adjusted).

Month 10 (January 2024)

For Month 10 (Jan'24) the ICB reports a forecast **£0.1m** adverse position against plan due to Locum cover for additional capacity as a result of Industrial Action reported within Primary Care. The Acute position forecasts an adverse variance of c**£2.7m** driven by increased activity within Independent Sector and over performance on the variable elements of block contracts (namely Drugs & Devices). Non-Acute forecasts pressures of c£24.0m mainly driven by;

- **Primary Care Co-Commissioning** pressures (**-£12.5m**) due to costs for the Additional Roles Reimbursement Scheme (ARRS). The ICB is expecting ARRS costs to be fully reimbursed,
- **Continuing Healthcare** pressures (**-£8.2m**) driven by pressures reported within Adults Fully funded (£5.2m), Joint Funding (£1.3m), Funded Nursing care (£0.9m) and Childrens (£0.7m),
- **Prescribing** pressures due to increases in price and activity, and CIP slippage (**-£5.9m**),
- **Mental Health** pressures (**-£2.1m**) driven by increased s117 placement costs and activity within LD and Mental Health,
- Increase in Audiology, Gynaecology, Termination of Pregnancy (TOPS) and Community Equipment Services reported within **Community** (**-£1.3m**),
- Underspends reported within **Primary Care Dental, Ophthalmic & Pharmacy (DOP)** of **£5.7m** driven by underperformance within Dental,

Forecast pressures are offset by underspends reported in **Other Programme Services** (**£24.6m**) driven the recognition of expected ARRS allocations from NHSE, which will offset the pressure reported within Primary Care Delegated Commissioning, and underspends within **Running Costs (£2.0m)** driven by pay underspends.

Summary financial position (£m)

	YTD			Full Year		
	Bud	Actual	Var	Bud	FOT	Var
	£m	£m	£m	£m	£m	£m
Revenue Resource Limit	**3,034.7**	**3,034.7**	**0.0**	**3,630.8**	**3,630.8**	**0.0**
Acute	1,486.5	1,489.1	(2.7)	1,783.7	1,786.4	(2.7)
Non-Acute	1,385.6	1,398.5	(12.9)	1,653.0	1,676.9	(24.0)
Other Pgrm Services	94.5	79.7	14.8	112.5	87.7	24.9
Running Costs	26.3	25.5	0.8	31.6	29.6	2.0
COVID-19 Costs	32.8	33.0	(0.2)	39.4	39.7	(0.2)
Total Operational	**3,025.8**	**3,025.9**	**(0.1)**	**3,620.2**	**3,620.2**	**(0.1)**
Reserves & Contingency	0.0	0.0	0.0	0.0	0.0	0.0
Total Non Operational	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Total Expenditure	**3,025.8**	**3,025.9**	**(0.1)**	**3,620.2**	**3,620.2**	**(0.1)**
Surplus / (Deficit)	**8.9**	**8.8**	**(0.1)**	**10.6**	**10.5**	**(0.1)**

Month 10 Summary Position (cont.)

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Key points to note

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

Below are the key **adverse Forecast** variances reported at Month 10:

- **(£12.7m)** reported within Delegated Commissioning mainly due to costs for the Additional Roles Reimbursement Scheme (ARRS). The ICB is expecting the ARRS costs to be fully reimbursed in proceeding months,
- **(£8.2m)** reported within Continuing Care driven by pressures reported within Adults Fully funded, Joint Funding, Funded Nursing care and Childrens,
- **(£5.9m)** reported within Prescribing due to price and activity pressures, and slippage in achievement of this year's CIP target,
- **(£2.7m)** reported within Acute due driven by increased activity within Independent Sector (£1.2m) and over performance on the variable elements of block contracts, namely Drugs & Devices (£1.6m),
- **(£2.1m)** reported within Mental Health driven by increased s117 placement costs and activity within LD and Mental Health,
- **(£1.3m)** reported within Community due to increased activity within Audiology, Gynaecology, Termination of Pregnancy (TOPS) and Community Equipment Services.

The above has been offset by the below **favourable Forecast** variances;

- **£24.6m** Reported within Other Programme Services mainly driven by the recognition of expected ARRS allocation from NHSE, which will offset the pressure reported within Primary Care Delegated Commissioning (£12.5m), and by the release of non-recurrent measures to enable the ICB to report a breakeven position (£12.1m),
- **£5.7m** reported within Dental, Ophthalmic & Pharmacy (DOP) due to underperformance within Dental,
- **£2.0m** reported within Running Costs driven by pay underspends,
- **£0.5m** reported within Primary Care due to income from NHSE to fund agency staff working on capital projects (costs reported within Other Programme Services), £0.6m. This has been offset by pressures due to Locum cover for additional capacity as a result of Industrial Action (£0.1m).

Month 10 Summary Position (cont.)

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Month 10 Summary Position

Pay

The below tables summarises the Month 10 pay position split between Programme and Running Cost. The YTD position is £0.3m favourable.

Pay is forecasting a total favourable variance of £4.0m. This favourable variance is made up of £2.0m in pay budgets, this is improved by a further £2.0m of earmarked funding held in non-pay which is contributing towards pay costs.

The current pay forecast assumes that all vacancies are held to the end of the financial year.

Running/Programme	Budgeted WTE	YTD Budget	YTD Actual	YTD Variance (Fav)/Adv	2023/24 Annual Budget	Forecast Outturn	Forecsat Variance (Fav)/Adv	Income and Non Pay budgets	Revised Forecast Variance incl. Income/Non pay Fav/(Adv)
	WTE	£000	£000	£000	£000	£000	£000	£000	£000
Running	272	19,428	19,641	(213)	23,316	22,642	674	0	674
Programme	535	32,513	32,045	468	39,016	37,727	1,289	2,018	3,307
	806	**51,941**	**51,686**	**255**	**62,332**	**60,369**	**1,963**	**2,018**	**3,981**

Month 10 Summary Position (cont.)

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Efficiencies

The ICB plan assumes efficiencies of £30.7m being £25.6m recurrent and £5.1m non-recurrent. This planned efficiency target has reduced to £29.2m due to the revised implementation date of the new organisational structure from October'23 to April'24. Against this revised target of £29.2m the ICB is delivering a total of £27.4m, made up of £12.9m of recurrent achievements and £14.5m achieved non-recurrently, with slippage of c£1.7m. Included within non-recurrent is £6.9m of cost avoidance in Complex Care.

It is a 2024/25 planning assumption that 2023/24 recurrent efficiencies that have been delivered non-recurrently will be added to the 2024/25 efficiency target along with any 2023/24 CIP slippage.

Use of Non-Recurrent Funds

During 2023/24 planning the ICB committed the use of c£15m of non-recurrent funding to deliver a planned surplus of £10.6m to achieve a System breakeven position. As at Month 10 this has been covered via in-year recurrent and non-recurrent measures. Noting that use of non-recurrent measures to support recurrent expenditure adversely affects the ICBs underlying position.

Risks & Mitigations

Total risks have been identified as c£28.4m, which has been risk adjusted to c£11.7m based on the likelihood of risks materialising.

The ICB reports a fully mitigated risk position for Month 10. All Executive Directors have been asked to review risk values and likelihoods as part of their business-as-usual budget meetings with their Finance Manager. The use of non-recurrent mitigations to cover recurrent risks will impact on the ICB's underlying financial position, adversely affecting the ICBs starting position in 2024/25.

ICB Month 10 Year to Date Financial Performance

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The table below provides commentary on variances by service area

YTD Financial Performance (£m)

Service	Year to Date			Key Variances
	Budget	Actual	Variance	
	£m	£m	£m	
Allocations				
In year allocations	3,034.7	3,034.7	0.0	
Total Allocations	**3,034.7**	**3,034.7**	**0.0**	
Expenditure				
Acute	1,516.6	1,519.2	(2.7)	**Adverse Variance:** Due to increased activity within Independent Sector (£1.4m) and over performance on the variable elements of block contracts, namely Drugs & Devices (£1.3m)
Non-Acute				
Mental Health & LD	365.5	367.3	(1.8)	**Adverse Movement:** Increased s117 placement costs and activity within LD and Mental Health
Delegated Commissioning	249.8	253.4	(3.6)	**Adverse Movement:** Mainly driven by Additional Roles Reimbursement Scheme (ARRS) costs above the budgeted amount. An additional allocation from NHSE is expected to fully fund this, which is reported within within Other Programme Services
Community Services	300.7	301.8	(1.1)	**Adverse Variance:** Variance arising due to increased activity within Audiology, Gynaecology, Termination of Pregnancy (TOPS) and Community Equipment Services.
Primary Care	40.7	40.4	0.3	**Favourable Variance:** Due to the release of capital funding to fund agency staff working on capital projects (costs reported within Other Programme Services), £0.4m. This has been offset by pressure due to Locum cover for additional capacity as a result of Industrial Action (£0.1m)
Primary Care - Prescribing	171.4	176.3	(4.9)	**Adverse Variance:** Due to increased price and activity, and slippage in achievement of this year's CIP target
Primary Care - Dental, Ophthalmic & Pharmacy	132.6	127.4	5.2	**Favourable Variance:** Driven by underperformance within Dental
Continuing Care	124.9	131.9	(7.0)	**Adverse Variance:** Driven by pressures reported within Adults Fully funded (£4.4m), Joint Funding (£1.1m), Funded Nursing care (£0.6m), Childrens (£0.7m) and Staffing & Support pressures of (£0.2m)
Total	**1,385.6**	**1,398.5**	**(12.9)**	
Other Programme Services & Running Costs				
Other Programme Services	97.3	82.6	14.6	**Favourable Variance:** Mainly driven by the recognition of expected ARRS allocation from NHSE, which will offset the pressure reported within Primary Care Delegated Commissioning (£3.4m), with the remaining due to the release of non-recurrent measures to enable the ICB to report a breakeven position
Running Costs	26.3	25.5	0.8	**Favourable Movement:** Driven by pay underspends
Total	**123.6**	**108.1**	**15.5**	
Total Expenditure	**3,025.8**	**3,025.9**	**(0.1)**	
Surplus / (Deficit)	**8.9**	**8.8**	**0.1**	

ICB Forecast Outturn Financial Performance

North Central London
Integrated Care Board

The table below provides commentary on variances by service area

FOT Financial Performance (£m)

Service	Forecast			Key Variances
	Budget	Actual	Variance	
	£m	£m	£m	
Allocations				
In year allocations	3,630.8	3,630.8	0.0	
Total Allocations	**3,630.8**	**3,630.8**	**0.0**	
Expenditure				
Acute	1,819.8	1,822.5	(2.7)	**Adverse Variance:** Due to increased activity within Independent Sector (£1.2m) and over performance on the variable elements of block contracts, namely Drugs & Devices (£1.6m)
Non-Acute				
Mental Health & LD	438.4	440.5	(2.1)	**Adverse Movement:** Increased s117 placement costs and activity within LD and Mental Health
Delegated Commissioning	295.1	307.8	(12.7)	**Adverse Movement:** Mainly driven by Additional Roles Reimbursement Scheme (ARRS) costs above the budgeted amount. An additional allocation from NHSE is expected to fully fund this, which is reported within within Other Programme Services
Community Services	356.7	358.1	(1.3)	**Adverse Variance:** Variance arising due to increased activity within Audiology, Gynaecology, Termination of Pregnancy (TOPS) and Community Equipment Services.
Primary Care	48.2	47.7	0.5	**Favourable Variance:** Due to the release of capital funding to fund agency staff working on capital projects (costs reported within Other Programme Services), £0.6m. This has been offset by pressure due to Locum cover for additional capacity as a result of Industrial Action (£0.1m)
Primary Care - Prescribing	205.7	211.6	(5.9)	**Adverse Variance:** Due to increased price and activity, and slippage in achievement of this year's CIP target
Primary Care - Dental, Ophthalmic & Pharmacy	159.1	153.4	5.7	**Favourable Variance:** Driven by underperformance within Dental
Continuing Care	149.8	158.0	(8.2)	**Adverse Variance:** Driven by pressures reported within Adults Fully funded (£5.2m), Joint Funding (£1.3m), Funded Nursing care (£0.9m) and Childrens (£0.7m)
Total	**1,653.0**	**1,677.0**	**(24.0)**	
Other Programme Services & Running Costs				
Other Programme Services	115.8	91.2	24.6	**Favourable Variance:** Mainly driven by the recognition of expected ARRS allocation from NHSE, which will offset the pressure reported within Primary Care Delegated Commissioning (£12.5m), with the remaining due to the release of non-recurrent measures to enable the ICB to report a breakeven position
Running Costs	31.6	29.6	2.0	**Favourable Movement:** Driven by pay underspends
Total	**147.4**	**120.7**	**26.6**	
Total Expenditure	**3,620.2**	**3,620.2**	**(0.1)**	
Surplus / (Deficit)	**10.6**	**10.5**	**(0.1)**	

Month 10 Risks & Mitigations

North Central London
Integrated Care Board

Risk Summary

Directorate	Risk value Month 10 £'000	% RAG rating	Rag Rating	Risk value adjusted Month 10 £'000	Comments
RISKS					
Primary Care	(13,276)	29%		(3,848)	Driven by risk of ARRS funding shortfall (£3.1m), increased premises costs (£0.6m)
Acute - Variable Element of Block Contract	(6,275)	40%		(2,510)	Increased costs against the variable elements of block contracts, namely Drugs & Devices
Continuing Healthcare Team	(5,000)	50%		(2,500)	Risk of additional costs to the Local Authority for jointly funded services
Other	(899)	95%		(854)	VOID cost pressures and non delivery of efficiency targets
Acute Other	(732)	77%		(564)	Risk of increased activity within Independent sector
Primary Care Co-Commissioning (DOP)	(500)	95%		(475)	Potential expenditure earmarked against Dental budgets
Primary Care - Prescribing	(420)	95%		(399)	Judicial Review of the ICBs Home Oxygen Service
Community	(750)	40%		(298)	Increased pressures with Community ENT services provided by Whittington
Change Management Programme	(500)	50%		(250)	Transition costs relating to the new structures as part of the Organisational Change Programme
TOTAL RISKS	**(28,352)**	**41%**		**(11,698)**	
MITIGATIONS					
Mitigations identified	24,671	51%		12,582	
TOTAL Mitigations	**24,671**	**51%**		**12,582**	
NET RISK POSITION	**(3,680)**	**-24%**		**885**	
Mitigations required	*3,680*	-24%		*(885)*	
REPORTED RISK POSITION	**0**	**0%**		**0**	

Month 10 Risk Position

Total risks have been identified as c£28.4m, which has been risk adjusted to c£11.7m based on the like likelihood of risks materialising.

Around 40% of the risk adjusted risk value sits within Primary Care and mainly relates to ARRS funding shortfall risks.

The ICB reports a risk adjusted position of £2.5m in relation to High-cost drugs and devices.

Any recurrent risks that materialise, and covered via non- recurrent measures, will adversely impact the ICBs underlying position.

Mitigations

The ICB reports a fully mitigated risk position for Month 10, identified mitigations are currently c£12.6m. Noting that the use of non-recurrent mitigations to cover recurrent risks will impact on the ICB's underlying financial position, adversely affecting the ICBs starting position in 2024/25.

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Financial Accounts

Appendices

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

Appendix 1 - Income & Expenditure

	2023/24 In-Month AP10 - JAN 24			2023/24 Year to Date AP9 - DEC 23			2023/24 Annual Forecast			2022/23 Outturn		
	Admin	Prog	Total	Admin	Prog	Total	Admin	Prog	Total	Admin	Prog	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Operating Revenue												
Prescription fees and charges	0	(1,259)	(1,259)	0	(12,158)	(12,158)	0	(13,545)	(13,545)	0	0	0
Education, training and research	0	0	0	0	0	0	0	0	0	0	0	0
Non-patient care services to other bodies	0	(2,988)	(2,988)	0	(18,407)	(18,407)	0	(21,823)	(21,823)	(60)	(18,898)	(18,958)
Other Contract income	0	2,563	2,563	0	(2,580)	(2,580)	0	(6,494)	(6,494)	(1,062)	(3,977)	(5,040)
Other non contract revenue	0	(546)	(546)	0	(10,261)	(10,261)	0	(13,017)	(13,017)	0	0	0
Total Operating revenue	**0**	**(2,230)**	**(2,230)**	**0**	**(43,406)**	**(43,406)**	**0**	**(54,878)**	**(54,878)**	**(1,122)**	**(22,875)**	**(23,997)**
Operating Expenses	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Expenses												
Perm E/ees - Salaries and Wages	1,337	2,066	3,403	13,698	19,519	33,217	14,540	21,201	35,741	13,841	16,299	30,139
Perm E/ees - Social Security Costs	164	271	435	1,670	2,549	4,219	2,756	4,161	6,916	1,552	2,162	3,714
Perm E/ees - Em/er Contribs to NHS Pension	2,688	337	3,025	4,365	3,326	7,691	5,383	4,336	9,718	3,274	2,634	5,908
Perm E/ees - Apprenticeship Levy	17	0	17	182	0	182	218	0	218	135	0	135
Perm E/ees - Termination benefits	0	2,944	2,944	0	2,944	2,944	0	10,877	10,877	387	0	387
Other E/ees - Salaries and Wages	184	244	427	2,048	5,180	7,228	2,269	5,751	8,020	2,027	4,281	6,307
Total Gross employee expenses	**4,389**	**5,862**	**10,251**	**21,964**	**33,517**	**55,481**	**25,165**	**46,326**	**71,491**	**21,215**	**25,375**	**46,590**
Other Operating Expenses												
Services from other CCGs and NHS England	30	0	30	63	66	129	86	79	165	40	15	55
Services from foundation trusts	0	135,143	135,143	0	1,101,777	1,101,777	0	1,312,361	1,312,361	0	946,446	946,446
Services from other NHS trusts	0	105,378	105,378	0	942,691	942,691	0	1,128,200	1,128,200	0	817,952	817,952
Purchase of healthcare from non-NHS bodies	0	4,756	4,756	0	349,018	349,018	0	430,018	430,018	0	296,026	296,026
Purchase of social care	0	788	788	0	6,625	6,625	0	7,775	7,775	0	5,131	5,131
Chair and Non Executive Members	26	0	26	262	0	262	206	0	206	188	88	276
Supplies and services – clinical	0	132	132	0	1,320	1,320	0	1,584	1,584	0	1,194	1,194
Supplies and services – general	35	(25,719)	(25,684)	853	43,336	44,189	1,290	37,674	38,963	2,625	17,371	19,996
Consultancy services	0	4	4	0	29	29	0	0	0	0	1,230	1,230
Establishment	84	381	466	312	3,263	3,575	431	3,855	4,286	567	2,926	3,493
Transport	(0)	0	(0)	1	0	1	0	0	0	1	1	3
Premises	20	(39)	(19)	223	3,125	3,348	278	3,793	4,071	343	2,503	2,846
Depreciation	84	0	84	841	0	841	1,009	0	1,009	726	0	726
Audit fees	21	0	21	201	0	201	242	0	242	224	0	224
· Internal audit services	19	0	19	242	0	242	280	0	280	129	0	129
· Other services	0	0	0	0	0	0	0	0	0	26	0	26
General Dental services and personal dental services	0	7,905	7,905	0	66,872	66,872	0	81,134	81,134	0	0	0
Prescribing costs	0	17,631	17,631	0	176,309	176,309	0	211,570	211,570	0	156,184	156,184
Pharmaceutical services	0	4,029	4,029	0	37,216	37,216	0	43,383	43,383	0	0	0
General Ophthalmic services	0	936	936	0	12,009	12,009	0	14,642	14,642	0	0	0
GPMS/APMS and PCTMS	0	27,228	27,228	0	263,332	263,332	0	319,751	319,751	0	224,113	224,113
Other professional fees excl. audit	10	135	144	115	1,649	1,764	37	2,491	2,528	177	1,911	2,088
Legal Fees	190	11	202	326	35	361	383	56	440	124	76	199
Education and training	(8)	40	32	68	726	794	139	857	996	244	1,373	1,617
Other expenditure	2	(740)	(738)	20	885	905	24	0	24	22	23	45
Total other costs	**515**	**278,000**	**278,514**	**3,529**	**3,010,283**	**3,013,812**	**4,405**	**3,599,224**	**3,603,629**	**5,437**	**2,474,561**	**2,479,998**
Net Operating Expenditure	**4,904**	**283,862**	**288,766**	**25,493**	**3,043,801**	**3,069,294**	**29,570**	**3,645,550**	**3,675,120**	**26,652**	**2,499,936**	**2,526,588**
Net Expenditure	**4,904**	**281,632**	**286,536**	**25,493**	**3,000,395**	**3,025,888**	**29,570**	**3,590,672**	**3,620,242**	**25,530**	**2,477,061**	**2,502,591**
Revenue Resource Limit	**4,571**	**281,890**	**286,460**	**26,334**	**2,999,479**	**3,025,813**	**31,596**	**3,588,571**	**3,620,167**	**30,629**	**3,311,758**	**3,342,387**
Surplus / (Deficit) from Operations	**(333)**	**258**	**(75)**	**841**	**(916)**	**(75)**	**2,026**	**(2,101)**	**(75)**	**5,099**	**834,697**	**839,796**

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Appendix 2 - Cash Flow Statement

	AP1 - APR 23	AP2 - MAY 23	AP3 - JUN 23	AP4 - JUL 23	AP5 - AUG 23	AP6 - SEP 23	AP7 - OCT 23	AP8 - NOV 23	AP9 - DEC 23	AP10 - JAN 24	AP11 - FEB 24	AP12 - MAR 24	Total
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	F/Cast	F/Cast	F/Cast
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance bfwd	**950**	**2,716**	**2,018**	**1,394**	**381**	**924**	**513**	**1,016**	**1,205**	**632**	**2,969**	**214**	**950**
RECEIPTS													
Main Cash Drawdown	260,000	261,500	264,000	266,000	280,000	277,000	277,000	268,000	268,000	332,000	284,000	278,000	3,315,500
Supplementary Drawdown	26,500	0	0	0	0	0	0	0	0	0	0	0	26,500
Other	4,779	4,244	3,376	1,478	3,692	885	4,611	2,728	2,230	13,270	8,166	0	49,460
VAT	676	453	160	449	878	331	335	270	313	167	300	300	4,633
Total Receipts	**291,955**	**266,198**	**267,536**	**267,927**	**284,570**	**278,216**	**281,947**	**270,998**	**270,543**	**345,437**	**292,466**	**278,300**	**3,396,092**
PAYMENTS													
NHS Payables	194,865	198,285	202,422	203,699	218,662	211,813	207,954	206,768	205,984	235,017	226,270	221,665	2,533,402
Non NHS Payables	90,874	64,162	60,043	59,513	60,664	62,189	68,926	59,443	60,460	101,270	64,005	49,425	800,975
Salaries & Wages (inc Tax, NI & Pension)	4,451	4,449	5,695	5,728	4,702	4,625	4,563	4,598	4,673	6,812	4,945	7,245	62,485
Total Payments	**290,189**	**266,896**	**268,160**	**268,940**	**284,027**	**278,627**	**281,444**	**270,809**	**271,117**	**343,099**	**295,220**	**278,335**	**3,396,863**
BALANCE CFWD	**2,716**	**2,018**	**1,394**	**381**	**924**	**513**	**1,016**	**1,205**	**632**	**2,969**	**214**	**180**	**180**

Appendix 3 – Block Contracts

North Central London
Integrated Care Board

NCL ICB Block Contract Summary as at 31st January 2024

Area	Trust	Budget £'000
Acute Services - NHS (BLOCK)	Barts Health NHS Trust	31,325
	Barking, Havering And Redbridge University Hospitals NHS Trust	1,232
	Chelsea And Westminster Hospital NHS Foundation Trust	4,344
	East And North Hertfordshire NHS Trust	1,568
	Great Ormond Street Hospital For Children NHS Foundation Trust	20,295
	Guy's And St Thomas' NHS Foundation Trust	18,039
	Homerton University Hospital NHS Foundation Trust	18,772
	Imperial College Healthcare NHS Trust	23,364
	King's College Hospital NHS Foundation Trust	3,551
	Lewisham And Greenwich NHS Trust	855
	London Ambulance Service NHS Trust	81,544
	London North West University Healthcare NHS Trust	18,393
	Mid and South Essex NHS Foundation Trust	695
	Moorfields Eye Hospital NHS Foundation Trust	31,470
	North Middlesex University Hospital NHS Trust	305,868
	The Princess Alexandra Hospital NHS Trust	1,526
	Royal Free London NHS Foundation Trust	568,181
	Royal National Orthopaedic Hospital NHS Trust	24,209
	St George's University Hospitals NHS Foundation Trust	1,772
	The Royal Marsden NHS Foundation Trust	1,204
	University College London Hospitals NHS Foundation Trust	376,350
	West Hertfordshire Hospitals NHS Trust	2,037
	Whittington Health NHS Trust	217,877
	LVA - NHST	3,180
	LVA - NHFT	7,547
Acute Services NHS Block Total		**1,765,197**

Appendix 3 (cont.) – Block Contracts

North Central London
Integrated Care Board

NCL ICB Block Contract Summary as at 31st January 2024 (cont.)

Area	Trust	Budget £'000
Mental Health Services Block	Barnet, Enfield And Haringey Mental Health NHS Trust	185,791
	Central And North West London NHS Foundation Trust	6,783
	Camden And Islington NHS Foundation Trust	137,176
	Central London Community Healthcare NHS Trust	2,526
	East London NHS Foundation Trust	1,122
	Royal Free London NHS Foundation Trust	2,228
	South London And Maudsley NHS Foundation Trust	1,811
	Tavistock And Portman NHS Foundation Trust	15,317
	Whittington Health NHS Trust	3,606
	North Middlesex University Hospital NHS Trust	1,250
Mental Health Services Total		**357,608**
Community Health Services Block	Barnet, Enfield And Haringey Mental Health NHS Trust	217
	Central And North West London NHS Foundation Trust	43,087
	Central London Community Healthcare NHS Trust	58,372
	Camden And Islington NHS Foundation Trust	227
	London North West University Healthcare NHS Trust	170
	North Middlesex University Hospital NHS Trust	41,393
	Royal Free London NHS Foundation Trust	18,342
	Tavistock And Portman NHS Foundation Trust	40
	University College London Hospitals NHS Foundation Trust	43
	Whittington Health NHS Trust	107,431
Community Health Services Block Total		**269,321**
Primary Care Dental, Opthalmic & Pharmacy	Secondary Dental Care – Intra Trust	30,210
	Secondary Dental Care – Inter Trust	9,113
	Secondary Dental Care – LVA Trust	607
Primary Care Dental, Opthalmic & Pharmacy Total		**39,930**
Other Programme Services Block	North Middlesex University Hospital NHS Trust	6,051
Other Programme Services Block Total		**6,051**
Total Commissioning Expenditure		**2,438,108**

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
26 March 2024

Report Title	Board Assurance Framework ('BAF') Report	**Date of report**	8 March 2024	**Agenda Item**	3.3
Lead Director / Manager	Ian Porter, Executive Director of Corporate Affairs	**Email / Tel**		Ian.porter3@nhs.net	
Board Member Sponsor	Phill Wells, Interim Chief Executive Officer				
Report Author	Andrew Spicer, Assistant Director of Governance, Risk and Legal Services	**Email / Tel**		Andrew.spicer1@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** The BAF report assists the ICB in managing its most significant financial risks.			
Report Summary	This report is the NCL ICB Board of Members Board Assurance Framework ('BAF'). It captures the most serious risks that have been identified as threatening the achievement of the ICB's strategic objectives. This report contains the following sections: • Risk Overview. This sets out the movement of the BAF risks together with key highlights to bring to the Board's attention. This section also focusses on the key interrelationships between the risks and on emerging areas of risks that the Executive Management Team would like to draw the Board's attention to; • BAF Risk Overview Report. This report is at Appendix 1. It is a strategic snapshot of the each BAF risks including risk scores, strategic updates and movement over the previous four Board meetings; • BAF Register. This is the full BAF risk register should Board members want to go into detail on each risk and the risk plans to control the risks (including controls, gaps in controls and actions). The full version of the BAF risk register is here. **Risk Overview** There are 11 risks in total on the BAF: • 5 are ICB only risks; • 1 is an ICB risk generated from risks or issues in other organisations; • 5 are system risks. There are two new risks- both of which are system risks and relate to the system capital allocation. Further detail is set out below.				

	Three risks have decreased: • QUAL69- Failure to conduct timely Deprivation of Liberty Assessments ('DoLS') on our NCL ICB-funded clients (Threat): Decreased from 16 to 12. This risk has dropped from the BAF but will continue to be overseen by the Quality and Safety Committee. This risk has reduced as a Project Manager has been recruited to provide support to the ICB to deal with the highest risk patients; • PERF18- Failure to effectively develop the primary care workforce (Threat). Decreased from 16 to 12. This risk has dropped from the BAF but will continue to be overseen by the Primary Care Committee. This risk has reduced as Primary Care Networks have been able to access additional funding for a range of staff and are supported by the Training Hubs; • PC5- Failure to successfully implement the ICB Change Programme (Threat). Decreased from 12 to 9. This risk is below the BAF threshold but will continue to be on the BAF for Board oversight. The risk has reduced as the organisation is in the final phase of the Change Programme. One risk has closed: • PERF7- Failure to manage patient flow during heightened periods of pressure, including winter, Easter, other Bank Holidays and Industrial Actions. (Threat). Closed. Further information is provided below. 5 risks are below the BAF threshold but are included on the BAF for oversight: • PERF28- Failure of Primary Care patient access (Threat); • COMM22- Failure of the Integrated Care Board to effectively and safely manage the specialist services devolution in 2024/25, impacting on the delivery of population health improvements (Threat); • PC5- Failure to successfully implement the ICB Change Programme (Threat); • FIN16- Failure to Deliver the ICB's 2023-24 Financial Plan (Threat); • FIN29- Failure of North Central London Integrated Care Board ('ICB') to remain within its Running Cost Allowance ('RCA') 2024/25 and 2025/26 (Threat). The other risks remain at a constant level. The risks together with their strategic narratives are contained in the BAF Risks Overview Report in Appendix 1. Key highlights to bring to the Board's attention are: <u>Finance</u> At month 10 the ICB is predicted to meet its 2023-24 financial plan (see FIN16). This is supported by the ICB's Cost Improvement Plan ('CIP) process for 2023/24 financial year which has identified 100% if the required efficiency savings and that all CIP schemes that are slipping are being covered through non-recurrent in year measures. <u>System Capital Allocation</u> A new risk has been added (FIN36) which reflects the projected shortfall in the funding for the St Pancras hospital transformation programme. Whilst actions are being taken to mitigate this risk a key impact is that the system will be required to reprioritise and reallocate it Capital Departmental Expenditure Limits ('CDEL'). This will add additional pressure on the Integrated Care System's ('ICS') CDEL which is insufficient to meet the ICS's estate needs whilst also delivering the ICS's

	strategic priorities. A new risk (FIN39) has been added to the BAF to address the risk around insufficient ICS capital allocation. <u>Performance</u> The issues with patient flow during heightened periods of pressure (including winter and holidays) are a consistent challenge each year. Recent developments to address this include the System Control Centre being established and the Surge Team being in-housed to the ICB. These changes reflect a shift in the ICB's approach and a move to address the issues as part of the ICB's core business as usual activity. The on-going risk of timely access to urgent and emergency care for the residents of North Central London is covered through risk PERF29 which remains on the BAF. Consequently, risk PERF7 addressing patient flow and heightened periods of pressure was closed following review. **<u>Looking Forward</u>** The ICB's approach to risk management continues to evolve with oversight by the Audit Committee. A review of all Target Risk Scores is being undertaken to ensure Target Risk Scores are realistic and achievable.
Recommendation	The Board of Members is asked to: • **NOTE** the report and provide feedback on the risks; and • **IDENTIFY** any strategic gaps within the Board's remit, and propose any areas where further investigative work may support further risk mitigation.
Identified Risks and Risk Management Actions	The BAF is a risk management document which highlights the most significant risks to the achievement of the ICB's strategic objectives.
Conflicts of Interest	Conflicts of interest are managed robustly and in accordance with the ICB's Conflict of Interest Policy.
Resource Implications	Updating of the BAF is the responsibility of each risk owner and their respective directorates. The Governance and Risk Team helps to support this by providing monitoring, guidance and advice.
Engagement	The BAF report is presented to each Board of Members meeting. There has also been discussions on risk with the Executive Management Team and the Audit Committee.
Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	The Board Assurance Framework report is presented to each Board of Members meeting. Risks are kept under review by the risk owners and by the committees of the Board of Members.

Next Steps	The next steps are as follows:
	• To continue to manage risks in a robust way;
	• To continue the development of the ICB's approach to system risk management. This includes:
	  ○ Increased independent scrutiny and oversight of our key risks and our developing approach through the Audit Committee;
	  ○ Further identification and development of system risks;
	  ○ Building relationships with key system colleagues including the Local Authorities;

	○ Strengthening the role of the NCL Governance Leads Network as a key mechanism for collaboration and information sharing on key health system risks.
Appendices	The following documents are included: • Appendix 1- BAF Risks Overview Report; • BAF Register • Risk Scoring Key.

North Central London ICB BAF Risks - Oversight Report

Risk ID	Risk Title	Risk Owner	Risk description	Strategic update	2023 - 2024 Current Risk Score MAY	JULY	OCT	MAR	Movement From Last Report	Target Risk Score
New System Risks										
FIN36	St Pancras Hospital Transformation Programme Funding (Threat).	Bimal Patel - Interim Chief Finance Officer	**CAUSE:** If there is insufficient funding to deliver the complete St. Pancras transformation programme, **EFFECT:** There is a risk that the system will need to significantly reevaluate and reprioritise it use of its Capital Departmental Expenditure Limits allocation to ensure the transformation programme has sufficient funds to complete. **IMPACT:** This may result in a number of other capital schemes being cancelled, delayed or reprioritised, having a negative impact across the system, patients and services effected, reputation damage and relationships.	This is a new risk. There is currently a financial shortfall in the St Pancras Hospital ('SPH') Transformation Programme ('Programme'). The CFO at Camden and Islington NHS Foundation Trust ('C&I') is currently investigating the size of the financial shortfall. If the ICB wants the Programme to complete in full, the system may be required to reprioritise and reallocate it's Capital Departmental Expenditure Limits ('CDEL'). This in turn may have an impact on other North Central London capital programmes. However, the size and scale of the potential impact will not be known until the exact size of the financial shortfall is confirmed. The shortfall figures and underlying analysis were presented to the CEO Sponsor Group on 9 October 2023 and the SPH programme Finance & Business Case group on 17 October 2023, during which the mid-range value was agreed to be taken as the base case from which to develop further work. Once the exact size of the financial shortfall is known options can be explored and mitigations can be proposed.				20	→	9
FIN39	Insufficient ICS Capital Allocation to Deliver ICS Strategic Priorities and Address Issues with Key Infrastructure (Threat).	Bimal Patel - Interim Chief Finance Officer	**CAUSE:** If the ICS does not have sufficient capital allocation and the ICB does not effectively allocate the capital allocation, **EFFECT:** There is a risk that the ICS will not be able to deliver its strategic priorities whilst also addressing issues with key infrastructure. **IMPACT:** This may result in under delivery of ICS strategic priorities, some key estates becoming unusable or sub-par, a negative impact on population health and patient care and reputation damage.	This is a new risk. The NCL ICS capital allocation for 2024/25 is c£178m. However, the current ICS strategic priorities together with the list of urgent capital projects submitted by system partners significant exceeds the 2024/25 capital allocation and likely future allocations. The ICB is working with system partners to understand the underlying issues, associated risks, mitigations and any opportunities. The main competing priorities are to make new investments, such as Start Well, Electronic Patient Records (part funded by the national team but needing a significant local funding element), improving Primary Care estate, alongside maintaining and replacing equipment and estate. A significant element of the NCL estate requires backlog maintenance and there is insufficient capital allocation to meet all demands. The current 10-year ICS pipeline shows a £3.3bn (c£330m per year) deficit.				20	→	15
System Risks										
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.	NHS England ('NHSE') have engaged with systems nationally to complete an H2 Operating Plan Assurance exercise. Two of the key priority deliverables are 78 week wait clearance by year end, and 65 week wait growth mitigation. The British Medical Association industrial strike action has had a significant adverse impact on elective capacity and long waiting patient recovery throughout the year to date ('YTD') • Industrial action held since March 2023 has resulted in large volumes of patients missing activity earlier in their pathways who are now having subsequent delays with every additional period of industrial action; • Significant growth to the total number of patients waiting 52 weeks increases the 65 week wait tip-in (to the next cohort) risk across all providers; • Industrial action has impacted provider's ability to treat long waiting patients, but has also driven growth in the Patient Transfer List ('PTL') as a whole. This growth means that there are now more patients in the cohort tipping-in to 65+; • 65 week waits have grown by an average of 150 patients per month since the start of April, however due to increasing tip-ins Providers across NCL now have to treat an additional 475 65+ patients per month than in April to prevent the 65+ cohort growing. NCL Providers continue to target: • Allocation of treatment / to come in ('TCI') dates to all patients currently waiting longer than 52 weeks who will breach 78 weeks in March 2024 if they remain unscheduled; • 78 week patient waits clearance to year end; • Booking and rescheduling 65+ week waits to sustain cohort growth; • A reduction in 52+ week waits where possible throughout 2023/24; • Constituted diagnostic backlog recovery across imaging and endoscopy in line with provider trajectories. Further Junior Doctor Industrial Action across Quarter 3 and Quarter 4 has adversely impacted the rate of long waiting patient recovery across the majority of NCL Trusts. Great Ormond Street Hospital ('GOSH') Paediatric Dentistry remains a key risk to the system's delivery of year end clearance target. The loss of University College London Hospital ('UCLH') mutual aid capacity and lower than forecast patient uptake from Guys and St Thomas ('GSTT') Evelina Hospital due to complexity, has led to a revised year end forecast from the Trust. To mitigate this risk, supported by NHSE, NCL ICB is facilitating an insourcing arrangement between GSTT and GOSH, with consultant and the required clinical staff being provided by GSTT to transfer across to provide operational capacity to GOSH. CEO to CEO engagement has been held between GOSH & UCLH to rectify any consultant mutual aid constraint. Urology waits at Royal Free London ('RFL') is a growing risk to 78ww and continues to contribute to backlog growth for NCL, with an increasing volume of tip-ins reported weekly from the cohort of patients on ticking pathways waiting under 78 weeks. NCL tip in rates into the 52 week wait and 65 week wait cohorts has increased since November, and is a long-term risk to sustaining the progress made with clearance of the 78 week wait cohort into 2024/25.	16	16	16	16	→	12
PERF29	Failure to deliver timely urgent and emergency care for the residents of NCL (Threat).	Sarah Mansuralli - Interim Deputy Chief Executive and Chief Strategy and Population Health Officer	**CAUSE:** If NCL ICB fails to ensure provider delivery of commissioned capacity to meet emergency care demand within the system, **EFFECT:** There is a risk that the ICB will fail to achieve urgent and emergency care national performance standards. Pressures may result in patients being located in the wrong part of the system or not seen within appropriate timescales, which may have an adverse effect on their health outcome. **IMPACT:** This may result in the ICB missing the national standards expected for all patients, increasing patient waiting times in the Emergency Department ('ED') and potential risk of harm and negative patient experience and outcomes.	A&E 4-hour performance is maintained at 65%. Average Category 2 ('CAT2') response times remain above 50 minutes for the third consecutive week (51mins week ending 11 February 2024) against a standard of 30 minutes. Pathway 2 bed occupancy remains high at 88% with referrals continuing to be pushed through the Intermediate Community Escalation Bed Hub. Mental Health out of area placements remain low (1 reported week ending 11 February 2024). Ambulance handover within 45 minutes remains stable at 81% with variation across providers (98% UCLH – 65% NMUH). Average CAT2 response times remain above 50 minutes for the third consecutive week (51 minutes week ending 11 February 2024) against a standard of 30 minutes. In the absence of formal guidance, the ICB Performance and Transformation Directorate are working with providers and system partners to refresh existing operational plans, particularly in relation to performance improvement trajectories together with underpinning actions to deliver. For Urgent and Emergency Care ('UEC'), work is in underway to ensure that A&E 4 hour improvement trajectories reflect national and regional requirements such as the Urgent Care Recovery Plan 5 priority initiatives. A gap analysis against actions to recover performance will be further discussed at Flow Board on 12 March 2024 together with a revised system discharge escalation process.		16	16	16	→	12

PC3	Strikes by NHS staff (Threat).	Sarah Morgan - Chief People Officer	**CAUSE:** If industrial action taken by various Unions within healthcare, due to pay and working conditions disputes, continues without resolution, **EFFECT:** There is a risk that services will face significant reduction, cancellations of elective activity, and a reduced ability for London Ambulance Service ('LAS') to respond to non-life and limb patients during the time of industrial action. **IMPACT:** This may result in an increase in negative patient experience and negative patient outcomes, and a reduction in the quality of service delivered and capacity. This may also result in a disengaged workforce, and may exacerbate exiting system-wide workforce challenges.	This risk has emerged from national industrial action taken by unions and NHS staff regarding pay and working conditions disputes. Sector and pan-London Management, to keep minimal services running and protect the Urgent and Emergency Care pathway, is co-ordinated through the Flow Oversight Group, System Management Board and Clinical Advisory Group. The Junior doctors 5 day strike from 13 - 18 July 2023 was very challenging in NCL. Derogations submitted to the NHS England regional and national team requesting approval from the British Medical Association ('BMA') were not granted. The London derogation process was updated after the After Action Reviews undertaken by Royal Free London and University College London Hospitals from the Junior Doctor's strike in July. This improved the process during the August strikes however no derogations were granted by the national BMA for NCL or nationally. Great Ormond Street Hospital has had action on every strike since November 2022. Consultant strikes were undertaken on 19 and 20 September and co-ordinated action with the junior doctors of 2 -5 October 2023. Consultants voted to reject the latest pay offer, although no further strikes have been announced. Junior Doctors held strike action from 20 - 23 December and their longest ever strike of 6 days from 3 to 9 January 2024 which was timed to coincide with one of the busiest periods of the year in healthcare settings. Further action by Junior Doctors took place from 24 - 28 February 2024. The current risk is acuity of patients attending through the urgent care pathway and being admitted and the increased bed occupancy which is reducing flow. A focus on hospital discharge is currently underway and managed through the usual controls.	20	20	20	20		→	15
System Risk dropping below BAF threshold and not included in BAF											
QUAL69	Failure to conduct timely Deprivation of Liberty Assessments ('DoLS') on our NCL ICB-funded clients (Threat).	Chis Caldwell - Chief Nursing Officer	**CAUSE:** If the ICB fails to conduct our Deprivation of Liberty ('DoLS') Assessments for NCL ICB-funded clients within the scheduled assessment period, **EFFECT:** There is a risk that individuals in receipt of ICB funding may unlawfully be deprived of their liberty, and that the ICB will fail to comply with its statutory responsibility under the Mental Capacity Act 2005. **IMPACT:** This may result in the ICB failing to ensure patients who are under high levels of care and supervision, but lack the mental capacity to consent to those arrangements for their care, are safeguarded. The ICB is also at risk of reputational damage and may incur financial penalties.	The ICB has sourced project manager ('PM') support to identify all of the higher risk patients known to the ICB who may meet the requirements of DoLS, and there is a significant risk to the individual e.g. there is a dispute about the nature of the deprivation, the care package is by its nature extremely restrictive (e.g. those patients requiring close supervision and/or restriction) or the patient is at risk if they are not supported by a DoLS application. All of our Continuing Healthcare teams have provided current data of their cases and the ICB has identified almost 400 patients (with either physical disability and/or learning disability) that could meet the requirements of being deprived. Further work is being undertaken by the PM to prioritise the cases so that the ICB takes forward those of the highest risk. The draft DoLS Review Business Case to recruit resources to address the ICB's highest risk cases and provide management of the application process (the maximum a court authorisation lasts is 12 months) and further applications for those cases where required. The ICB would accept that all cases of people who may be deprived of their liberty would not be sent to the court for resolution, however it would focus only on those cases where it could show a significant risk in relation to the legal status of an individual. The plan, if approved, would be to identify those cases where there is a very high risk of dispute/legal challenge, accepting a degree of risk in relation to the ICBs other potential DoLS cases. the Director of Safeguarding will oversee the process of triage and agree all cases that require a court application. The Liberty Protection Safeguards ('LPS') Task & Finish Group is refocussed on DoLS and Mental Capacity Act ('MCA') with training for Best Interest Assessors delivered. Each borough will have access to MCA/DoLS expertise via the Continuing Healthcare teams and through the designated safeguarding professionals. Each borough will review DoLS cases on a regular basis to ensure appropriate escalation where a court resolution may be required. With the PM in place there is now a clear and up to date list of the affected patients, and this has reduced the risk's rating from 16 to 12.		20	16	12		↓	8
Closed System Risk											
PERF7	Failure to manage patient flow during heightened periods of pressure, including winter, Easter, other Bank Holidays and Industrial Actions. (Threat).	Richard Dale - Executive Director of Performance and Transformation	**CAUSE:** If NCL ICS Providers fail to manage non-elective flows within planned hospital and community capacity to meet surges during periods of heightened pressure, **EFFECT:** there is a risk that patients may receive sub-optimal care and long waiting times. Patients may also remain in inpatient placements longer than anticipated. There may be an impact on capacity for elective pathways **IMPACT:** This may result in the local system being unable to deliver against the priority areas as set out in the UEC Recovery Plan and improvement trajectories not being met.	The NCL System Control Centre has been established and the Surge Team in-housed to the ICB, so this risk is now being managed as part of BAU.	16	16	16			→	9
ICB Risk arising from risks or issues in other organisations - below BAF threshold, but included for oversight											
PERF28	Failure of Primary Care patient access (Threat).	Sarah McDonnell-Davies - Executive Director of Place	**CAUSE:** If the ICB fails to address patient and stakeholder concerns around timely and appropriate access to general practice, **EFFECT:** There is a risk that patients do not present to the right place at the right time. There is a risk to the reputation of provision and commissioning. There is a risk to NHS staff of negativity and abuse. **IMPACT:** This may result in pressures elsewhere in the system. There may be a negative impact on the workforce and providers.	Access remains a key challenge and risk. Demand has increased significantly during and since the COVID-19 pandemic exacerbating access challenges. This is under discussion at the London Primary Care Board with NCL input. The ICB published a system capacity and access plan in November 2023 as part of responding to the Access Recovery Plan. This showed that we were on track with delivery and highlighted specific areas of more challenged delivery which are common to those experienced by other ICBs. The next update is required to the public Board in March 2024. Further work will be required to address access as a core part of the primary care agenda locally, including: • patient experience; • ease of access (including digital inclusion / exclusion); and, • contributing factors including workforce and patient needs and expectations. With such a significant rise in activity in general practice work is also needed on demand. The ICB Board of Members has been clear that work is needed to understand demand versus need. This will be overseen by the Primary Care Committee.	12	12	12	12		→	9
ICB Risk arising from risks or issues in other organisations - dropping below BAF threshold and not included on BAF											
PERF18	Failure to effectively develop the primary care workforce (Threat).	Sarah McDonnell-Davies - Executive Director of Place	**CAUSE:** If the ICB is ineffective in developing the primary care workforce, **EFFECT:** There is a risk that it will not deliver the primary care strategy. **IMPACT:** This could mean that, for example, patients with long term conditions are not fully supported in primary care and require more frequent hospital care.	This risk highlights the importance of Primary Care workforce development, and the ongoing challenges with recruitment and retention. A range of national and local schemes are in place to mitigate the risk. These include the national Primary Care Network ('PCN') additional roles reimbursement scheme ('ARRS') which has enabled PCNs to access national funding to recruit into a range of 18 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. The focus of work with the Training Hub, on supervision, considers the way that the ARRS roles can be supported to operate within the wider multi-disciplinary team in general practice. This will in turn inform approaches to supervision in integrated neighbourhood teams as they develop over time. With the People Board is looking closely at primary care roles and the Training Hub is providing development and support to new roles, this risk has reduced from 16 to 12.	16	16	16	12		↓	9
ICB Only Risk											

QUAL72	Failure to manage the financial costs of CHC and CIC packages due to uncontrollable market factors (Threat).	Chis Caldwell - Chief Nursing Officer	**CAUSE:** If the ICB is unable to effectively manage and negotiate CHC and CIC packages due to uncontrollable external market forces, including, inflation, provider stock levels, clinical demand and complexity and commissioning pattern changes, through established brokerage arrangements and discharge processes, **EFFECT:** There is a risk that the ICB is exposed to higher than budgeted costs and service demands leading to commissioning care packages beyond the agreed financial envelope. **IMPACT:** This may result in a negative impact on patient care, financial sustainability, the ICB not meeting its statutory duties and increased complaints resulting in reputational damage.	The 2023/24 NCL ICB Complex Care Month 9 financial position has a forecasted overspend of Complex Individualised Commissioning ('CIC') £3.4m and Continuing Healthcare ('CHC') £7.8m, which is driven by an adverse position for both CHC and CIC due to external market factors namely, increased demand and complexity of clients, economic and inflationary pressures from providers, change in commissioning patterns and dependence on local authority engagement/social worker allocation, which has delayed assessments and resulted in the ICB incurring costs. At the NCL ICB Finance Committee on 30 January 2024, it was recognised that the Complex Care service is bounded by legislation and has a high interdependency with local authorities. However, though the service continues to ensure that costs are managed/contained, based on clinical need, via Departmental Budget Review meetings, and through close collaborative working with local authority partners, ICB-level Finance oversight and support will be needed. The ICB/Local Authority ('LA') Joint Funding & S117 Reconciliation Principles/Approach (including for Uplifts) agreement are under discussion for 2024/25. Additionally, with the established weekly joint funding reconciliation meetings the aim is to for the closure of historical reconciliation queries and processing the 2023/24 reconciliations with Local Authority Finance/Commissioner leads. The 2023/24 NCL ICB Uplift Requests has only two cases outstanding, which is with the Provider for response by 1 March 2024. The 2024/25 Uplift Policy and Process approach is being finalised. The invest to save Patient Level Dataset Cleanse and Reclaims is delivering positive impact with identifying packages of care that can be closed and clawbacks, however, the CHC Personal Health Budget Cost & Improvements recruitment has been rescheduled to 2024/25, however, in March 2024 BAU clinicians will commence the high-priority reviews.			16	16		➔	9
ICB Only Risks below BAF threshold, but included for oversight												
COMM22	Failure of the Integrated Care Board to effectively and safely manage the specialist services devolution in 2024/25, impacting on the delivery of population health improvements (Threat).	Sarah Mansuralli - Interim Deputy Chief Executive and Chief Strategy and Population Health Officer	**CAUSE:** If the ICB fails to effectively manage the devolution of many specialist services to the ICB, and the opportunity to integrate pathways and tackle the underlying population health issues that are causing the growth in specialist activity and spend is lost, **EFFECT:** There is a risk that the expected improved health outcomes are lost and that provider services are destabilised and expertise is lost. There is also a risk that services are lost, particularly fragile services including Highly Specialised Services which, whilst not being devolved, could be destabilised if other related services experience issues. Changes to services and changes to the funding formula for specialised services could also lead to further provider and/or individual service pressures and resulting impacts on outcomes and performance. **IMPACT:** This may result in a negative impact on quality and equity of access, as well as, loss of workforce, increasing waiting times, significant cost pressures and the lost opportunity to improve outcomes.	Work has progressed on the Legacy Risk Log both for NCL and London and we expect to see a final draft from all ICBs by the end of March 2024. This will be discussed (for NCL) at our April Delegated Services Board. The aim is to have mitigations in place for September 2024 and for the condition to be lifted at the same time. A new programme director has commenced work in London working for NHS England (but hosted by NEL ICB). Marina Muirhead will take the lead on addressing the conditions for delegation and refresh of the Roadmap setting out the plan to delegation in April 2025. The Delegated Services Board have agreed the recruitment of a perm team to support delegated services (including Dentistry). A follow up paper is due to EMT to finalise plans for this and agree budgets. The intention is that providers fund 50% of the overall cost through a recurrent reduction in their allocations. Work on our clinical priorities continues with NCL now the lead for London on Sickle Cell. An NCL clinical priorities list will be prepared by our Clinical Reference Group.	16	12	12	12		➔	9
FIN16	Failure to Deliver the ICB's 2023-24 Financial Plan (Threat).	Bimal Patel - Interim Chief Finance Officer	**CAUSE:** If the ICB failures to deliver the required level of recurrent and non-recurrent efficiency savings described in the 2023/24 financial plan for the Integrated Care Board, **EFFECT:** There is a risk of external imposition of additional financial controls onto the ICB in order to support in year efforts to maintain its financial position. **IMPACT:** This may result in a limiting of the ICB's ability to deliver its population health ambitions, improve patient outcomes and invest in services, alongside a loss of credibility with regulatory bodies.	As at Month 10, January 2024, the ICB is reporting a small adverse variance of £0.1m to the 2024/24 financial plan of £10.6m surplus for this financial year. The reporting of this adverse variance is due to NHS England reporting requirements to report Locum strike costs. To achieve a balanced position the 2023/24 plan assumes c.£30.7m of efficiencies and c£15m non-recurrent actions will be achieved in full. The Cost Improvement Plan ('CIP') has been reduced in year to c£29.2m due to changes in the timeline for implementation of the new organisational structure. At Month 10 approximately £12.9m has been identified recurrently, noting the non-recurrent CIP and cost avoidance CIP impacts on the 2024/25 CIP requirement. In addition, there is an estimated c.£12m of risk which is fully mitigated. The financial position, including risks and CIP are regularly reviewed by the Executive Management Team and strong expenditure controls are in place. As a result of the month 10 financial position the target risk score has been reduced from 9 to 6.			12	12		➔	6
FIN29	Failure of North Central London Integrated Care Board ('ICB') to remain within its Running Cost Allowance ('RCA') 2024/25 and 2025/26 (Threat).	Bimal Patel - Interim Chief Finance Officer	**CAUSE:** If the ICB fails to mitigate any RCA overspend in Financial Years 2024/25, and 2025/26 due to the failure of the Organisational Design Programme to deliver the required efficiencies savings and/or due to the delayed implementation of new structures impacting on the delivery of 2024-25 RCA efficiencies, **EFFECT:** There is a risk that the ICB will be in breach of its statutory duty to stay within its RCA. **IMPACT:** This may result in the ICB being referred to the Secretary of State by its Auditors, with associated increased financial scrutiny and intervention from NHS England, and causing significant reputational damage.	As the organisational change programme progresses, there will be continual review of the controls and Running Cost Allowance ('RCA') impact on pay and non-pay costs to provide assurance on meeting required reductions. Financial modelling is currently forecasting achievement of the running cost reduction, noting there is some risk to 2025/26 dependent on actual costs of staff. If a risks to achieving RCA reductions does emerge this will be managed through RCA vacancies and reduced non-pay costs. Financial modelling will continue to be updated as further information becomes available. The transition into the new structure is expected for 1 April 2024 and 2024/25 budgets will be set in accordance with the Running Cost Allocation. RCA budgets will be monitored in year to ensure that the required savings are delivered.			12	12		➔	6
Reducing ICB Only Risk below BAF threshold, but included for oversight												
PC5	Failure to successfully implement the ICB Change Programme (Threat).	Phill Wells - Interim Chief Executive Officer	**CAUSE:** If the ICB fails to plan, design, and implement the Organisational Change programme to ensure that the ICB operates in a more effective and efficient manner within the ICS **EFFECT:** There is a risk that the ICB will no longer be able to commission appropriate health services to meet the entire needs of the population, the workforce may become demotivated or leave the organisation, and the ICB will not meet the efficiency savings required by NHS England. **IMPACT:** This may result in negative patient outcomes, a workforce that is unable to deliver on the ICB's objectives, negative reputation impacts, and the ICB being financially unsustainable without other efficiency savings.	Prior to the establishment of the ICB on 1 July 2022, the Executive Management Team was restructured in order to better deliver on the ICB's expected objectives. On 1 February 2023 a pan-NCL ICB Organisational Change Programme was launched. The goal is to design an organisational structure and ways of working that better enable us to work together with our system partners to meet the needs of our population and our people. The programme has 3 phases: 1. 'Reset and re-envisage', scheduled to be completed by April 2023; 2. 'Review and revision', to be completed by July 2023; and, 3. 'Relaunch and renew' from September 2023. The phases are to determine the ICB's future operating model, identifying the needs of the design and its implementation, and then operationalising the model. The programme is now in phase 3 and is on track, although the risk will continue to develop over the remainder of 2023/24. Formal consultation closed on 21 August 2023 and all of the feedback considered. The Voluntary Redundancy scheme pre-approval was received on 24 August 2023. An all staff briefing was held							

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**