North Central London
Integrated Care Board

NHS North Central London ICB
Board of Members Meeting

Tuesday, 7 May 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 Meeting on 26 March 2024	Mike Cooke	Approve	9	
1.4	Matters Arising	Mike Cooke	Note	20	2.05pm
1.5	Report from the Chief Executive Officer	Phill Wells	Note	22	2.10pm
2.	**STRATEGY AND BUSINESS**				
2.1	Dental, Optometry and Community Pharmacy Services Delegation Update	Sarah Mansuralli/ Sarah McDonnell-Davies	Note/ Agree	28	2.20pm
2.2	2023 Staff Survey Results	Sarah Morgan	Note	79	2.30pm
2.3	NCL ICS People Strategy Annual Report	Sarah Morgan	Approve	100	2.40pm
2.4	2024/25 Financial Planning Update	Bimal Patel Richard Dale	Note	122	2.50pm
3.	**OVERVIEW REPORTS**				
3.1	Integrated Performance and Quality Report	Richard Dale and Dr Chris Caldwell	Note	132	3pm
3.2	Board Assurance Framework	Ian Porter	Note	154	3.10pm
4.	**GOVERNANCE**				

4.1	Update to Committee Terms of Reference	Ian Porter	Approve	162	3.20pm
5.	**ITEMS FOR INFORMATION AND ASSURANCE**				
5.1	Minutes of the Finance Committee Meeting on 30 January 2024	Usman Khan	Note		3.25pm
5.2	Minutes of the People Board Meeting on 20 November 2023	Liz Sayce	Note		
5.3	Minutes of the Quality and Safety Committee Meeting on 9 January 2024	Liz Sayce	Note		
5.4	Minutes of the Strategy and Development Committee Meeting on 7 February 2024	Mike Cooke	Note		
6.	**ANY OTHER BUSINESS**				
7.	**DATE OF NEXT MEETING**				
7.1	23 July 2024				
8.	**PART 2 MEETINGS**				
8.1	To resolve that as publicity on items contained in Part 2 of the agenda would be prejudicial to public interest by reason of their confidential nature, representatives of the press and members of the public should be excluded from the remainder of the meeting. Section 1 (2) Public Bodies (Admission to meetings) Act 1960.				

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Board of Members Meeting
7 May 2024

Report Title	Declaration of Interests Register – NCL ICB Board of Members	**Date of report**	26 April 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		
		Labour Party	no	no	yes	direct	Member of the Labour Party		current	22/12/2023		
	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	yes	yes	yes	Direct	Lay member of Council and Audit and Risk Committee Chair	25/11/2018	current	31/07/2024	27/03/2024	
	Member of ICB Finance Committee	English Heritage Trust	yes	yes	yes	Direct	Director	30/12/2021	current	11/07/2022	17/07/2023	

	Member of ICB Remuneration Committee	Isle of Wight Youth Trust	no	yes	no	Direct	Chair	12/07/2023	current	12/07/2023		They are commissioned by the Hampshire and Isle of Wight ICB to provide counselling services, not involved in any NCLICB work
		Institute of Directors	no	no	no	Direct	Member	08/03/2024	current	27/03/2024		
		UK Research and Innovation, Medical Research Council	yes	yes	no	Direct	Senior Independent Member	01/04/2024	current	27/03/2024		
		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**	Standing Participant of the ICB Board		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	
		KU Leuven University, Belgium	yes	yes	yes	Direct	Visiting Professor in Health Management and Policy		current	07/09/2022	18/07/2023	
		South East Coast Ambulance Service	yes	no	no	Direct	Chair	15/04/2024	31/05/2027	16/04/2024		
		New York University (London)	yes	no	no	Direct	Global Lecturer		current	20/03/2024		
		Bevan Commission	no	no	yes	Direct	member		current	20/03/2024		
		European Health Forum Gastein	no	no	yes	Direct	Advisory Committee member		current	20/03/2024		
		Health Shared (Axiom Medical Ltd)	no	no	no	Direct	ad hoc advice pro bono	01/03/2024	current	16/04/2024		
Baroness Julia **Neuberger DBE**	Partner Member of the Board 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**	Partner Member of the Board 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**	Standing Participant of the ICB Board		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**	Partner Member of the ICB Board		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**	Partner Member of the ICB Board		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	

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

		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**	Partner Member of the ICB Board, Leader of Islington 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
26 March 2024 between 2pm and 3.30pm
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
Richard Dale*	Executive Director of Performance and Transformation
Usman Khan	Non-Executive Member
Sarah Mansuralli*	Chief Strategy and Population Health Officer
Sarah McDonnell-Davies*	Executive Director of Place
Sarah Morgan*	Chief People Officer
Bimal Patel	Chief Finance Officer
Ian Porter*	Executive Director of Corporate Affairs
David Probert	Chief Executive, UCLH NHS Foundation Trust
Dr Jo Sauvage	Chief Medical Officer
Liz Sayce	Non-Executive Member
In Attendance:	
Paul Allen	Assistant Director of Strategy, Communities and Inequalities
Sarah D'Souza	Director of Strategy, Communities and Inequalities
Rebecca Kingsnorth	Assistant Director for Primary Care Programmes and Transformation
Apologies:	
Cllr Kaya Comer-Schwartz	Leader, Islington Council
John Hooton	Chief Executive, Barnet Council
Jinjer Kandola	Chief Executive Officer, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust
Mark Lam*	Chair, Royal Free Hospitals and NMUH
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
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.

* Standing Participant

1.1.2	Apologies had been received from Cllr Kaya Comer-Schwartz, John Hooton, Jinjer Kandola, Mark Lam, Dr Jonathan Levy, Baroness Julia Neuberger and Dr Alpesh Patel. David Probert was attending on behalf of Baroness Neuberger.
1.2	**Declarations of Interest relating to the items on the Agenda**
1.2.1 1.2.2	Mike Cooke invited Members to declare any interests relating to items on the agenda. There were no additional declarations. The Board of Members: • **NOTED** the requirement to declare any interests relating to the agenda; • **NOTED** the Declaration of Interests Register and the requirement to inspect their entry and advise the Board Secretary of any changes; • **NOTED** the requirement to record any relevant gifts and hospitality on the ICB Gifts and Hospitality Register.
1.3	**Minutes of the NCL ICB Board of Members Meetings on 7 November and 5 December 2023**
1.3.1	The Board of Members **APPROVED t**he minutes as accurate records.
1.4	**Matters Arising**
1.4.1	The Board of Members **NOTED** the Action Log.
1.5	**Report from the Chief Executive Officer**
1.5.1	Phill Wells provided an overview of the report. He began by thanking everybody involved in responding to the system pressures over recent months and then highlighted the following points: • The Urgent and Emergency Care pathway has been a particular focus, particularly because of the imperative to achieve 76% four-hour wait performance across England. This work is starting to have an impact and over the last few days all sites have achieved 70% at least once. There is a strong system focus on supporting NMUH, which is one of NCL's most challenged sites, as well as recent work with LAS and colleagues at other Trusts around the 'postcode flow' for that hospital • Barnet Hospital has declared two business critical incidents in recent weeks, mainly because of discharge capacity and this has therefore also been a strong focus for the system • Cancer performance in NCL has improved significantly since the previous Board meeting and the 62 day backlog has been reduced to below 500 (the lowest figure since June 2021), although it is acknowledged that this number is still too high • NCL remains on track to deliver a break-even financial position at year-end. This is a testament to the hard work across the system on achieving financial outcomes alongside the performance metrics. The financial outlook for 2024/25 for London and across England is extremely challenging and work on setting the financial plan for 2024/25 remains ongoing. The ICB's financial performance in 2023/24 means that NCL CCG's historic debt will be written off. This will be a significant boost to both the ICB and the system going forward • The Start Well public consultation has now concluded. Hundreds of stakeholder and community events have been held across NCL over recent months and the responses to the proposals are now being analysed before a final decision is taken • The new Population Health Outcomes Framework, which has been published on the ICB website, starts to show transparently the metrics that the ICB is seeking to improve. This Framework will be regularly referenced in the future as the ICB makes progress • The Change Programme is now in its final stages as the ICB stands up the new organisation on 1 April 2024 and meets its financial obligation regarding the reduced Running Cost Allowance.

	• The significant focus will now be on how colleagues work with each other and external partners in the new structure, the leadership capacity required to make this successful, the development of high-performing teams and continuing to deliver efficiency and efficacy through the work of the ICB • The ICB has received a change of control notification from AT Medics, who hold eight GP contracts in NCL. Contract holders are required to obtain the consent of the commissioner as part of the change of control process. The ICB is working with London colleagues to understand what this will involve and have also shared this request with the public via multiple channels to give people the opportunity to ask questions and inform the due diligence process. A final decision on the change of control request will be taken in due course at a meeting of the Primary Care Committee.
1.5.2	The Board then discussed the paper, making the following comments: • In response to a query about the impact of the fertility clinic at the Homerton Hospital having its licence suspended, it was noted that issues had been experienced for some time around access to Homerton services and alternative arrangements have been put in place to ensure that NCL can offer choice to local residents. The new ICB Fertility Policy will also serve to address this by mitigating some of the risks associated with provision at the Homerton not being available • The progress made in the past 12 months since Dental Services were delegated to the ICB and the plans to embed transformational changes was commended • The impact of the Wood Green Community Diagnostic Centre and its continuing expansion since its opening in 2022 was also praised.
1.5.3	The Board of Members **NOTED** the Report.
2.	**STRATEGY AND BUSINESS**
2.1	**Population Health and Integrated Care Strategy – NCL Joint Forward Plan**
2.1.1	Mike Cooke highlighted that the Board was being asked to approve the paper, rather than note it.
2.1.2	Sarah Mansuralli then provided an overview of the report, highlighting the following points: • The document follows on from the discussion at the Board Seminar in February where it was agreed to bring together the Joint Forward Plan that had been produced for NHS England and the Delivery Plan that had been developed to underpin the Population Health and Integrated Cate Strategy • The document therefore sets out the progress and key achievements over the past 12 months and looks at how NCL will build on this going forward to maintain momentum and continuity over the next 18 months • As the Joint Forward Plan needs to be published on the ICB website, this presents an opportunity to communicate to residents the work taking place around Population Health • The slide deck contains place holders for design content and pictures to be added, subject to the Board approving the content • The content of the Delivery Plan reflects much of the work undertaken since the Population Health and Integrated Care Strategy was approved in April 2023 and sets out the critical path which NCL needs to follow in terms of focusing on outcomes. The Plan will be refreshed annually while still working to the 18 month horizons which have been drawn up and will evolve in terms of the clarity of the deliverables and how they are measured, supplemented by an Annual Outcomes Report • A cycle has been built into the delivery planning for monitoring and oversight, giving the system the ability to track progress and understand where it is making a difference as well as identifying where corrections might need to be made. The Outcomes Framework dashboard will be integral to this

	• A large amount of engagement work has taken place with different parts of the system around how the dashboard can be used to provide insight into the work that is taking place. As part of the next phase the Borough Partnerships and system transformation programmes will apply the Outcomes Framework to look at the current position in different areas and consider future aspirations within the 18 month cycle • The Outcomes Framework will enable the Delivery Plans to become more granular in terms of year on year goals • This work will remain in a state of evolution and will be brought back to the Board at regular intervals with regards to both an annual report and a refresh of the Plan, as well as a separate Outcomes Framework annual report.
2.1.3	The Board then discussed the paper, making the following comments: • The collation of the achievements to date was welcomed. • Assurance was given that the different priorities for various parts of the system are all aligned to the Population Health and Integrated Care Strategy and often overlap as enablers for work to be delivered effectively in other parts of the system. • The Delivery Plan recognises that there has been a large amount of mapping of the work of the Borough Partnerships which has identified that although much excellent work is taking place in each partnership, there is an opportunity to refine and hone this to focus on the key Population Heath risks at Borough Partnership level • The Integrated Care Partnership (ICP) recognises that through their endorsement and support, as well as their collective focus and resources, system changes can be more impactful. The 'supercharged' improvement in vaccinations and immunisations is a prime example of this. Heart health is another example of an area where the ICP is seeking to supercharge change • It was noted with regards to the opportunities afforded around greater use of digital and greater personalisation that activation levels are important in terms of self-care and health improvement but activated patients tend to be from the less deprived local population, so it important to apply an inequalities lens when promoting self-care to avoid entrenching wider disparities. • It was agreed that it would be helpful to use any engagement around the Delivery Plan as an opportunity to impart messages around self-care and lifestyle choices to develop a shared approach with residents around managing their health • It was noted that although the Long Term Conditions which are not currently treated to target tend to be fairly universal across the local population, the approach will need be tailored for different communities to gain people's trust and encourage them to come forward, as that is currently one of the largest barriers to equitable access • It was highlighted that a piece work was carried out on personalisation and self-activation a few years ago, culminating in a paper published by the Health Foundation, which measured the activity of Islington residents across all practices and then triangulated levels of activation with long-term conditions and outcomes. That retrospective information can be applied to the current population in the context of managing and optimising the treatment of hypertension. • New modelling which was recently reviewed by the ICB Executive Management Team can look at the level of additional intervention and support that people may need to improve their activation. Calculations can be undertaken on the return on investment by looking at the population and different levels of risk, the cost of various interventions and how that then translates into return on investment by optimising care proactively • It was clarified that patient activation signifies a person's health literacy based on a questionnaire which provides an understanding of the sort of barriers that an individual might encounter when engaging with an intervention, as well as their confidence, motivation and ability to change • It was noted that a large amount of the local population overlaps in different priority cohorts in the individual priorities and it would therefore be beneficial for different treatments to be provided under one roof, rather than having people treated in isolation

	• In response it was noted that the Integrated Neighbourhood Teams are beginning to develop a team around the individual patient but this team must not detract from the fact that patients wants to see a health professional, so it is important not to seek to replace that. Some of the more complex patients may well benefit from a more integrated and rapid response team. Work is taking place with the Provider Alliance to consider how the Alliance might do some very specific work, utilising some of the capacity and capability of specialists in the system to provide some of that rapid 'wraparound' assessment treatment. However, this will need to be closely integrated with primary care and the voluntary sector so that is fully embedded • The coherency of the multiple actions and the plans sitting beneath them was welcomed. It was suggested that it would be helpful for individual actions to be brought together for the Population Health Committee to assess whether they are making a difference to Population Health at scale and whether inequalities are being addressed. It was also suggested that there is scope to improve some of the measurements – for instance, a 3.5% increase in immunisation coverage may not be a meaningful metric in the context of the threshold needed to prevent outbreaks • It was acknowledged that some of the entries need to be more robust and the offer for the Population Health Committee to follow this up and carry out further work was welcomed • The references to health equity were welcomed as a particularly positive way of framing the need to avoid increasing health inequalities. It was suggested that that the emphasis on this point could perhaps be strengthened in the document • The achievement in distilling so much complex information into one document was applauded. However, it was suggested that the document would benefit from greater clarity around what is meant by an input and an outcome, as well as some of the timeframes before any wider engagement. Greater clarity around the priorities would also strengthen its Impact • It was recommended that the Plan should be published in its current form for the time being, prior to Jane Simmonds (Director of Communications and Engagement) and her team producing a resident-friendly version • It was noted that although the cover sheet refers to getting the Delivery Plan designed under the next steps, the key next step will actually be to deliver the priorities • In response to a query about what area had exceeded expectations this year and which one has proved particularly challenging, it was noted that progress has been easiest when plans have already been in place to deliver early on, with attached resources and clear understanding of responsibility for delivery. The work on speech and language therapy, where investment has gone into more deprived areas with a clear focus on addressing inequalities is a prime example of this and its impact is already visible through things like the SEND inspections. By contrast, achieving progress is more challenging when trying to deal with something more amorphous across the system where it is unclear where responsibility lies and resourcing is more complex. This is an area where the system will need to improve if it is to achieve its Population Health ambitions.
2.1.4	Mike Cooke welcomed the discussion and recommended that it should be developed further at the next meeting of the Strategy and Development Committee.
2.1.5	The Board of Members: • **APPROVED** the NCL Delivery Plan • **NOTED** the development of other resident-friendly products to support the communication of work the ICB and partners are doing to improve population health • **SUPPORTED** the prioritisation of the work set out in the NCL Delivery Plan through 2024/25.
2.2	**Sustainable Healthcare: Green Plan Annual Report**
2.2.1	Jo Sauvage and Sarah D'Souza provided an overview of the Annual Report, highlighting the following points:

	• It is recognised that some of the datasets are being collated at a national level, which means that NCL Is potentially seeking to deliver in an environment where there is a time lag in how some of the aggregate data is captured • Since the discussion at the Board Seminar in February the ICB has met two inhaler emissions targets in Quarter 3 and has also stopped the use of desflurane • NCL carbon admissions data for 2021/22 has now been received from NHS England and will provide a helpful baseline to measure future progress across the 10 local Trusts. As the 2022/23 data is unlikely to be available until February 2025, the ICB is working with NHS England (London) in the meantime to understand its position comparative to other London ICBs. The latest pack of benchmarking data shows that NCL is performing well around inhalers and anaesthetic gases but further progress is needed to catch up with other London ICBs around procurement, supply chain, travel and transport. This information will be used to refine and iterate the NCL plan to ensure focus on areas of greatest impact • To date the ICB has cut its cloth to meet its resource and expertise but there has not been any additional national funding for structural changes which might be required around particular estates to make them more energy efficient. This accounts for 75% of the emissions in NCL. • Although strong collaborative relationships have been developed there are some tough challenges ahead. The first is around dedicated capacity, particularly around programme management and clinical support. Active discussions are currently taking place with Trusts about how this is done collaboratively • To partially address the funding challenge, the ICB will investigate Green Investment Bonds as it believes that there is a potentially 'easy win' around investment and demonstrable savings going forward. Community Infrastructure Levies will also be looked into • The report highlights that support will be required from the regional and national teams in order that better use is made of system levers to incorporate this work into planning processes going forward.
2.2.2	The Board then discussed the paper, making the following comments: • The challenge to the Board to commit to actions was welcomed. However, with regards to the specific recommendation that the Board should commit to supporting the decisions that can be made as an ICS to speed up the pace of change, it would be helpful for the Board to have visibility of these decisions and hard choices, as well as where and when they are going to be made within the governance structure • Since the ICB knows the relative contribution and footprint of the things that have been done and has baseline data, it was queried whether it would be possible to project where NCL is in the trajectory to meet the target for 2040 while awaiting data that will only be available in 2025 • In response it was confirmed that the ICB will be looking in more detail at the material available from NHS England and the extent to which it can forecast forward based on its activity. This information is now available at a granular level by Trust as well as differential outputs, so this will also help the ICB to focus on its biggest areas of opportunity • The key contribution played by the Primary Care Network pharmacists in the achievement of the inhaler emissions targets was highlighted • It was noted that UCLH had declared a climate emergency in 2021. The main driver behind this was the fact that this is an issue which the workforce cares passionately about. This level of engagement and best practice has been shared more widely over time as staff move around the system • It was suggested that the ICB should set aspirations for hospitals and GP practices that all organisations can meet and which do not require capital investment • A key contribution that can be made through the model of care is to reduce where possible the need for patients come into hospital, building on the shift to more online consultations that occurred during the pandemic

	• Tackling the climate crisis will require systemic engagement because this will impact the disease profile and the ability to tackle it. The system needs to create a culture where people feel energised to do something positive while also helping to allay some of the climate anxiety that is prevalent • Maintaining the prominence of this piece of work is therefore vital. The ICB will be meeting Hannah Whitty, Regional Finance Director and convening a round table session to facilitate a system conversation about how some of the financial levers might be aligned slightly differently • Assurance was given that work is taking place with the Estates Board and the Local Care Infrastructure Delivery Board to ensure that green issues are embedded, as well as with the Digital Board around digital-related emissions • It was agreed that it would be helpful to take a paper on the work taking place around social value to a future meeting of the Population Health Committee. The ICB is demonstrating strong leadership in this area, particularly around its own social value procurement.
2.2.3	Mike Cooke thanked Members for their observations which would be absorbed and followed up. He commented that it would be helpful if the Estates Board could be asked to confirm its approach to building improvements/new builds through a green lens, while acknowledging issues around affordability.
2.2.4	The Board of Members: • **NOTED** the progress made to deliver the Green Plan in 2023/24 and the work planned for 2024/25 and the further support required to deliver the ICB's ambitions • **NOTED** the 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 • **COMMITTED** to actions identified to champion sustainability as Board members and system partners.
2.2.5	Action: Sarah Mansuralli to bring a paper on the ICB work around social value and anchor for discussion at a future Board Seminar.
2.2.6	Action: Bimal Patel to arrange for the Estates Board to review its programmes/projects of work, ensuring appropriate attention is paid to the 'Green' agenda.
2.3	**Primary Care Access Recovery Plan**
2.3.1	Sarah McDonnell-Davies provided an overview of the report which summarises progress since the previous presentation to the Board in November 2023 and marks the end of the first year of a two year programme of work. She highlighted the following points: • There has been significant work at practice level since November on systems and processes, ways of working and interfaces such as GP websites. The practice-level change support offer has been mobilised. This is a mixture of clinical leadership operational expertise and digital change facilitators, reflecting the focus on embedding digital tools and ways of working • Supplementary communications and engagement activity has been commissioned • Additional enhancements have been made over and above what is required with regards to digital inclusion, including funding pilots in each Borough which connect practice teams to the voluntary sector, as well as developing an impact monitoring approach • As the programme moves into its second year it is anticipated that demand will continue to outstrip capacity and resources in general practice so there will be a need to think about the multiplicity of approaches that can help practices and the system address that challenge. This will include things such as self-service, greater self-activation and the role of technology • The role of Community Pharmacy will be expanded, including a commissioned Pharmacy First scheme that will enable over the counter medications to be provided free of charge to patients who cannot afford them, to ensure that pharmacy pathways can be effectively used by all residents

	• The strategic estates planning work has also been brought into this programme to consider what the modern general practice access model means for the estate in order to align capital to primary care in NCL and to convert and modernise the estate, particularly to enable clinical intervention and face to face care • Going forward, discussions will need to take place with Trust colleagues about the interface between primary and secondary care as this will need co-production with acute colleagues because this is the aspect of recovery planning that areas are finding most challenging.
2.3.2	The Board then discussed the paper, making the following comments: • It was acknowledged that almost half of the NCL general practice estate was built before 1948 and the vast majority was built before 1990, so far more progress is needed to create a primary care infrastructure which is truly fit for purpose. That said, discussions are more mature in NCL than most other areas, to the extent that NCL is the only ICB to have allocated 5% recurrently of its capital funding to general practice. Nevertheless, it will take decades for the general practice estate to reach the state that it is needed, so the ICB will need to continue to talk to the Estates Board and system colleagues about how this might be addressed • The need to have a system in place to monitor prescribing through ARRS (Additional Roles Reimbursement Scheme) and Pharmacy First was highlighted. In recent years the ICB has provided practices with excellent education around prescribing but these groups will not be part of that envelope, so it is important to ensure that they are prescribing appropriately and cost-effectively while also operating within their remit • In response it was noted that the ARRS workforce has been crucial in recent years but this scheme is drawing to a close so there is a question about how the workforce challenge will be met if demand continues to grow. The role of the GP will be critical to this. • Assurance was then given that the Integrated Medicines Optimisation Committee (IMOC) has discussed Pharmacy First prescribing previously. It was recognised that there will be a need to closely monitor quality, prescribing patterns in terms of appropriateness and cost, as well as potential conflicts of interest • Although the focus in the paper on digital was welcomed, concern was expressed about practices often lacking laptops and PCs. It was suggested that extra funding from the ICB is required to address this • In response it was noted that there had been a revolution in the general practice operating model during the pandemic, centred significantly around digital and IT, but sustaining this, let alone developing it, will be challenging • It was further clarified that the GPIT funding allocation covers hardware in practices, rather than laptops for remote usage, although ICBs were allowed to purchase laptops non-recurrently during the pandemic. It would be helpful to have discussions with practices about the optimum 'mix' going forward as part of the Digital Strategy which is currently being refreshed • The strong rationale for the decision taken to support practices with 5% of the capital allocation which has traditionally gone to secondary care providers was highlighted. Practices occupying the worst of the NCL estate have fewer GPs per head of population and therefore more conveyances to A&E as a result and also offer fewer training places than those in higher quality estate, so there is a clear argument for investment in primary care estate. • The system needs to continue to make the case collectively to NHS England and the Treasury to invest in this part of the health system as the capital regime does not support it well enough and as a result there is a reliance on organisations seeking support through the Community Infrastructure Levy/Section 106 and other funding sources to fund the kind of development that is needed. NCL's ambitions exceed the amount of money available and it is the capital regime which is the constraint. The ICB may need to be more creative about sources of finance to support the rebuild of the primary care estate over the next decade • It was suggested that it would be helpful if some metrics could be included in future reports about what this work means for the primary care workforce, including their satisfaction levels

	• Recognising the need for capital and revenue, it would be helpful to review the Primary Care infrastructure position (estates and digital) at a future Board Seminar • The level of engagement from practice teams, despite them often being under intense pressure, was acknowledged • Assurance was given that the ICB has worked with the voluntary sector and primary care in multiple ways over recent years, including call and re-call and work on high intensity users. However, the prevention agenda is a huge untapped opportunity for integrated working between primary care and the voluntary sector. There are significant gaps which the voluntary sector can help to fill in terms of access based on need rather than demand.
2.3.3	The Board of Members **APPROVED** the Primary Care Access Recovery Plan.
2.3.4	Sarah McDonnell-Davies to arrange for the Board to review the Primary Care infrastructure position (estates and digital) at a future Board Seminar.
3.	**OVERVIEW REPORTS**
3.1	**Integrated Performance and Quality Escalation Report**
3.1.1	Richard Dale and Chris Caldwell introduced the paper, highlighting key points and providing further updates since the paper was published: • NCL continues to be one of the highest performing ICBs in the country in respect of access to diagnostics – this is a credit to the system working across the Diagnostic Network • Excellent progress has been made on reducing the number of mental health out of area placements which have decreased by almost 50% compared to the previous quarter. However, there has recently been a slight increase so there is a system focus to understand the cause of this • At an aggregate level, practices are consistently meeting the national expectation that 90% of primary care appointments are booked within 2 weeks • There are continuing challenges around access to CAMHS in the community – this is an area that will require particular attention as part of the planning for 2024/25 • There is a still a number of patients who have been waiting longer than 104 weeks for treatment, the majority of whom are paediatric dentistry patients being treated by GOSH. Work is taking place with other providers and the national team to address this • The recent industrial action has had a negative impact on the ambition to eliminate the 78 week waiters. The ICB is leading a collaborative system approach to clearing the backlog through mutual aid and demand management initiatives • The ICB needs to maintain a strong focus on three Urgent and Emergency Care metrics: A&E performance, ambulance handovers and 12 hour breaches. Although improvements are being made in all three areas, there is nevertheless day to day volatility. The consistent application of clinical practice will be key to overcoming this • All sites are continuing to experience significant numbers of medically optimised patients. This is posing operational challenges as most sites are operating at or above 100% basic capacity. These numbers are being reviewed daily by pathway so that patients can be escalated as quickly as possible. A concerted plan will be needed to ensure that the system has moved to a different position by the summer • Over the next 12 months future iterations of the report will include more horizon-thinking, using the Outcomes Framework to take a broader view of the health and care system • The ICB has been supporting organisations' applications to the Maternity Incentive Scheme which supports the delivery of safer maternity care. Although the Royal Free, UCLH and Whittington Health were fully compliant with the 10 safety actions, NMUH did not meet two of them, so the ICB will be working with the Trust over the next year through the Maternity and Neo-Natal system as part of their wider improvement programme • The ICB is in the final stages of completing a dashboard for maternity performance which will also help to demonstrate that it has leadership and oversight of maternity services in the same way that it does for Urgent and Emergency Care

	• A future report will include more information about the support being given to people with learning difficulties, particularly with regards to annual health checks and how they are then acted on, as well as the learning from the deaths of people with learning difficulties.
3.1.2	The Board then discussed the paper, making the following comments: • It is important to note that considerable progress has been made outside the periods of industrial action. Unfortunately there is now the possibility of further industrial action which could have an even greater impact than it has to date • The excellent work of the Cancer Network, which brings together colleagues from providers and primary care, is a key factor in the progress on cancer targets. • Although the progress on reducing diagnostic waiting times was welcomed, the figures remained concerning and it is imperative to avoid them becoming normalised
3.1.3	Mike Cooke concurred with this comment and reflected that although it is important to focus on where things have gone well and the excellent work taking place, this is in the context of also highlighting the downsides which need to be addressed.
3.1.4	The Board of Members **NOTED** the key issues set out in the paper for escalation and the actions in place to support improvement.
3.2	**Finance Report**
3.2.1	Bimal Patel introduced the Month 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: • NCL ICS is reporting a £71.1m deficit at Month 10 (£56.2m excluding the impact of industrial action). This is adverse to plan by £35.7m. The forecast out-turn at Month 10 is a deficit of £15.5m. However, during Month 11 the system has received funding for the direct cost impact of the industrial action. Via the ICB and providers the ICS has been able to consume the pressures relating to the indirect costs on a non-recurrent basis. Costs include lost activity and lost efficiencies. The system is therefore still forecasting a break-even position at year-end. • As stated earlier, the ICB's financial position will enable NCL CCG's historic debt to be written off. This achievement will also result in a capital incentive for the ICB for 2024/25. This is likely to be in the region of £4-6m depending on the final NHS financial position. • Provider efficiency within the ICS shows a shortfall, which is partly, but not entirely, due to the industrial action. The impact of this will be carried over into next year as part of underlying deficits • The capital position is slightly over plan but this will be mitigated in Month 12 • The ICB is reporting a £0.1m adverse position against plan at Month 10 which will be mitigated in Month 11. Non-acute is overspent by £24m, mainly around Continuing Healthcare, prescribing and primary care co-commissioning. These forecast overspends are largely off-set by the ARRS (Additional Roles Reimbursement Scheme) allocation which has been subsequently received in Month 11 and the dental underspend.
3.2.2	The Board of Members **NOTED** the Finance Report.
3.3	**Board Assurance Framework (BAF)**
3.3.1	Ian Porter introduced the paper, highlighting the following points: • Two new risks have been added to the BAF regarding the capital programme and the St Pancras Hospital Transformation Programme • The risk concerning patient flow at peak times has been closed on two grounds: a set of 24/7 operating procedures is now in place to support the system at all times and secondly, spikes are a recurring phenomenon, so that risk has been combined with PERF29 which concerns urgent and emergency care at all times • Good progress has been made on the risk relating to Deprivation of Liberty assessments and as a result the score has been reduced from 16 to 12

	• A new risk management system is being implemented which will make risk reporting and analysis much easier • Positive discussions continue to take place with the Audit Committee about the ICB approach to risk management. As a result, it has been agreed that the Target Risk Score column on the Risk Register will be supplemented with a Target Date.
3.3.2	The Board of Members discussed the paper. It was highlighted that a large amount of work is taking place, particularly in terms of distinguishing between system risks, provider-led risks and ICB-only risks, as well as considering which risks warrant deep dives and which ones need to be reported to the Board. Setting target dates will help to identify instances where the ICB has to tolerate a certain level of risk.
3.3.3	The Board of Members **NOTED** the Board Assurance Framework.
4	**ITEMS FOR INFORMATION AND ASSURANCE**
4.1	**Minutes of the Audit Committee Meeting on 19 September, 14 November 2023 and 16 January 2024**
4.1.1	The Board of Members **NOTED** the minutes of the Audit Committee.
4.2	**Minutes of the Finance Committee Meetings on 10 October and 12 December 2023**
4.2.1	The Board of Members **NOTED** the minutes of the Finance Committee.
4.3	**Minutes of the Integrated Medicines Optimisation Committee Meeting on 26 September and 28 November 2023**
4.3.1	The Board of Members **NOTED** the minutes of the Integrated Medicines Optimisation Committee.
4.4	**Minutes of the People Board Meeting on 20 November 2023**
4.4.1	The Board of Members **NOTED** the minutes of the People Board.
4.5	**Minutes of the Procurement Oversight Group Meetings on 20 September, 8 November and 13 December 2023**
4.5.1	The Board of Members **NOTED** the minutes of the Procurement Oversight Group**.**
4.6	**Minutes of the Quality and Safety Committee Meeting on 18 July and 24 October 2023**
4.6.1	The Board of Members **NOTED** the minutes of the Quality and Safety Committee.
4.7	**Minutes of the Strategy and Development Committee Meeting on 27 September and 6 December 2023**
4.7.1	The Board of Members **NOTED** the minutes of the Strategy and Development Committee.
5.	**ANY OTHER BUSINESS**
5.1	There was no other business.
6.	**DATE OF NEXT MEETING**
6.1	7 May 2024.
7.	**PART 2 MEETING**
7.1	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

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On Agenda	
Needs Urgent Update	
In Progress	
Completed	

Meeting Date	Action Number	Action	Lead	Deadline	Update
7 November 2023	19	**Mental Health Update Paragraph 2.1.5** To lead a discussion on Mental Health at a future Board Seminar, building on the discussion at today's meeting.	Jinjer Kandola	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	July 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.

26 March 2024	21	**Sustainable Healthcare: Green Plan Annual Report** **Paragraph 2.2.5** To bring a paper on the ICB work around social value and anchor for discussion at a future Board Seminar.	Sarah Mansuralli	December 2024	A discussion will take place at the Board Seminar on 10 December 2024.
26 March 2024	22	**Sustainable Healthcare: Green Plan Annual Report** **Paragraph 2.2.6** To arrange for the Estates Board to review its programmes/projects of work, ensuring appropriate attention is paid to the 'Green' agenda.	Bimal Patel	July 2024	An update on this will be brought to the July Board meeting.
26 March 2024	23	**Primary Care Access Recovery Plan** **Paragraph 2.3.4** To arrange for the Board to review the Primary Care infrastructure position (estates and digital) at a future Board Seminar.	Sarah McDonnell-Davies	December 2024	A discussion will take place at the Board Seminar on 10 December 2024.

North Central London
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North Central London ICB
Board of Members Meeting
7 May 2024

Report Title	Chief Executive's Report	**Date of report**	23 April 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. Change of control at AT Medics

2.1 AT Medics Ltd provides General Practice services across London and England and currently hold 8 GP contracts across Camden, Haringey and Islington. On 30 November 2023, AT Medics Ltd wrote to London ICBs advising that Centene Corporation (their legal owner) were proposing to sell their UK General Practice business to T20 Osprey Midco Limited.

2.2 Due to a clause in the Alternative Provider of Medical Services (APMS) contract, the contract holder must obtain consent from the commissioner before undergoing a change of control, with clear procedures and governance processes to follow.

2.3 ICBs across England commenced a process of due diligence with independent support, with those in London working together to co-ordinate this exercise. ICBs also communicated this request to patients and stakeholders and commenced engagement to ensure people had the opportunity to ask questions and inform the process. NCL ICB committed to taking decisions in public meetings of our Primary Care Committee.

2.4 On 15 March 2024, NCL ICB was informed that ownership of Operose Health Ltd had in fact transferred from MH Services International (UK) Ltd to T20 Osprey Midco Ltd on 28 December 2023, resulting in a 'change of control' for AT Medics Ltd.

2.5 The NHS was not informed of this at the time nor had prior authorisation been given. Under the terms of APMS contracts, providers may not undergo a change of control without such prior authorisation. This is therefore a breach of contract. We issued a public statement on this change, and the initial response of commissioners to it, on 15 April 2024.

2.6 In light of this, we are looking at our options, process and timeline. NCL ICB is considering next steps carefully and decisions will be made in due course at a meeting of our Primary Care Committee which is held in public.

2.7 The change of control is a change in ownership and does not result in any change to the legal entity holding the APMS contracts (AT Medics Ltd), the APMS contracts themselves or the services AT Medics Ltd are required to provide, including locations, opening hours and service standards.

2.8 The change of control does not mean that these GP practices will close or that registered patients need to find a new doctor. We monitor quality and performance of all General Practice services ongoing, to ensure care that meets the requirements set for all providers of NHS services.

2.9 Whatever decisions are made, as a commissioner of NHS services our priority is the provision of high quality, safe and accessible services for local people.

2.10 Our due diligence process and our patient and stakeholder engagement will continue. When it considers its options, the Primary Care Committee will be able to draw on feedback on the change of control proposal and any feedback on the early completion of this.

2.11 Our public information and engagement materials will be revised to reflect this change. Further information is available on our website alongside a survey to capture views and an email address for comments and queries nclicb.changeofcontrol@nhs.net

2.12 We have May and June Primary Care Committee meetings. We welcome Board views and will ensure that further updates are shared.

3. 2023/24 Financial Achievements

3.1 It is expected that the system will report a c£25m surplus in 2023/24 despite the challenges in year due to a high level of planned efficiency savings and the continuing industrial action throughout the financial year. This 2023/24 revenue outturn, if confirmed during the audit process, will benefit the system in 2024/25 with capital for achieving system the planned breakeven and £ for £ capital funding in recognition of the system surplus. Achieving ICB and system financial balance in 2023/24, in addition to having achieved ICB and system financial balance in 2022/23, ensures that NCL ICS meets the NHS England conditions for not needing to pay back the historic accumulated debt for the former NCL CCGs of c£100m.

4. Implementation of Pharmacy First and the NCL Self Care Medicines Scheme

4.1 The national *Pharmacy First* service has been launched across NCL, supporting optimisation of community pharmacy and helping residents quickly access help, advice and where needed treatment for minor illnesses in a pharmacy setting.

4.2 This should be more convenient for patients and residents and reduce pressure on GP surgeries and urgent care. We currently have 97% of pharmacies signed up to deliver this scheme and are working closely with them on implementation, efficacy and quality.

4.3 Pharmacies are now able to assess and, where appropriate, supply medicines for seven common conditions via robust clinical pathways. Alongside the expansion of blood pressure and contraception services, this will reduce pressure on general practice teams and help patients access quicker and more convenient care.

4.4 Early data suggests in the first few weeks of the service, acute sore throat and uncomplicated UTI's accounted for almost half of the new consultations. Approximately two thirds of these consultations resulted in supply of a medication. In around 5% of the consultations, the patient was urgently escalated to another service in line with directions to monitor for and act on 'red flag' symptoms.

4.5 To complement the expansion of pharmacy services, NCL has fully commissioned our previously piloted *Self-Care Medicines Scheme*. This locally commissioned service provides free over the counter medicines for a range of minor illnesses where patients meet key criteria and would otherwise struggle to afford them. This should help ensure everyone can equitably access and benefit from community pharmacy services. The scheme is currently being rolled out with the ICB Medicines Team providing training, monitoring and oversight for this expanded service.

5. MMR and whooping cough vaccination campaign underway

5.1 The UK Health Security Agency (UKHSA) recently published guidance detailing the risk of a significant outbreak of measles in England. In response, partners including the NHS, Local Authorities, Public Health, UKHSA and voluntary sector are working together to protect people, with a particular focus on the most vulnerable.

5.2 The latest UKHSA figures show measles infections continue to rise. Our teams have focused on increasing measles, mumps and rubella (MMR) vaccination uptake across our five boroughs. Examples of initiatives implemented to achieve this include:

1. Letters and text messages to all un/under vaccinated parent or patient aged 1-26
2. Delivery of MMR vaccination in schools
3. Community clinics in accessible locations (e.g. children's centres, community centres, vaccination bus, university and college settings, etc.)
4. Engagement with our lower uptake populations to understand barriers to vaccination
5. Tailored communications with populations with lower uptake
6. Training for clinical and non-clinical staff to support increased uptake

5.3 As of 16 April 2024, in NCL, 87% of children (aged 1-5 years) and 84% of children (aged 1 – 12) have received at least one dose of MMR vaccination. This is an improvement but there is still work to do to ensure all children are protected.

5.4 Aside from the focussed work to increase uptake of MMR vaccinations, we continue to strive to improve uptake of all childhood immunisations across NCL. These efforts have resulted in 5% more children (aged 1 and 2) who are fully vaccinated in comparison to April 2022. Vaccination remains one of the best ways to protect from serious illnesses such as whooping cough, and other preventable illness.

6. Extra Capacity for Sight Saving Surgery – New Eye Surgery Hub at Edgware Hospital

6.1 In February 2024, the Strategy and Development Committee approved the clinically-led proposal to develop an Ophthalmology Surgical Hub at Edgware Hospital. This was following an eight-week engagement period with over 600 patients, the public and wider stakeholders through surveys, visits to targeted resident and patient groups (following a Health Inequalities Impact Assessment) and working with Healthwatch Enfield to carry out outreach in hospital ophthalmology departments.

6.2 The changes mean that most straightforward cataract operations performed by the Royal Free London (RFL) NHS Foundation Trust will be delivered at Edgware Hospital, and more complex procedures will remain at Chase Farm Hospital and Royal Free Hospital. RFL will no longer deliver eye surgery at Whittington Hospital.

6.3 Of the approximately 25,000 eye surgery procedures delivered a year in NCL, the changes will affect around 5,000 procedures. By doing more procedures on fewer sites evidence suggests we can improve the efficiency and productivity of our theatres. We estimate that an additional 3,000 procedures a year can be undertaken through the changes which could reduce waiting times for some patients by up to four weeks. We also expect the surgical hubs to improve clinical outcomes and patient experience and reduce the risk of surgery being cancelled last minute due to emergency care pressures.

6.4 Patients will continue to attend their local or preferred hospital for tests and outpatient appointments before and after having surgery. Existing ophthalmology surgery services at North Middlesex University Hospital, Moorfields sites and relevant independent sector providers will continue as they are, and patients will continue to be able to choose to be referred to any provider that has an NHS contract to provide the service they need.

6.5 The additional surgical capacity created at Whittington Hospital and Chase Farm Hospital will be used to help tackle waiting lists in other surgical specialties.

7. Integrated Care Partnership update

7.1 The NCL Integrated Care Partnership (ICP) met on 16 January 2024, chaired by ICS Chair, Mike Cooke, to discuss progress against priorities in the NCL Population Health and Integrated Care Strategy. This included the Heart Health programme, which is aimed and reducing deaths from cardiovascular disease across the system through a specific focus on high blood pressure to deliver in-year impact. As well as being easy to measure, blood pressure is also amenable to medications, exercise, better diet and smoking cessation. This aligns with a range of interventions that are already being delivered to address public health risk factors.

7.2 The proposal highlighted an opportunity build on what is already in place via systematic work in primary and secondary care, linking to the work by public health teams and the VCSE sector at a hyper-local level with specific communities of interest. Given the evidence of impact on population health outcomes, the ICP endorsed blood pressure as the area of focus, particularly given it would complement the newly implemented Long Term Conditions Locally Commissioned Service model.

7.3 The Partnership also discussed an emerging programme of work on Admissions Avoidance. Analysis indicated that there are currently 581 avoidable admissions per month across NCL. It was noted that this is a 17% reduction on 2019/20, but still a significant number of patients not requiring hospital care. When looking at avoidable admissions through an equity lens, it was highlighted that 20-30% more emergency admissions were from deprived communities, suggesting interventions that target the wider determinants of health may be

efficacious. The importance of working with communities and voluntary sector organisations to support these residents was an important factor. We need to consider, as a partnership, how the work of the voluntary sector can be optimised in this area to reduce inequalities.

7.4 Finally, the Partnership received an update on the work of Borough Partnerships aligned to the Population Health and Integrated Care Strategy. The paper highlighted the breadth of priorities being progressed by partnerships and considered whether there was a need to streamline and refine priorities for the year ahead with a clear focus on tackling inequalities. A further update will be provided as part of the Population Health and Integrated Care Delivery Plan updates.

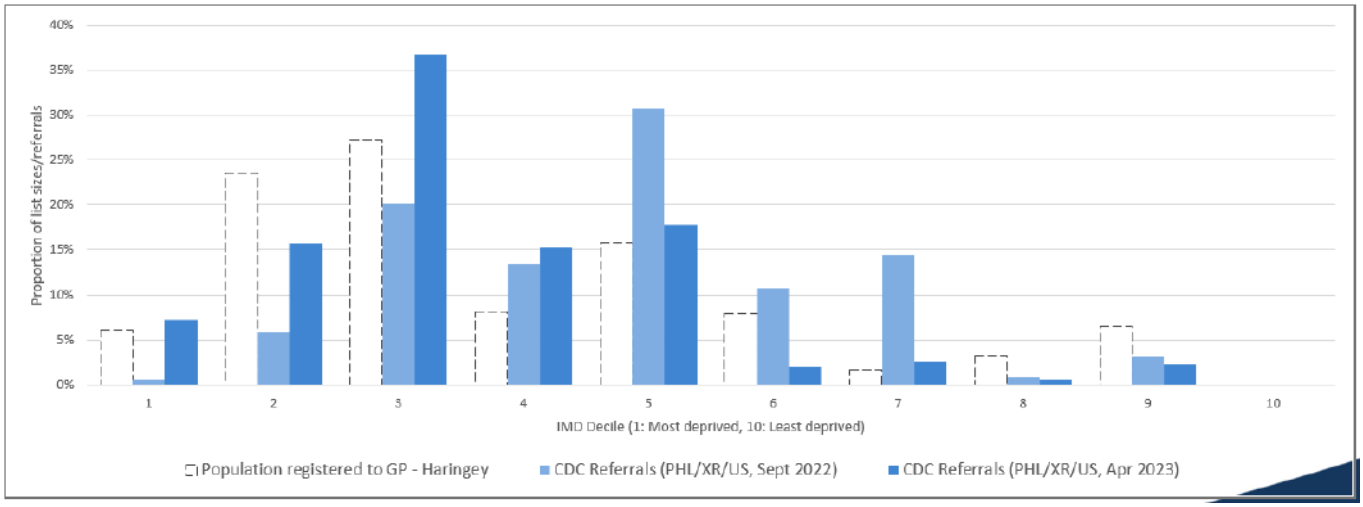
8. Wood Green Community Diagnostic Centre (CDC)

8.1 Wood Green CDC continues to help people to access diagnostic tests in the community, closer to where they live, rather than needing to visit an acute hospital site. It has recently been recognised in the All-Party Parliamentary Group report on Diagnostics and CDC performance and serves as an exemplary model of the positive outcomes achievable when healthcare services are integrated into the community, more specifically, a shopping centre on the high street.

8.2 The team are always looking for new ways to remove friction in the pathways and improve the referral to diagnosis (and treatment) wait times for patients. To this end, Wood Green will be launching new patient pathways around Targeted Lung Health Checks, Rapid Diagnostics and same day CT follow-up scans, among other initiatives in Quarter 2 of 2024/25.

8.3 As of the end of March 2024, Wood Green CDC has delivered nearly 90,000 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 these tests were for people from the three areas of greatest deprivation in Haringey.

8.4 The chart below shows a breakdown of the deprivation deciles of patients seen by the CDC and how this has changed over time. As can be seen from the chart, there has been a marked shift in the CDC towards increasingly reaching more deprived communities over time, particularly in the most deprived deciles (deciles 1-3). This has been achieved through development of a GP referral dashboard, that monitors levels of referrals from individual Haringey GPs and a targeted communication to help increase referrals from GPs located in our most deprived communities.



9. T Level in Health

9.1 On Friday 19 April our CNO Chris Caldwell, who is also a Visiting Professor at Middlesex University, and Mayyah Bilal, our Associate Director of Maternity and Neonatal Care and a practicing midwife, attended the final 'insight day' for pupils completing the T Level in Health at Saracens High School. They joined with partners to celebrate the pupils' achievements, spoke to pupils about their career ambitions and presented them with certificates for completing their insight hours as part of the course.

9.2 The T Level in Health is an academic alternative to A levels and a great place from which to build a career in health and care. This Midwifery T-Level is the result of a partnership between Middlesex University, Barnet Education and Learning Services and Saracens High School and adds to the existing huge amount of work already taking place within North Central London by Middlesex University with a wide range of health and care partners, contributing to the long-term development of a local health workforce.

9.3 The pupils were extremely positive about their experience. They have all expressed a desire to progress into health careers, not just midwifery but also nursing, healthcare science, pharmacy and dentistry. Most indicated that they intended to stay local both for their training and in their future careers. Saracens High School, located adjacent to Grahame Park, is the only school in Barnet to have adopted the T level to date.

10. Dutch Health Minister Visit

10.1 Just before the Easter weekend, Chris Caldwell and I had the pleasure of visiting Rathmore House, a care home in Camden where we hosted Dutch health officials including Conny Helder, the Minster for Health, Welfare and Sport.

10.2 The visit was designed to share information and best practice about the integration of health and care, and to showcase the latest technologies and innovations that have been put in place in the care home. These include the Whzan Blue Box, our Silver Triage system, and the acoustic monitoring system which all aim to provide better care for residents, reduce hospital admissions, empower care home staff and support better care integration .

10.3 The visit also included a demonstration of the Wellbeing Bus which travels across NCL providing health checks for care home workers who may not otherwise have time to visit the GP or to prioritise their own health and wellbeing.

11. Safeguarding Conference

11.1 Our CNO Chris Caldwell has been busy! She also opened our second – first in-person – NCL ICS Safeguarding Conference on Friday 19 April. The theme was ‘Promoting Curiosity’, with the aim of increasing professional curiosity in safeguarding practice. The event was co-produced with the NCL System Learning Group, the safeguarding leads from across the NCL health and care system. 130 delegates attended from acute and community health providers, local authorities, and the police.

11.2 Expert speakers shared their insights on topics ranging from non-fatal strangulation, to FGM, to extremism and gaming. Innovative research was presented alongside personal accounts of lived experiences. NHS England also gave an update of the regional and national safeguarding structures. The feedback from this CPD-accredited event has been extremely positive. The delegates appreciated the quality and originality of topics and described the day as groundbreaking and impactful, with much learning to take into their future practice.

12. Brand refresh

12.1 We are refreshing both the ICS and ICB brands, building on the existing look but modernising them and making sure they are fully accessible and work better on social media and our website.

12.2 The ICB logo cannot be changed but we will be using more colour alongside it while the ICS logo will be updated, and you will start to see the new look from May onwards.

Phill Wells
Interim Chief Executive

23 April 2024

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Board of Members Meeting
7 May 2024

Report Title	Dental, Optometry and Community Pharmacy (DOP) Services Delegation Update	**Date of report**	April 2024	**Agenda Item**	2.1
Lead Director / Manager	Sarah Mansuralli Chief Strategy & Population Health Officer & Deputy CEO Sarah McDonnell-Davies, Executive Director of Place	**Email / Tel**		Sarah.mansuralli@nhs.net sarah.mcdonnell1@nhs.net	
Board Member Sponsor	None.				
Report Author	Mark Eaton, Director of Strategic & Delegated Commissioning Louise Coughlan, Deputy Chief Clinical Officer & ICS Chief Pharmacist	**Email / Tel**		Mark.eaton1@nhs.net louise.coughlan1@nhs.net	
Name of Authorising Finance Lead	Sarah Rothenberg, Director of Finance Primary Care	**Summary of Financial Implications** Dental, Optometry and Community Pharmacy (DOP) Services represent a total budgeted spend of £161.4m/year to the NCL ICB with actual spend of £158.8m in 23/24. This paper makes no request for additional funding to support the on-going transformation work but does note that the ICB has committed resources to date and committed to investing where possible in additional staffing to support Delegated Services (which includes Specialised Services, Dentistry, Optometry and Pharmacy and Section 7a). The ICB has also agreed a number of transformation initiatives including both non-recurrent and recurrent investment to open up additional capacity and improve outcomes.			
Report Summary	In April 2023 Dental, Optometry and Community Pharmacy Services (collectively referred to as DOP Services) were delegated from NHS England (NHSE) to				

	Integrated Care Boards (ICBs). This included the transfer of budgets (~£162m for NCL) for the three service areas including responsibilities for contract management, service development and transformation. Prior to the date of delegation, the ICB Board discussed the Delegation Agreement (and the related Pre-Delegation Assurance Framework or PDAF that preceded it). At this point the ICB Board requested that we bring back a summary of progress 12 months following delegation. This paper provides the 12 months post delegation update that was requested. The delegation of the DOP Services was accompanied by the transition of the former team who supported all routine DOP activities (invoicing, monitoring, contract management etc) from NHSE to the ICBs. It was agreed that North East London ICB (NEL ICB) would host these services on behalf of all London ICBs and a Memorandum of Understanding (MOU) was agreed between the ICBs to outline the relationship with the team (called the DOP Hub). In addition, a governance structure was established to collaboratively oversee the services at a London level. DOP Services landed safely and, within the North Central London (NCL) ICB, the responsibility for Dental and Optometry services sits within the Strategy & Population Health Directorate. The responsibility for Community Pharmacy sits within the Chief Medical Officer & Place Directorate. In terms of the split of income, Dentistry represents 71% of the total of £161.4m, Optometry 9% and Community Pharmacy 20% (respectively £114.5m, £13.9m and £32.9m). During the first year of delegation (M1-M12 of 2023/24), the ICB has been undertaking work to embed responsibility and oversight for these services into ICB team remits and into governance structures, to understand and respond to the challenges that have transferred with the services and to identify and realise opportunities to transform and improve outcomes. We have also undertaken an audit, led by the ICB's internal auditors (PwC), into the effectiveness of the delegation process. The PwC Audit has highlighted the need to strengthen both the MOU and the KPIs/Processes we have with the DOP Hub. It also emphasised the need to review the capacity the ICB has to support the transformation of these important services. These two key findings (and the other three identified during the audit) are also helpful in preparing the organisation for future delegation including of Specialised Services, Section 7a responsibilities and the clinical complaints function all of which NHSE are keen to progress in 2025. In terms of the three services themselves, for Dentistry the ICB has commenced a wide-ranging transformation programme that has already seen a significant increase in activity during the first year of delegation and which is set to improve access for people experiencing homelessness (including asylum seekers), for those in care settings (mainly residential care to start with) and for Children and Young People (CYP). We have continued our commitment to ensuring that anyone in acute pain has rapid access to urgent support (including often same day treatment) through the 111 Service, expanded the capacity of our community services and started to see a reduction in waiting times for CYP waiting for more complex interventions. We have commenced our work in response to the National Dental Recovery Plan and built strong and enduring relationships with Local Authorities around our shared agenda for Oral Health Promotion as well as Local Dental Committees, the Confederation and British Dental Association. Further work is underway to expand our support to people in other care settings outside of

	Residential Care and to provide support to people with diabetes who have related oral health problems. For Optometry, we have a relationship with our Local Optometry Committee and have undertaken a review which shows that we do not have a capacity issue within community optometry for eye tests but highlighted inconsistencies in our referral pathways including inconsistent application of patient choice as well as some inconsistency in the other services we provide. In response to these findings, we have expanded the work undertaken by the RNIB (Royal National Institute for the Blind) to support all people within NCL who are at risk of sight loss and expanded the Primary Eyecare Services that the ICB previously commissioned (outside of DOP Delegation) to all of NCL. We are also procuring a new Single Point of Access partner to help us create consistent referral pathways, manage demand into acute care, ensure patient choice is offered correctly, provide early intervention support where needed to improve outcomes and help us shape the future structure of community optometry and community ophthalmology support across NCL. Within Community Pharmacy, there has been significant progress in implementation of the *Pharmacy First* service, aimed at supporting residents to access advice and treatment for minor illnesses and defined clinical pathways in a pharmacy setting, rather than GP surgeries or Urgent Treatment Centres. To complement this, the ICB have commissioned a local scheme to allow supply of certain over the counter medicines to those unable to pay for them – this will support a narrowing of inequalities in access, mitigate the impact of the cost of living crisis and help ensure efforts to increase use of Pharmacy are effective. The ICB Integrated Medicines Optimisation Committee (IMOC) has focused on community pharmacy (including through a dedicated Seminar), to ensure we understand the services and risks and have put in place appropriate measures to support safe and effective community pharmacy services. The Medicines team are refreshing documentation covering governance and roles and responsibilities to ensure effective worked between NCL and the NEL POD. Local Pharmaceutical Committees in NCL are closely involved, helping to optimise current services for the benefit of our population. This report provides a summary of progress during the first year of delegation with the clear messages being delegation has been achieved safely, we have seen a positive change in access for the population of NCL, we are successfully responding to the many challenges and need for transformation across NCL and we have done all of this collaboratively with a wide range of parties. The report is presented to the Board for noting the progress to date as well as the future plans for improvement and action across all three service areas.
Recommendation	The Board of Members is asked to: • **NOTE** the progress made by the NCL ICB team for all three DOP services since they were delegated in April 2023 and the lessons learned through the PwC internal audit, noting further that many of these are equally applicable to the delegation of other services in 2025. • **NOTE** the future plans the ICB has for each DOP Service to improve access, outcomes and performance for our population. • **AGREE** any next steps that the Board feels would be appropriate to take as an ICB and when the Board would like a further update on the progress of delegated DOP Services.

<table>
<tr><td>Identified Risks and Risk Management Actions</td><td>
<table>
<tr><th>Risk</th><th>Impact</th><th>Likelihood</th><th>Mitigations</th></tr>
<tr><td>Staffing (Applicable to all of DOP)
Whilst all services make good use of the DOP Hub to manage risk there is limited resources available for transformation or to respond to new initiatives.</td><td>High</td><td>Medium</td><td>The ICB has taken steps to expand the Delegated Services team supporting Dentistry and Optometry but there remains a question about whether there is sufficient resource within the Medicines Optimisation Team to support Community Pharmacy.</td></tr>
<tr><td>Governance (Applicable to all DOP)
The PwC audit identified a need to strengthen the existing MOU with the DOP Hub and consider how we might need to change the governance associated with DOP Services.</td><td>Medium</td><td>Medium to Low</td><td>The ICB team have taken steps for formalise the reporting structures associated with DOP Services and to strengthen the working relationship with the DOP Hub further. However, there remains work to do in terms of addressing the issues with the MOU that were identified within the audit by PwC.</td></tr>
<tr><td>Dentistry
We are yet to fully understand the impact on recurrent budgets brought about by the National Dental Recovery Plan and also the increased activity brought about by both the continuing recovery from the pandemic and the work undertaken in NCL to open up capacity and improve access.</td><td>High</td><td>Medium</td><td>We have undertaken an initial assessment of the risk to budgets but will need to keep this under investigation throughout 24/25. It is unlikely that this will present the ICB with a cost pressure but may result in less funding be available to support the priorities for transformation identified by the ICB in terms of supporting people in Care Settings and providing support to patients with Diabetes who need support with their oral health.</td></tr>
<tr><td>Optometry
Whilst we do not believe there is a risk to Community Optometry access or capacity, there remains different referral pathways and differing access to services across NCL that represent inequities to our population.</td><td>Medium</td><td>Medium to Low</td><td>The introduction of the new Single Point of Access will be accompanied in the standardisation of pathways across NCL and will also ensure patient choice is being applied correctly. In terms of access we have expanded the services offered by RNIB to the whole of NCL and also expanded the services of Primary Eye Care Services to ensure equity of community provision. These latter changes are outside of the scope for delegated optometry services and fit within the ICB's normal remit.</td></tr>
<tr><td>Community Pharmacy
The remains work to do both to strengthen the infrastructure to support Community Pharmacy and embed this into the wider Primary Care system to ensure activity and capacity is optimised and collectively reduces the risks to the wider health system.</td><td>Medium</td><td>Medium</td><td>The roles within the Medicines Optimisation Team are being aligned to the functions required to both support and integrate Community Pharmacy into the wider Primary Care network as well as ensure we meet our obligations for oversight and management.</td></tr>
</table>
</td></tr>
<tr><td>Conflicts of Interest</td><td>None identified.</td></tr>
<tr><td>Resource Implications</td><td>See Financial Implications Section. This paper makes no request for additional funding or staffing that has not already been agreed.</td></tr>
<tr><td>Engagement</td><td>All three DOP Services have extensive engagement networks including Local Dental, Optical and Pharmacy Committees, Local Authorities, Patient Groups and others.</td></tr>
<tr><td>Equality Impact Analysis</td><td>Not applicable to this paper.</td></tr>
<tr><td>Report History and Key Decisions</td><td>DOP Service Delegation has previously been discussed by the ICB Board prior to delegation in April 2023 and the Board requested an update following the end of the first year of delegation.</td></tr>
<tr><td>Next Steps</td><td>Depending on the discussion at the ICB Board meeting we expect the next steps to be:

For all DOP Services
• Resolution of the issues flagged in the PwC Audit including the strengthening of the MOU with the DOP Hub.

Dental Services</td></tr>
</table>

	• Gaining clarity on the financial implications of the National Dental Recovery Plan to determine impact on budgets and the ability of the ICB to expand investment into supporting patients in Care Settings and those with Diabetes who need oral health support. • Delivering the transformation programme for 24/25 as outlined within this paper including delivering the prevention work and our aspirations around improving oral health in partnership with our Local Authority partners. **Community Optometry** • Implementation of the new Single Point of Access and development of consistent referral pathways across NCL for patients with ophthalmic issues. • Ensuring that patient choice is correctly applied by Community Optometrists at the point of referral to meet our obligations with regards to this important matter. • Finalising our plans to ensure there is a consistent service offer across each of the NCL Boroughs for eye screening services including those covered by Community Optometry plus those funded directly via the ICB's Core Allocation such as AQP Contracts and Community Ophthalmology Services. **Community Pharmacy** • Continue to develop the local infrastructure to engage, support and provide oversight to Community Pharmacy. • Continue the work on integrating Community Pharmacy into the wider primary care system and ensuring they are seen as a trusted partner by General Practice and other Primary Care clinicians. • Finalise the work to align roles and responsibilities within the Medicines Optimisation Team to Community Pharmacy requirements. • Establish a mechanism to be able to capture results of patient satisfaction surveys.
Appendices	Appendix 1 - PwC Audit on DOP Delegation.

Dental, Optometry & Pharmacy (DOP) Services Delegation Update

Executive Summary

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Prior to the date of delegation, the ICB Board discussed the Delegation Agreement (and the related Pre-Delegation Assurance Framework or PDAF that preceded it). At this point the ICB Board requested that we bring back a summary of progress 12 months following delegation. This paper provides the 12 months post delegation update that was requested.

The delegation of the DOP Services was accompanied by the transition of the former team who supported all routine DOP activities (invoicing, monitoring, contract management etc) from NHSE to the ICBs. It was agreed that North East London ICB (NEL ICB) would host these services on behalf of all London ICBs and a Memorandum of Understanding (MOU) was agreed between the ICBs to outline the relationship with the team (called the DOP Hub). In addition, a governance structure was established to collaboratively oversee the services at a London level.

DOP Services landed safely and, within the North Central London (NCL) ICB, the responsibility for Dental and Optometry services sits within the Strategy & Population Health Directorate. The responsibility for Community Pharmacy sits within the Chief Medical Officer & Place Directorate. In terms of the split of income, Dentistry represents 71% of the total of £161.4m, Optometry 9% and Community Pharmacy 20% (respectively £114.5m, £13.9m and £32.9m).

During the first year of delegation (M1-M12 of 2023/24), the ICB has been undertaking work to embed responsibility and oversight for these services into ICB team remits and into governance structures, to understand and respond to the challenges that have transferred with the services and to identify and realise opportunities to transform and improve outcomes.

We have also undertaken an audit, led by the ICB's internal auditors (PwC), into the effectiveness of the delegation process. The PwC Audit has highlighted the need to strengthen both the MOU and the KPIs/Processes we have with the DOP Hub. It also emphasised the need to review the capacity the ICB has to support the transformation of these important services. These two key findings (and the other three identified during the audit) are also helpful in preparing the organisation for future delegation including of Specialised Services, Section 7a responsibilities and the clinical complaints function all of which NHSE are keen to progress in 2025.

In terms of the three services themselves, for Dentistry the ICB has commenced a wide-ranging transformation programme that has already seen a significant increase in activity during the first year of delegation and which is set to improve access for people experiencing homelessness (including asylum seekers), for those in care settings (mainly residential care to start with) and for Children and Young People (CYP).

We have continued our commitment to ensuring that anyone in acute pain has rapid access to urgent support (including often same day treatment) through the 111 Service, expanded the capacity of our community services and started to see a reduction in waiting times for CYP waiting for more complex interventions. We have commenced our work in response to the National Dental Recovery Plan and built

strong and enduring relationships with Local Authorities around our shared agenda for Oral Health Promotion as well as Local Dental Committees, the Confederation and British Dental Association. Further work is underway to expand our support to people in other care settings outside of Residential Care and to provide support to people with diabetes who have related oral health problems.

For Optometry, we have a relationship with our Local Optometry Committee and have undertaken a review which shows that we do not have a capacity issue within community optometry for eye tests but highlighted inconsistencies in our referral pathways including inconsistent application of patient choice as well as some inconsistency in the other services we provide.

In response to these findings, we have expanded the work undertaken by the RNIB (Royal National Institute for the Blind) to support all people within NCL who are at risk of sight loss and expanded the Primary Eyecare Services that the ICB previously commissioned (outside of DOP Delegation) to all of NCL. We are also procuring a new Single Point of Access partner to help us create consistent referral pathways, manage demand into acute care, ensure patient choice is offered correctly, provide early intervention support where needed to improve outcomes and help us shape the future structure of community optometry and community ophthalmology support across NCL.

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This report provides a summary of progress during the first year of delegation with the clear messages being delegation has been achieved safely, we have seen a positive change in access for the population of NCL, we are successfully responding to the many challenges and need for transformation across NCL and we have done all of this collaboratively with a wide range of parties.

The report is presented to the Board for noting the progress to date as well as the future plans for improvement and action across all three service areas.

Overview of DOP Services in NCL

Dental, Optometry and Community Pharmacy Services (collectively referred to as DOP Services) were delegated from NHS England (NHSE) to ICBs in April 2023 along with a budget (for North Central London (NCL)) of ~£161m across the three areas.

This spend is spread across nearly 700 different contracts within NCL as shown in the table below, with the largest contracts being for hospital and community based Dental Contracts with UCLH, Royal Free and Whittington Health.

OVERVIEW OF NCL DOP SERVICES	Provider/No. of Providers	NCL ICB 23/24 DOP Budget £m
Acute Dental Services	UCLH/ RFH/ Out of Sector	35.4
Community Dental Services (CDS)	Whittington Health	4.5
General Dental Services & Orthodontics	167	74.6
General Ophthalmic Services	219	13.9
Community Pharmacy Services	304	32.9
TOTAL NCL ICB DOP BUDGET (£m)		161.4

The table above gives a snapshot of the contracts at a point in time given that new contracts are constantly being added/amended and some are handed back. The values fluctuate as well based on activity seen, with some funding being returned to the ICB for reallocation where not spent, as well as the fluctuations due to changes initiated in year, some of which are alluded to in the focus sections within this report for each of the three services. Therefore, the table above should be seen as providing an indication of the spend and contracts as at the time of writing this report.

The delegation of DOP Services was accompanied by the delegation of the DOP Staffing Hub, consisting of the team who previously supported DOP Services within NHSE London Region but are now hosted by North East London (NEL) ICB on behalf of all London ICBs. This team provides the administrative and management functions to manage the routine aspects of the ~5,000 contracts across London including dealing with budgets, contracts, invoices, claims, challenges, terminations and all other routine management actions. Transformation of services lays within the remit of each ICB who, across London, use the DOP Hub Team to support the implementation of improvement initiatives.

The DOP Hub, whilst managed day to day by the NEL ICB for London, is overseen by a DOP Governance Group involving all London ICBs. This group is provided with information on activity, spend and progress for each of the three services.

For NCL, DOP Services then report into the NCL Delegated Services Board (for Dental & Optometry Services) and to the IMOC (Integrated Medicines Optimisation Committee) for Community Pharmacy Services. Ultimately all three services report into the ICB's Strategy & Development Committee (S&DC) providing a clear route for escalation of issues and agreement of plans.

This report provides an update on the DOP Services including major changes that have occurred and initiatives that have commenced since the responsibility for services was delegated to the ICB. Before we provide a focus on each of the three services we need to consider the results of an audit undertaken by the ICB's internal auditors (PwC) and the actions arising from this audit.

PwC Audit on DOP Delegation

Between December 2023 and February 2024, PwC undertook an audit of the actions taken prior to and post delegation of DOP Services in April 2023. This was undertaken as part of the Internal Audit plan but also to see whether the ICB could be assured that there was grip over these important services as well as seeing whether we would be able to take any learning from DOP Delegation and apply this to the Delegation of Specialised Services that will occur in April 2025.

The audit (which can be seen in full in Appendix 1) had the ability to rate the risk to the ICB as either Critical, High, Medium or Low, with the NCL ICB being rated as Medium Risk along with the following comment from the auditors:

The ICB compares well to comparator organisations based on the work we've performed, with some improvements required to enhance the adequacy and effectiveness of the framework of governance, risk management and internal controls.

The Audit identified 5 'findings', 3 rated as Medium Risk and 2 as Low Risk, these being:

- **Finding 1 -** A lack of formalised contract management arrangements for overseeing the POD hub (Medium risk)
- **Finding 2 -** The MoU does not provide clear guidelines on delegated authority for General/Local/High Street practices dentistry (Medium risk)
- **Finding 3 -** The ICB depends on a small number of employees for overseeing POD delegation (Medium risk)
- **Finding 4 -** There are gaps in the governance for overseeing the POD services (Low risk)
- **Finding 5 -** The MoU needs to be supplemented with checklists or aide-memoires to clarify roles and responsibilities (Low risk)

In response to each of these 'findings', the ICB has undertaken the following actions:

Finding 1
We have clarified within our Governance structure that Dental and Optometry Services report into the NCL Delegated Services Board and ultimately to the Strategy & Development Committee within the ICB whilst Community Pharmacy feeds into the IMOC (Integrated Medicines Optimisation Committee). This provides additional oversight and assurance to DOP Services.

Finding 2
This relates to the fact that the DOP Hub team are able to make a wide range of decisions based on the previous processes and limits that existed when the team had formed part of NHSE London team but the process for escalating matters and limits/thresholds for decision making had not been reviewed prior to delegation. Following the identification of this finding we have initiated a review of the MOU in full including the Key Performance Indicators that apply and the limits/thresholds for decision making so that they are aligned to the NCL ICB Standing Financial Instructions. We expect this work to be completed by the end of June 2024.

Finding 3
This finding relates to the fact that no additional staff were taken on by the ICB to support delegation. The DOP Team within the Hub are only resourced to focus on business as usual processes and have extremely limited capacity to deal with engagement of the public/partners, drive the transformation agenda or deal with ICB Governance and Assurance. This has meant that the ability of the organisation to respond to the opportunities arising from delegation has been constrained and what work has been achieved (as will be discussed later) has fallen onto the shoulders of existing staff.

In response to this finding, the ICB has aligned the Community Pharmacy work to roles within the Medicines Management Team and for Optometry and Dentistry (albeit mainly dentistry) we have obtained support from NCL Providers to expand the Delegated Services team both to support Dental

Transformation as well as the wider Specialised Services Delegation programme. The ICB has made a commitment during its Change Programme to focus any flexibility in running costs of a small number of areas, one being delegated commissioning.

Finding 4

This finding is related to both Finding 1 (around Governance) and Finding 3 (around Resourcing) both of which have been addressed and therefore we view this Finding as resolved as well.

Finding 5

The MOU referenced in this Finding relates to that held by the DOP Hub and the five London ICBs. The MOU has clear gaps in it relating to escalation processes, governance and decision making as well as how priorities are identified. We have in the most part mitigated this risk through close working relationships both with the DOP Hub but also with London ICB colleagues, but it is accepted that we need to strengthen the MOU. For Community Pharmacy a new Aide Memoire has been agreed that sets out how the ICB and DOP Hub team will work with regards to Incidents and around issues of Business Continuity. For all three DOP Services however there remains work to be undertaken to strengthen the MOU around KPIs and decision making and this will need to be agreed with London ICB colleagues. This wider work is expected to complete in September 2024.

One of the key reasons for undertaking the audit with PwC was determine learning from DOP Delegation (with a total spend of £164m) that could be applied to Specialised Services Delegation (with a total system financial impact ten times the size of DOP Services and a value of ~£1.6b). The key aspects that we have learned from the DOP Audit that we will apply to Spec Comm Delegation are:

1. The MOU needs to be robust from the outset and clearly set out Governance, Operating Principles, Decision Making Processes, Escalation Processes and also how the Spec Comm Staffing Hub (of ~90 people) will be aligned to the work at ICB and at North/South London level. In particular, we will need to ensure we have addressed how conflicts of interest are managed between providers and between ICBs/ICSs as well as between NHSE London/National and the Host ICB who will look after the Spec Comm Hub.

2. To inform the strengthening of MOU we will need to undertake a series of scenario tests of it prior to delegation and to include these as Aide Memoires and examples of how the MOU would be used to ensure effective collaboration and operation post delegation.

   We will need to ensure we have sufficient staff to address the major transformation workstreams that arise through delegation such as the end-to-end integration of services, improvements in population health outcomes, improvements in the sustainability of fragile services and the realisation of system efficiencies and other benefits. This has in part been addressed through the expansion of the ICB's Delegated Services Team that is currently underway but will need to continue to be monitored to ensure that the staffing for the Hub itself is not reduced over time by the Host ICB (still yet to be determined and for which NCL have indicated an interest in running on behalf of London) in a way that has a detrimental impact on capacity required to undertake transformation activities.

3. Related to the expansion of the team we need to create a Clinical Strategy for services to prioritise where we focus the expanded (but still limited) team we will have to support Delegated Services. This Clinical Strategy will be aligned to, and support the delivery of, the NCL Population Health & Integrated Care Strategy and the associated outcome improvements we want to drive. This work has already commenced through a structured programme to assess the risks that will transfer with the

services in April 2025 (when Spec Comm Delegation is set to occur) as well as early work we are undertaking to improve Sickle Cell, Liver Disease and Renal pathways.

The PwC Audit on DOP Services can be seen attached as Appendix 1 and has usefully provided input to our work to support all three services and, as referenced above, the future delegation of Specialised Services from April 2025.

The next 3 sections of the report provide a detailed focus on each of the three DOP Services (Dental, Optometry and Community Pharmacy) in turn.

Focus on Dental Services

Of the £161.4m associated with DOP Services, Dentistry accounts for £114.5m (71% of the total). Prior to delegation the ICB undertook a deep dive into the issues, challenges and opportunities around Dental Services. Some of the strategic issues around dentistry, both identified through the initial deep dive and also through later work, are summarised below:

- The ICB has limited ability to influence the structure and payments associated with the GDC (General Dental Contract). Dentists are paid based on UDAs (Units of Dental Activity) and dentists sign up to providing a certain number of UDAs per year but many do not achieve the contracted amounts. The NCL ICB has worked hard with the DOP Hub to ensure that as much of this underspend is returned back into Dentistry to target inequalities and increase access. This will be explored in more detail later in this section.

- A key point to note is that unlike Primary Care General Practitioners (GPs), patients have no right of registration with a practice and whilst this means they can access treatment from any NHS Dentist, should there be capacity for them to be seen, it does mean that many patients cannot get access to NHS funded treatment. Not all NHS treatment is free in all cases and adult patients need to contribute toward their treatments based on a scale of charges.

- In terms of workforce, which remains an issue for the NHSE National team rather than a matter that can be tackled directly by the ICB, there continues to be a movement of clinicians (dentists and dental nurses). The access to workforce has been affected by industrial action as well.

- The impact of the pandemic is still be felt in dentistry with a general increase in patient acuity, particularly amongst children and young people. This reduces access for the wider population as individual patients need longer treatment to restore them to good oral health. This also reduces the payments received by dentists as they have to do more work per UDA.

- Secondary care dental support continues to be affected by lack of anaesthetists and access to beds, especially when there are higher priority patients to be supported. Access has also been affected materially by the recent industrial action, adding to waiting lists.

- Media coverage of dentistry is relatively high with the diagnosis of oral cancers the most recent topic. As any patient in acute pain living within London can access an urgent appointment via the 111 Service (a service not available anywhere else in the country) and with increased primary care access in London compared to elsewhere in the country and relatively short waiting times in secondary care the challenges in London are less pronounced than elsewhere.

During 23/24, the NCL ICB in collaboration with our DOP Hub colleagues have achieved a number of important improvements in dental services including:

- Using the under-spend in the budget to significantly increase capacity across NCL and improve performance to plan from <70% to 88% at the end of the first year of delegation.

- Commit to a recurrent investment in dental services of £600k/year to target a wide range of initiatives including expanding Community Dental Services capacity to reduce waiting times for Children & Young People (CYP), providing a consistent offer for those experiencing homelessness including asylum seekers and rough sleepers, improving care for those in Care Settings (with an initial focus on those in Residential Care) and undertaking targeted work with CYP in deprived areas to improve oral health.

- We have also committed to investing in oral health promotion to augment the work undertaken by our Local Authority partners, for whom Oral Health Promotion (OHP) is a statutory duty. This has allowed us to improve coordination of work across health and care settings and to form a collaborative OHP Working Group to better leverage the combined investment in this important area.

- Continued our commitment to patients in acute pain having urgent (and normally same day) access to emergency appointments in the community via calling 111, a service not available elsewhere in England.

- The ICB team with our DOP Colleagues have built a collaborative network to tackle dental improvement involving Local Dental Committees, Managed Clinical Networks, Dental Public Health Consultants and the NHS England Workforce, Training and Education Directorate (previously Health Education England) to improve the delivery of dentistry in NCL specifically and London more widely.

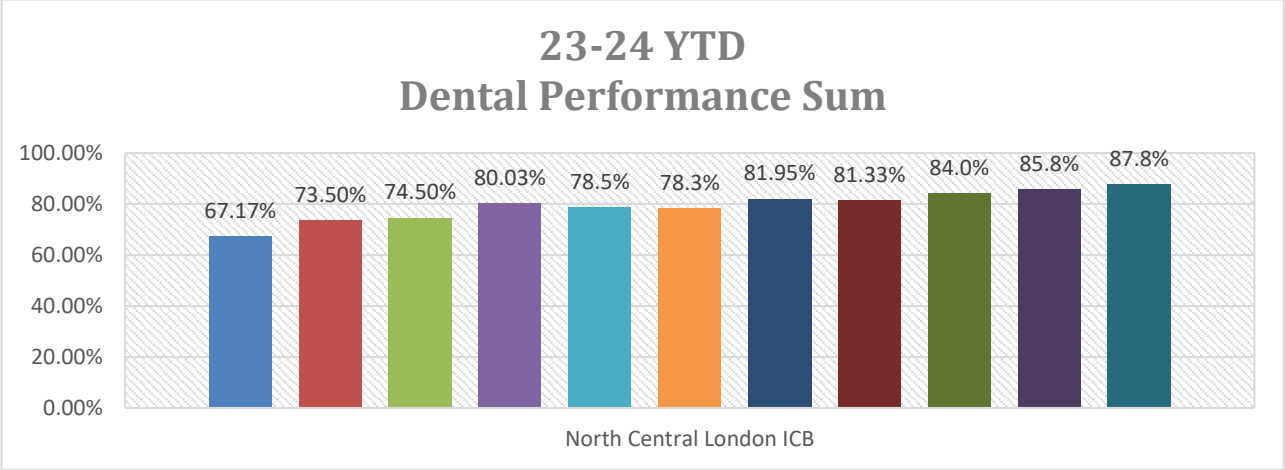
Primary Care Dentistry

Delivery across Primary Care Dentistry during 2023/24 has seen a considerable increase in NHS activity across the ICB, and a reduction in the underperformance seen during the previous contracting years.

This has mainly been down to the ongoing post-pandemic recovery of dental services coupled with an injection of non-recurrent resource by London ICBs into selected dental practices to increase access and activity. Primary Care performance in 23/24 (whilst still waiting for final reconciliation) is expected to be 88% of the plan across London, leaving an underperformance of ~£8m for NCL. This is a significant improvement on previous years where performance was frequently below 70% of plan and we can show a steady increase in activity to plan as shown in the table below.

ICB	GDS/PDS Dental Contract UDA Delivery 2023/24 (%)										
	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
North Central London	*67.2*	*73.5*	*74.4*	*80.0*	*78.5*	*78.3*	*82.0*	*81.3*	*84.0*	*85.8*	*87.8*
North-East London	69.4	76.5	79.3	84.8	83.8	82.3	85.8	85.0	87.4	88.7	91.0
North-West London	64.5	70.1	73.0	78.9	77.1	79.3	85.9	85.6	88.1	88.2	90.0
South-East London	63.4	70.2	73.4	78.8	79.4	79.8	84.6	83.8	86.2	86.4	89.0
South-West London	65.0	69.8	73.4	79.3	79.9	81.9	87.3	86.3	88.9	87.4	88.0
London Wide	**65.9**	**72.0**	**74.7**	**80.4**	**79.7**	**80.3**	**85.1**	**84.4**	**86.9**	**87.3**	**89.2**

Specifically, for NCL the growth in activity compared to plan is shown in the graph below.



The additional capacity opened up within NCL is summarised below.

Borough	No of Practices	UDAs Awarded	Value of UDAs
Barnet	11	8,000	**£264,000.00**
Camden	6	5,000	**£165,000.00**
Enfield	8	6,000	**£198,000.00**
Haringey	9	6,500	**£214,500.00**
Islington	8	6,000	**£198,000.00**
TOTAL	**42**	**31,500**	**£1,039,500.00**

National Dental Recovery Plan

The Government's Dental Recovery plan; Faster, simpler and fairer: our plan to recover and reform NHS dentistry, was published on 7th February 2024 and the key strategic commitments made in the plan are:

- In 2024, significantly expand access so that everyone who needs to see a dentist will be able to. This will begin with measures to ensure those who have been unable to access care in the past 2 years will be able to do so – by offering a significant incentive to dentists to deliver this valuable NHS care. Introduction of mobile dental vans to take dentists and surgeries to isolated under-served communities.

- Launch 'Smile for Life' – a major new focus on prevention and good oral health in young children, to be delivered via nurseries and other settings providing Start for Life services and promoted by Family Hubs. The introduction of dental outreach to primary schools in under-served areas in addition to taking forward a consultation on expanding fluoridation of water to the north-east of England – a highly effective public health measure.

- Ramp up the level of dental provision in the medium and longer term by supporting and developing the whole dental workforce, increasing workforce capacity as committed to in the NHS Long Term Workforce Plan, reducing bureaucracy and setting the trajectory for longer-term reforms of the NHS dental contract.

The significant NHS aspects of the plan in respect of dental commissioning are:

- Increase in the minimum UDA value to £28.00; in NCL this affects 11 practices in total, increasing annual recurrent spend by £79k.

- Introduction of a new patient tariff for 2024/25. This will pay an additional amount between £15 and £50 for a new patient registration in addition to the funding the practice would already receive. This was implemented from 1st March 2024 and is time limited to end of financial year 2024/2025 and currently we are unable to predict the impact on registrations but expect this to be material.

- Outside of London, the plan also requires the roll out of dental vans in certain underserved ICBs. This is focused on isolated rural and coastal communities and therefore not applicable to London.

- Introduction of a 'golden hello' scheme (£20k per dentists, split over 3 years, available for posts agreed by regions / ICBs to be priorities for access) to encourage dentists to move into under-served areas and supporting those practices with the lowest rates of payment for their work. Given the relatively comprehensive access to dental support in London compared to the rest of the country it is not yet clear whether this incentive will be applied to London.

The plan also commits to bringing forward proposals for reform, however there is no specific detail around this, as they are subject to further work and will may require consultation.

Community Dental Services (CDS)

CDS serves following patient groups, paediatric, special care, elderly and homeless and provides oral health promotion (OHP) on behalf of the local authorirties that commission it. For NCL the CDS is delivered by Whittington Health. The contracts have had a significant impact on the number of patients who need to progress to more intense treatment in secondary care and has positively impacted a wide range of areas such as increasing the skills of primary dental practitoners and providing enhanced support to those experiencing homelessness and others. The initial contract issued by NHSE are due to come to an end and a plan is being pulled together to commence a direct award process using the Provider Selection Regime to issue new contracts for up to 10 years for these essential services across London.

Key facts associated with the CDSs across London with specific references to what NCL are doing to address these issues are summarised below:

- All referrals for more specialist care are triaged via the CDS and result in only 8% of all referrals being sent on for treatment in Acute Care.

- The overall number of referrals to specialist care are increasing predominantly in paediatrics and within NCL we have invested in increasing capacity in our CDS along with the increase in paediatrics general anaesthetic, inhalation and intravenous sedation capacity within the CDS Sector we are seeing waiting lists stabilise and show signs of reducing for the first time since the start of the pandemic

- CDSs are seeing an increase in paediatric oral decay due to poor diet. Supervised brushing activities in schools are currently at full capacity and NCL are seeking ways to expand this further through our Oral Health Promotion Working Group and the investment we have made in OHP.

- Demand for dental care amongst elderly people is also increasing driven by deteriorationg oral helath in the population though lack of nursing staff and therefore brushing of residents' teeth. This is being tackled within NCL through increased investment to provide a consistent offer to those in care settings (focusing initially on those in residential care settings) to address this need.

- We have implemented a consistent offer for roughtsleepers and expanded support to those experiencing homelessness (including asylum seekers) to improve oral health due to increasing numbers and spread of rough sleepers across NCL.

Child Friendly Dental Practices (CFDP) is a pilot set up by Eastman Dental Hospitals (NCL) in conjunction with London Dental Commissioners, initially in North West London, to improve the oral health of children in London, particularly amongst those who experience anxiety when being seen in a normal dental practice. The NCL ICB is fully supporting this initiative which shows significant improvements in the long term oral health for those CYP involved in the programme. We are working towards a full business case to come for approval to roll out the North West London pilot to key areas within NCL.

Secondary Care Dental Services

Since the introduction of the Community Dental Services (CDS) across London, there has been a significant change in the case mix of patients requiring treatment within a secondary care setting. This has seen an increase in the percentage of the total activity of neuro-diverse patients who generally require longer treatment times, which limits overall capacity. Work to understand this trend is likely to lead to the production of a detailed research paper and potentially changes to how this patient cohort is supported in community and primary care to reduce the number needing to be seen in a secondary care setting.

Post-pandemic we have seen a recovery of secondary dental services, but numbers remain high across North London for those waiting over 52 weeks (1,583 at date of writing) compared to South London who only have 168 patients. This difference is not yet fully understood within NCL but the Royal Free is challenged with its maxillofacial delivery and UCLH with its dental medicine specialties. The pressure on our services in North London is also affected by patients referred in from outside of London, more of whom end up on the waiting lists for acute trusts in North London which could be a contributory factor to the differential waiting list sizes in North compared to South London.

An overview of the two NCL ICB contracted dental centres (UCLH and RFL) is given below. Activity is also delivered at GOSH but remains directly commissioned by NHSE and this is in part overseen by clinicians from UCLH.

University College London Hospital

No patients over 65 weeks, the UCLH PTL is healthy and there are no concerns regarding the waiting times for patients in comparison to the national position.

It is highly unlikely that any patients will breach the 65-week threshold unless it is by their choice to delay treatment or the patient is transferred from another trust as their waiting time moves with them. UCLH continue to assist GOSH with their waiting lists for dentistry, which impacts on their own provision.

- **Oral Surgery**: only 8 patients waiting over 52 weeks, 7 of which have appointments booked.
- **Restorative**: 12 patients waiting over 52 weeks 7 of which have appointments booked.
- **Paediatric**: only 10 patients waiting over 52 weeks 3 of which have appointments booked, vacancy filled and additional theatre session should resolve this.
- **Orthodontic**: no patients waiting over 52 weeks.
- **Dental Medicine**: there is a considerable volume waiting over 52 weeks. However, all these patients have appointments booked and nearly all the patients waiting between 41 and 51 weeks have an appointment booked. There has been material improvement in tackling waiting lists in the last 3 months.

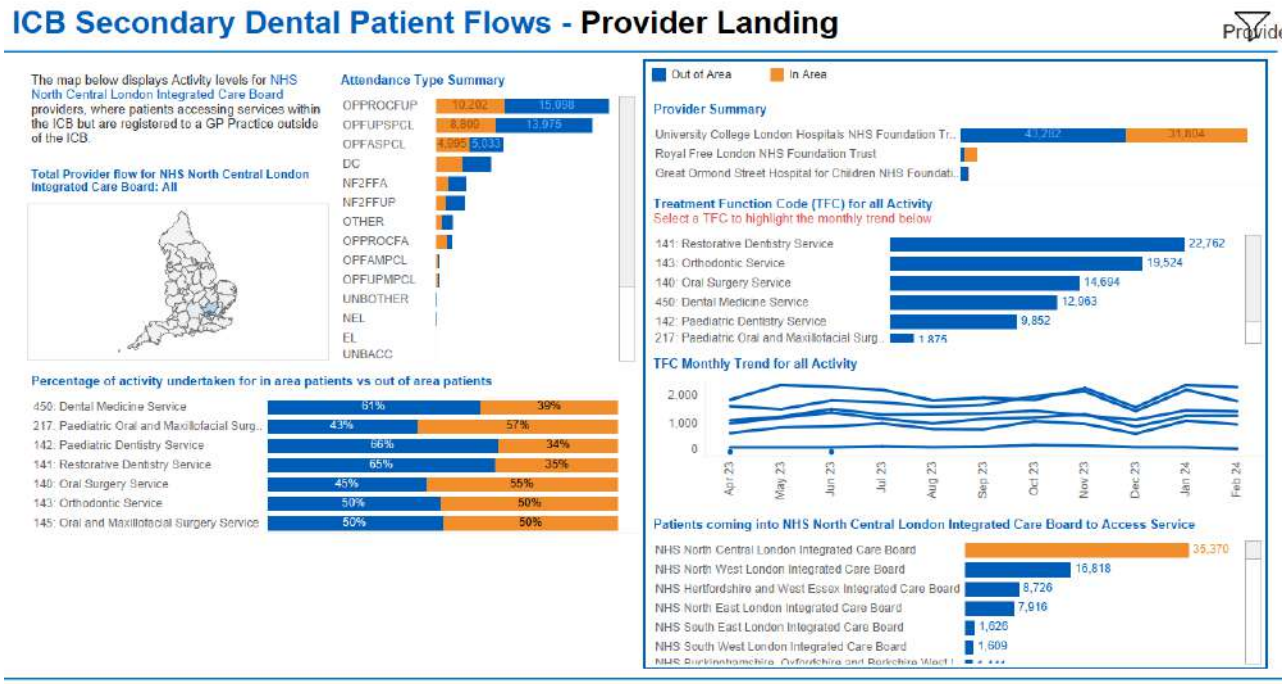
- **Special Care**: no patients waiting over 40 weeks.

Royal Free London

There are 25 patients waiting over 65 weeks under the maxillofacial specialty, they are included in the 52-65 week figures. There are some concerns around the recovery of Trust's waiting times as they are deteriorating slightly.

- **Oral Surgery**: majority of patients requiring oral surgery sit within the maxillofacial pathway.
- **Orthodontic**: 45 patients waiting over 52 weeks, this is a concern as there is an upwards trend.
- **Maxillofacial**: 147 patients waiting over 52 weeks, a slight upwards trend but remains a highly challenging specialty. Theatre lists regularly cancelled for higher priority cases, ad hoc lists are initiated wherever possible to mitigate cancellations.
- **Paediatric Maxillofacial**: 39 patients over 52 weeks waiting paediatric oral surgery, only 7 with booked appointments.

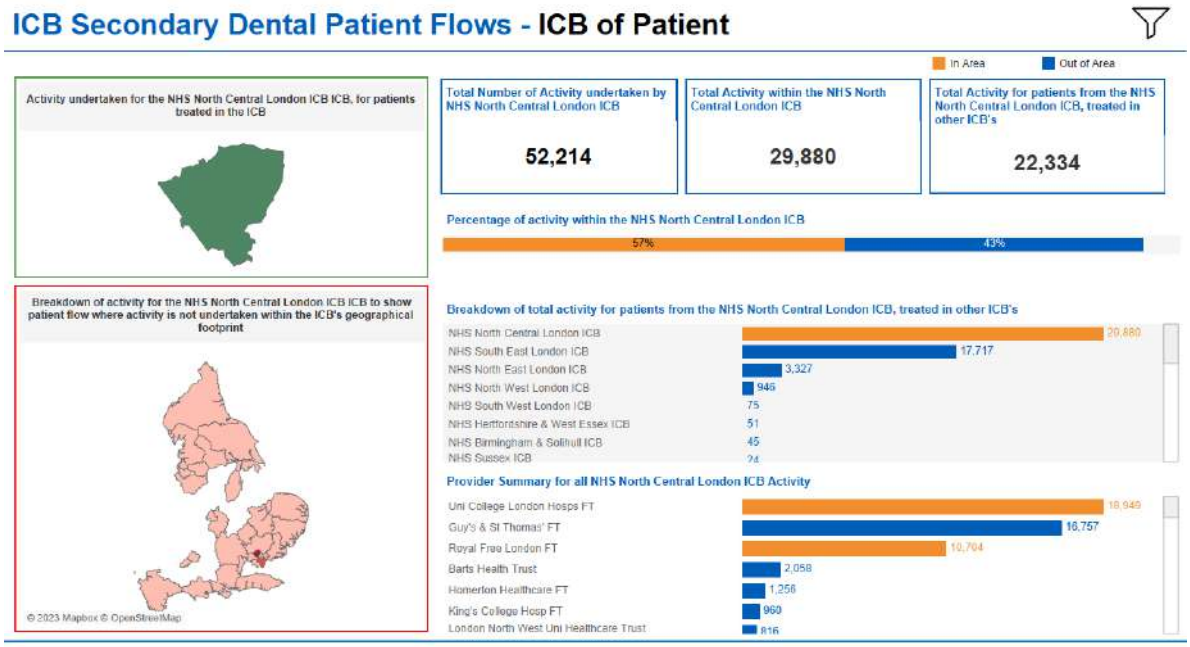
More detailed data concerning secondary care activity within NCL is given in the two tables below including a pictorial representation of the percentage of patients who come from outside of NCL for treatment within our providers and those NCL patients treated outside of our local area. To note there is a slight mismatch between the periods covered by the two charts within the first covering M1-M10 23/24 an the second covering M2-M11 23/24, which leads to a slight variation in numbers.



The table above shows activity undertaken within NCL with key highlights being:

- During 2023/24 M1-M10 there were 31,804 NCL patient attendances at UCLH, 3,230 NCL patient attendances at Royal Free (there is an issue with Royal Free data and this figure is innacurate) and 336 NCL patient attendances at GOSH (activity commissioned by Specialised Commissioning)
- Against the 31,804 NCL patients who attended our providers, they also had a total of 46,304 attendances for patients from outside NCL ICB including:
    - 16,818 of these attendances were for NWL patients
    - 8,726 attendances were for Hertfordshire and West Essex patients

- 7,916 attendances were for NEL patients



The table above shows the total activity for NCL patients (M2-M11 23/24) with key highlights being:

- In total there have been a total of 52,214 attendances for NCL patients
- 35,370 of which delivered in ICB (74%)
- 12,495 delivered in alternative ICBs (26%) although this value may be slightly higher due to issues with reporting activity at some out of sector acute trusts not being done accurately.
- Overall this shows that NCL is a significant net importer of Dental Care (as it is for Specialised Care as well).

Intermediate Minor Oral Surgery Services and Level 2 Complexity Endodontics

Most complex oral surgery is undertaken in hospitals. Sometimes the treatment required is too complex to be undertaken in a Geneal Dental Practice or the Community Dental Service but not sufficiently complex to be undertaken in a hospital. In these instances, treatment may be undertaken by an Intermediate Minor Oral Surgery (IMOS) service. IMOS services treat patients aged 16 years and over typically on referral from their regular dentist or their CDS. When the treatment has been undertaken, patients are discharged to their regular dentist for ongoing care.

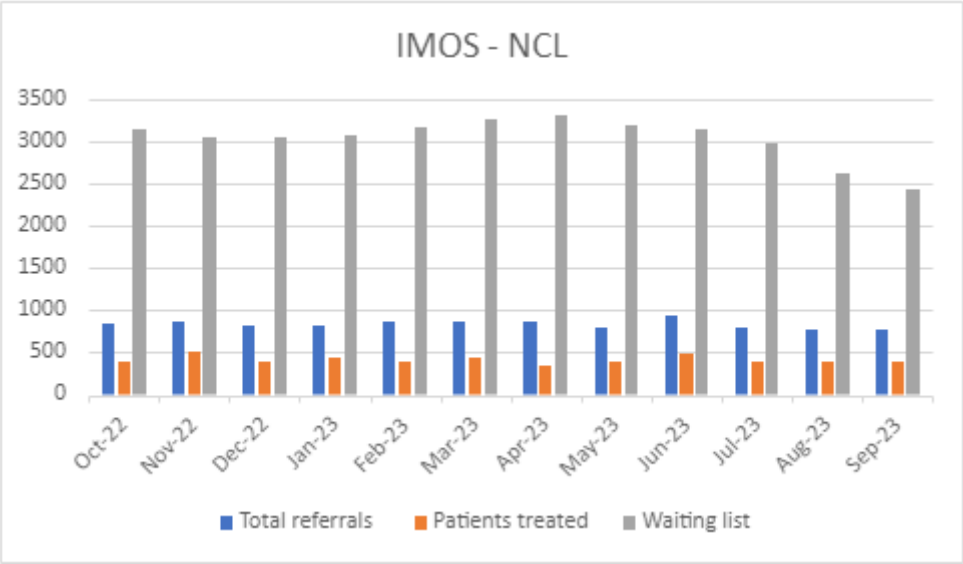
Within scope of the IMOS are Level 2 Complexity Endodontics, for teeth with incomplete root development, which includes the examination, diagnosis and possible placement of an orthodontic band (or other treatment) if required. The permanent restoration will be provided in General Dental Practice.

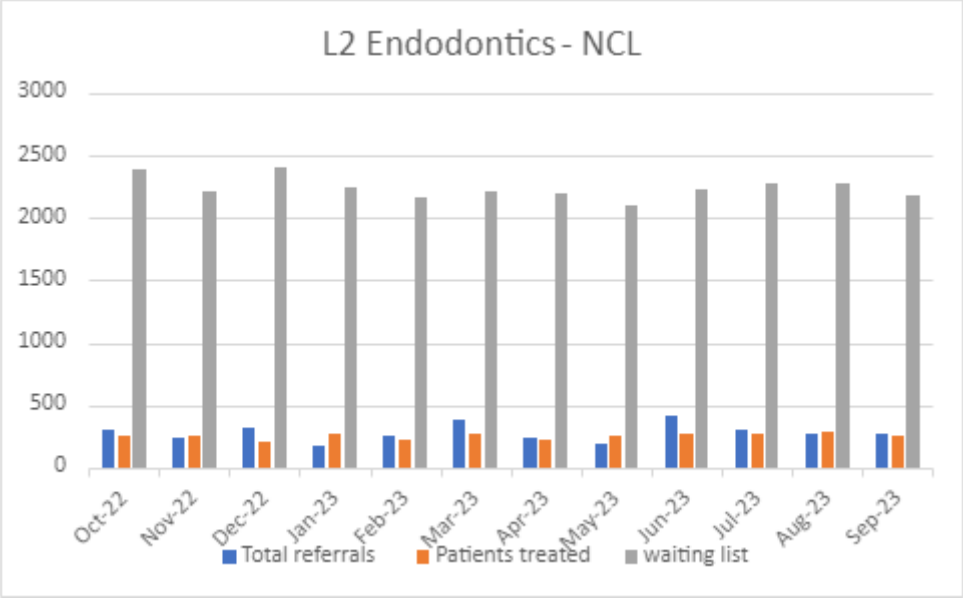
These services are seeing an increase in demand an also growing waiting times due to workforce shortages constricting capacity. To increase workforce in this area we are working with Managed Clinical Networks, Local Accreditation Panels and the Office of the Chief Dental Officer to create an accreditation process “with conditions”. This would means mean an applicant who is not quite suitable for full accreditation would be supervised when in practice until they are deemed competant to work in isolation and this is an innovative pathway being created by London to address waiting times.

In the short term, work is being piloted to move some level 2 complexity work into trusts that have capacity within their oral surgery service under the block contract arrangements and for NCL we have a

current waiting list of 2,431, a reduction of 23% compared to Q3 23/24. However, the current waiting list for NCL ICB L2 Endo providers is 2,172, which has not improved and will need to be addressed.

It is clear that further work is required to tackle this cohort of patients both to reduce the waiting times but also to avoid placing additional pressure on our acute providers who are the only other route for treatment for these cohorts of patients.





24/25 Plans within NCL

Most of the actions taken by NCL have been referred to earlier within this secton and we will continue to progress these during 24/25 with an additional focus on:

- Virtual training for care home staff to support care home residents.
- Provide additional clinics on the weekend (focussed in Haringey) for homeless rough sleepers.
- Work with nurseries to enhance our oral health offer through supervised toothbrushing.

This work we will be focusing on targeted actions as part of the National Dental Recovery Plan, and we are seeking to identify additional funding to support the expansion of support for people in Care Settings from those in Residential Care as well as focused support for people with diabetes who are experiencing oral health problems. The funding for this is yet to be identified and will depend on how much residual funding exists within the budget after our work to increase access in Primary Dental Services.

For the additional £600k of recurrent investment in Dental Services that the NCL ICB has committed to, we will deliver the following in 24/25:

Plans for 24/25	2024/25 (full year)
Increasing theatre capacity for the WH CDS	£323,762
Care Homes (Virtual Offer)	£17,683
Homelessness clinical capacity (Weekend Clinics)	£29,165
Oral Health Promotion (OHP) (in schools)	£99,600
CDS Provision weekend clinics	£107,523
Programme Management Cost	£22,195
TOTAL	**£599,928**

Summary

As can be seen from the above the NCL ICB has made material improvements in our performance and activity across a range of settings related to Dental Services. We have taken proactive steps to improve outcomes and improve oral health in adults and children across a wide range of settings. Our work has targeted inequalities such as care for those in care settings and those experiencing homelessness. We have continued our support for Community Dental Services, access to Urgent appointments for those in acute care and been proactive in delivering our commitments under the National Dental Recovery Plan.Two final areas we are proud to continue to support is access to support for Looked After Children and the proactive work we are doing with Local Authority colleagues to address the shared Oral Health Promotion agenda.

Focus on Optometry Services

Community Optometry Services represent a total of £13.9m for NCL (8.6% of the total for DOP Services) and primarily cover screening for diabetic patients and early detection of cataracts. Nearly all care for Ophthalmic conditions are treated within our secondary care sector including within Independent Sector (IS) Providers as well as specialist centres such as Moorfield Eye Hospital (MEH).

Also funded via our ICB budgets (ie these were not delegated with Community Optometry) we commission a wide range of AQP (Any Qualified Provider) Contracts designed to reduce pressure on our hospital based services and support from the RNIB (Royal National Institute for the Blind) for those at risk of losing their sight.

Unlike Dental Services, the deep dive undertaken into Community Optometry services did not identify any constraints on capacity for eye tests but highlighted inconsistencies with application of patient choice, a lack of consistency in referrals sent into secondary care and a growing demand for services in the Independent Sector with a range of contractors for whom we do not have a contract (but which patients can still be treated at through patient choice).

Since taking over responsibility for Community Optometry Services we have formed a relationship with our Local Optometry Committee and commenced work on designing a consistent referral pathway from Community Optometry into secondary care to tackle some of the issues identified during our deep dive. This includes establishing a consistent Single Point of Access (SPOA) for all referrals across NCL

ensuring consistency and quality of referrals from Community Optometrists, GPs, AQP Providers and others. The SPOA will also undertake triage on referrals and ensure that patient choice has been correctly and consistently applied at the point of referral and we expect the new SPOA to be in place from June 2024. This, we are confident, will tackle the issues identified during our deep dive.

Focus on Community Pharmacy Services

Community Pharmacy represents £32.9m of spend in NCL (20.4% of the total for DOP Services) and there are around 300 registered pharmacies in NCL, with 82% owned independently and the rest by large organisations such as Boots and Superdrug.

Community Pharmacies provide a range of services which can be categorised into:

- **Essential –** all contractors, part of the national contract
- **Advanced/enhanced –** part of the national contract but optional, must be delivered to a national specification.
- **Locally Commissioned –** according to the needs of the local population, via Local authorities and ICB

An example of the services provided under each of these three categories is shown below:

Essential Services	Advanced Services	Locally Commissioned (examples)
Dispensing of medicines	Pharmacy First	Needle exchange programme
Discharge medicines service	Flu Vaccination	Palliative Care medicines stock
Disposal of Medicines	Contraception service	Provision of emergency contraception
Healthy living pharmacy	Hypertension Care finding	Self-care medicines provision
Public health promotion	New Medicines Service	Covid Medicines provision
	Smoking Cessation	

As with General Practice commissioning, many community pharmacy services are managed via a nationally negotiated contract, supplemented by local enhanced services and transformation programmes. Significant work is taking place within the ICB Medicines team to develop and refresh knowledge of Community Pharmacy contracting forms, payment models, incentive structures, funding streams, reporting and assurance approaches (activity and outcomes) and the application of the Provider Selection Regime.

Governance & Oversight Arrangements

Following delegation it is the responsibility of ICBs to oversee these services and seek assurance around safety and quality of delivery.

The NCL Integrated Medicines Optimisation Committee (IMOC) has had community pharmacy added to its remit. Through this we will ensure community pharmacy is embedded in the local Pharmacy & Medicines Optimisation Strategy, make decisions relating to the commissioning of community pharmacy services and support implementation and delivery of responsibilities described in the Delegation Agreement.

The ICB team is working closely with the DOP Hub to ensure there is proportionate management and monitoring of the Community Pharmacy Contractual Framework (CPAF), to confirm the eligibility of pharmacies for any locally commissioned services, to monitor the marketplace, to implement Regulatory changes, to commission locally in line with need and population health goals and to transform and integrate services.

The team are also working close with NHSE and Regional colleagues, with the two Local Pharmaceutical Committees (LPC) and with wider providers and partners. The ICB Medicines Optimisation Team is developing local data and insight and regularly attend Local Pharmaceutical Committee (LPC) meetings and engage with local pharmacy contractors. This provides visibility of community pharmacy activity and issues at a local level.

Work will continue to ensure the IMOC and ICB team are equipped with the knowledge needed to make informed decisions that help us maximise value from community pharmacy and further integrate community pharmacy into the wider ICS system.
The IMOC recently hosted a seminar dedicated to Community Pharmacy and its delegation to ICBs with representations from the DOP Hub along with representatives from Community Pharmacy, Public Health and the NCL ICB. This provided the opportunity to describe current services, hear from a range of stakeholders and identify gaps in oversight, quality improvement and governance that could be addressed.

Activities and successes to date

Since delegation the NCL ICB has:

- Implemented the *Pharmacy First* initiative - a nationally commissioned service which enables patients to be seen for key clinical pathways as well as minor illnesses and urgent supply of regular medicines. Pharmacies are now able to assess and, where appropriate, supply medicines for 7 common conditions via a robust pathway. This is further supported via our local service to provide free over-the-counter medicines for those who can't afford them for a range of minor illnesses. Currently 95% of our pharmacies are signed up to deliver Pharmacy First.

- Led an expansion of the *NCL Self-Care Medicines scheme* (a locally commissioned service) – this provides free over the counter medicines to patients who meet key criteria and would otherwise struggle to afford them. The scheme will now cover all five boroughs recurrently and next steps will see the ICB team providing training, monitoring and oversight of this expanded service.

- Supported the *Independent Prescribing Pathfinders pilot* - a programme that aims to establish a framework for future commissioning as independent prescribing by community pharmacists in rolled out in 2025. The ICB has led on this project, establishing governance, pathways and guidance for the 2 participating pharmacies. The project is aiming to start Spring/Summer 2024.

- Discharge Medicines Service – dedicated staff are now supporting provider trusts to refer patients who would benefit from extra support on discharge, to a pharmacy of their choice.

- Continued support to pharmacies enabling them to provide a wider range of vaccination services and participate in other prevention and health promotion initiatives.

- Community Pharmacy and Urgent Care Interface group was recently formed to ensure that Community Pharmacy develops as an integral part of local urgent care services.

- Finally we are about to launch a communications campaign to increase awareness of the developments in Community Pharmacy and its role as an alternative to General Practice and other setting of care to increase use of Pharmacy services by local patients and residents. This forms part of the Primary Care Access Recovery Plan in NCL.

Future opportunities

Future opportunities that arise from the delegation of Community Pharmacy include:

- Local delegation of Community Pharmacy means that individual ICBs can more easily address local population health priorities using targeted bespoke locally commissioned services to match the local need, and can, as the commissioner, have direct oversight of activity levels, measurable outcomes, concerns, governance etc. This may require investment.

- Pharmacy services can be better integrated into and aligned to local pathways. In the same way, community pharmacy commissioned services can be easier aligned to local public health priorities and borough partnership workstreams. Community outreach can be improved and community pharmacy's role in this by working collaboratively with the ICB (a population health approach) needs to be further defined.

- There may be opportunity to 'work at scale' with independent contractors on areas such as workforce development and training.

- There is potential for electronic transmission of prescriptions from hospital outpatient clinics - the ICB will need to work with all providers to scope this new pathway.

There is clearly significant further work to undertake to fully integrate Community Pharmacy into the wider Primary Care system and through this support the NCL health and care system fully but it is equally clear that material progress has been made since delegation in April 2023.

Risks & Mitigations

The main risks arising from the delegation of DOP Services are summarised in the table below:

Risk	Impact	Likelihood	Mitigations
Staffing (Applicable to all of DOP) Whilst all services make good use of the DOP Hub to manage risk there is limited resources available for transformation or to respond to new initiatives.	**High**	**Medium**	The ICB has taken steps to expand the Delegated Services team supporting Dentistry and Optometry but there remains a question about whether there is sufficient resource within the Medicines Optimisation Team to support Community Pharmacy.
Governance (Applicable to all DOP) The PwC audit identified a need to strengthen the existing MOU with the DOP Hub and consider how we might need to change the governance associated with DOP Services.	**Medium**	**Medium to Low**	The ICB team have taken steps for formalise the reporting structures associated with DOP Services and to strengthen the working relationship with the DOP Hub further. However, there remains work to do in terms of addressing the issues with the MOU that were identified within the audit by PwC.
Dentistry We are yet to fully understand the impact on recurrent budgets brought about by the National Dental Recovery Plan and also the increased activity brought about by both the continuing recovery from the pandemic and the work undertaken in NCL to open up capacity and improve access.	**High**	**Medium**	We have undertaken an initial assessment of the risk to budgets but will need to keep this under investigation throughout 24/25. It is unlikely that this will present the ICB with a cost pressure but may result in less funding be available to support the priorities for transformation identified by the ICB in terms of supporting people in Care Settings and providing support to patients with Diabetes who need support with their oral health.
Optometry Whilst we do not believe there is a risk to Community Optometry access or capacity, there remains different referral pathways and differing access to services across NCL that represent inequities to our population.	**Medium**	**Medium to Low**	The introduction of the new Single Point of Access will be accompanied in the standardisation of pathways across NCL and will also ensure patient choice is being applied correctly. In terms of access we have expanded the services offered by RNIB to the whole of NCL and also

			expanded the services of Primary Eye Care Services to ensure equity of community provision. These latter changes are outside of the scope for delegated optometry services and fit within the ICB's normal remit.
Community Pharmacy The remains work to do both to strengthen the infrastructure to support Community Pharmacy and embed this into the wider Primary Care system to ensure activity and capacity is optimised and collectively reduces the risks to the wider health system.	**Medium**	**Medium**	The roles within the Medicines Optimisation Team are being aligned to the functions required to both support and integrate Community Pharmacy into the wider Primary Care network as well as ensure we meet our obligations for oversight and management.

Next Steps

Depending on the discussion at the ICB Board we expect the next steps to be:

For all DOP Services

- Resolution of the issues flagged in the PwC Audit including the strengthening of the MOU with the DOP Hub.

Dental Services

- Gaining clarity on the financial implications of the National Dental Recovery Plan to determine impact on budgets and the ability of the ICB to expand investment into supporting patients in Care Settings and those with Diabetes who need oral health support.
- Delivering the transformation programme for 24/25 as outlined within this paper including delivering the prevention work and our aspirations around improving oral health in partnership with our Local Authority partners.

Community Optometry

- Implementation of the new Single Point of Access and development of consistent referral pathways across NCL for patients with ophthalmic issues.
- Ensuring that patient choice is correctly applied by Community Optometrists at the point of referral to meet our obligations with regards to this important matter.
- Finalising our plans to ensure there is a consistent service offer across each of the NCL Boroughs for eye screening services including those covered by Community Optometry plus those funded directly via the ICB's Core Allocation such as AQP Contracts and Community Ophthalmology Services.

Community Pharmacy

- Continue to develop the local infrastructure to engage, support and provide oversight to Community Pharmacy.
- Continue the work on integrating Community Pharmacy into the wider primary care system and ensuring they are seen as a trusted partner by General Practice and other Primary Care clinicians.
- Finalise the work to align roles and responsibilities within the Medicines Optimisation Team to Community Pharmacy requirements.
- Establish a mechanism to be able to capture results of patient satisfaction surveys.

Recommendations

The NCL ICB Board is asked to:

- **NOTE** the progress made by the NCL ICB team for all three DOP services since they were delegated in April 2023 and the lessons learned through the PwC noting further that many of these are equally applicable to the delegation of Specialised Services in April 2025.

- **NOTE** the future plans the ICB has for each DOP Service to improve access, outcomes, experience and performance for our population.

- **AGREE** any next steps that the Board feels would be appropriate to take as an ICB and when the Board would like a further update on the progress of delegated DOP Services.

Pharmacy, Optometry and Dentistry delegation Internal audit report 2023/24

North Central London Integrated Care Board
Final
February 2024

pwc

Contents

Distribution list

For action:
Mark Eaton, Director of Strategic Commissioning & Procurement
Sarah Rothenburg, Director of Finance, Primary Care

For information:
Audit and Risk Committee
Sarah Mansuralli, Deputy Chief Executive and Chief Strategy & Population Health Officer (Joint Executive Sponsor)
Sarah McDonnell-Davies, Executive Director of Place (Joint Executive Sponsor)

Executive summary

Report classification

Medium Risk (11 Points)

See Appendix A for the scoring matrix.

Trend

A review of this nature has not been performed previously by the current internal audit provider.

Total number of findings: 5	Critical	High	Medium	Low	Advisory
Control design	-	-	3	2	-
Operating effectiveness	-	-	-	-	-
Total	-	-	3	2	-

Impact of our findings on opinion areas

Area	Impact
Risk Management	No findings have been identified that impact Risk Management.
Corporate Governance	1 finding has been identified that impacts Corporate Governance.
Internal Control	4 findings have been identified that impact Internal Controls.
Data Quality	No findings have been identified that impact Data Quality.
Value for Money	No findings have been identified that impact Value for Money

Background and Scope

This audit was undertaken as part of the 2023/2024 internal audit plan approved by the Audit Committee. The scope of the audit has focussed on the governance and due diligence in place leading up to and post the delegation of Pharmacy, Optometry and Dentistry (POD) that has been in place since 1st April 2023.

Our audit work was conducted through a series of walkthrough meetings with the Director of Strategic Commissioning & Procurement, the Director of Finance - Primary Care, the Head of Primary Care Commissioning - Dentistry, Optometry and Pharmacy (North East London ICB (NEL ICB)), and the Deputy Chief Clinical Officer & ICS Chief Pharmacist. We also reviewed key documentation such as Pre-Delegation Assessment Framework, the Delegation Agreement, the Memorandum of Understanding between the Five London ICBs, and the POD (Delegated Services) Commissioning Oversight Group Terms of Reference in order to identify the key processes and controls in place.

We have found that the ICB has yet to fully establish appropriate governance arrangements and resourcing to oversee the POD delegated responsibilities. This is not unexpected given that the arrangements only came into effect from 1st April and a significant proportion of the contracting work is undertaken by the POD hub, hosted by NEL ICB. However, the areas highlighted in this report will need to be quickly addressed and the lessons learnt ahead of the more substantial delegation of specialised commissioning responsibilities in the near future.

Comparison to wider sector

The ICB compares well to comparator organisations based on the work we've performed, with some improvements required to enhance the adequacy and effectiveness of the framework of governance, risk management and internal controls.

Executive summary

Summary of findings

The overall **medium risk rating** of this report is driven by **three medium risk and two low risk rated findings** that we identified from our review of documentation and discussions with management. Please find additional detail on each of these findings below:

- **Finding 1 - A lack of formalised contract management arrangements for overseeing the POD hub (Medium risk) -** The Memorandum of Understanding (MoU) between the five ICBs and the NEL POD hub does not include KPIs nor details on how each ICB is expected to contract manage the arrangement. The ICB recognises that greater clarity is needed on how the contract is to be owned and managed moving forward.
- **Finding 2 - The MoU does not provide clear guidelines on delegated authority for General/Local/High street practices dentistry (Medium risk)** - The MoU outlines that the POD hub can process contract variations on behalf of the ICB but it does not provide any guidance regarding how significant these changes can be before the ICB is required to provide its approval. There is also no regular reporting of the contract variations occurring on behalf of the ICB to enable the ICB to have oversight of these.
- **Finding 3 - The ICB depends on a small number of employees for overseeing POD delegation (Medium risk)** - The MoU outlines a series of roles and responsibilities that are expected to be performed by the ICB. However, the ICB does not have any additional dedicated resourcing to deliver on these responsibilities. This is creating a resource pressure and risk that the ICB may not have sufficient capacity to manage operational pressures whilst also having the band width to focus on the strategic commissioning of the POD services in the future.
- **Finding 4 - There are gaps in the governance for overseeing the POD services (Low risk) -** There is a lack of an overarching diagram that clearly outlines the governance structure for each POD service and how they interact with the wider POD hub and the POD Commissioning Oversight Group (that includes all five ICBs). Our discussions with key stakeholders have highlighted areas requiring further review including the governance/reporting in place to oversee optometry and pharmacy services as well as ensuring that risk management is clearly integrated across the governance structure.
- **Finding 5 - The MoU needs to be supplemented with checklists or aide-memoires to clarify roles and responsibilities (Low risk)** - The ICB is now working through operational contractual matters that require support by both the NEL POD Hub and the ICB. However, it is not always clear on the responsibilities on each party, such as during the recent business continuity incident within pharmacy, with the MoU not providing support on how specific operational matters are to be dealt with.

Good practice noted

From the work performed we have noted the following instance of good practice:

- Proactive dental commissioning - Following delegation, the ICB undertook a deep dive into Dental services working closely with the NEL ICB Hub. This work has identified a series of opportunities to redirect a percentage of the recurrent underspend in Dental services back into services that will improve access, reduce inequalities and improve outcomes for patients.
- Community pharmacy - The Integrated Medicines Oversight Committee (IMOC) has received a seminar on community pharmacy. The seminar provided in-depth background information on the community pharmacy contractual framework, landscape, workforce and funding arrangements, the responsibilities for the ICB associated with the delegated commissioning and the current oversight and assurance in terms of activity and patient outcomes. It is also noted that, since the completion of our fieldwork, the terms of reference for the IMOC has been revised to recognise delegated responsibilities, as has the Committee risk log.

Current year findings

1 A lack of formalised contract management arrangements for overseeing the POD hub

Control design

Finding rating

Rating	Medium

Finding and root cause

In the London Region of NHS England (NHSE), five London Integrated Care Boards (ICBs) each take on the delegated responsibility for Pharmacy, Optometry and Dentistry (POD) services from 1st April 2023: NHS North East London ICB; NHS North West London ICB; NHS North Central London ICB; NHS South West London ICB; NHS South East London ICB (referred to as 'the five ICBs').

The five ICBs determined that NHS North East London ICB (NEL ICB) would act as the "Host ICB", hosting a central POD Commissioning Team that includes staff whose employment transferred from NHS England, and that is responsible for coordinating the commissioning and contracting of POD services on behalf of all five ICBs.

There is a Memorandum of Understanding (MoU) between the five ICBs ('*Memorandum of Understanding between Five London ICBs for Operational Management of Pharmacy, Optometry & Dental (POD) Delegated Services from 1 April 2023*'), which is dated 2 March 2023. This MoU sets out the working arrangements between the ICBs and the POD hub (posted by NEL ICB). We reviewed the MoU and identified that:

- There are no clearly defined key performance indicators for overseeing the POD.
- The only reference to governance is pointing towards the POD Commissioning Oversight Group with no specific details on how the ICB is expected to contract managing the service.

This was further discussed with the ICB and it was recognised that a clear contract manager and contract management structure had yet to be established for overseeing the work of the POD.

Potential implications

As there are no KPIs included in the MoU as well as regular meetings to review the arrangement between the five ICBs, there is a risk that the service provided to the ICB is insufficient and the ICB does not receive sufficient information or have the opportunity to effectively manage the performance of delegated POD services.

Current year findings

1 A lack of formalised contract management arrangements for overseeing the POD hub

Control design

Finding rating

Rating	Medium

Recommendation

The ICB should consider:

- Establishing key performance indicators for the POD and incorporating these into an updated MoU.
- Clearly outlining the expected contract management structure/contract owner for the NEL hub.
- Establishing formal contract management meetings with the NEL hub

Evidence required: An updated version of the MoU including KPIs. Details of the contract management arrangements in place for the contract moving forward.

Management action plan

Actions agreed.	Responsible person/title:
	Mark Eaton / Director of Strategic & Delegated Commissioning and Sarah Rothenburg / Director of Finance, Primary Care
	Target date:
	30 October 2024

Current year findings

2 The MoU does not provide clear guidelines on delegated authority for dentistry

Control design

Finding rating

Rating	Medium

Finding and root cause

During the audit, we met with the Head of Primary Care Commissioning - Dentistry, Optometry and Pharmacy who oversees the POD hosted by NEL ICB. As part of running through the service provided for each of the three areas above, it was highlighted that the POD would process contract variations on behalf of NCL ICB for General/Local/High street practices, such as where there was a change in partnership/ownership, without any communication to NCL ICB except if the change was deemed to be material.

We therefore reviewed the MoU to ensure that this clearly captured this delegated authority into the POD. The MoU states that '7.1.4 Management of all contracts necessary for the commissioning of POD services, including the Pharmacy Framework Agreement, preparation and issue of any relevant contract variations and contract monitoring information for the five ICBs'. There is therefore no clearly defined threshold regarding what a 'material' contract variation is and when the ICB needs to be informed of the change.

We have also identified that there is no regular log of contract variations being provided to the ICB to enable oversight of the variations being made on its behalf.

Potential implications

A lack of clarity regarding the scale of changes that can be processed by the POD hub on behalf of the ICB may lead to significant changes occurring without the ICBs oversight. A lack of reporting around any changes being made also removes the opportunity for the ICB to check and challenge any changes processed.

Current year findings

2 The MoU does not provide clear guidelines on delegated authority for dentistry

Control design

Finding rating

Rating	Medium

Recommendation

The ICB should consider:

- Providing a clear expectation regarding the materiality of contract variations that can be processed on its behalf by the NEL POD
- Requesting that a quarterly report of all the contract variations being processed on its behalf is shared for review by the ICB.

Evidence required: An updated version of the MoU including clarity of the materiality of changes that can be made on its behalf. A report capturing all contract variations being processed on its behalf on a quarterly basis.

Management action plan

Actions agreed.

Responsible person/title:

Mark Eaton / Director of Strategic & Delegated Commissioning

Target date:

30 June 2024

Current year findings

3 The ICB depends on a small number of employees for overseeing POD delegation

Control design

Finding rating

Rating	Medium

Finding and root cause

A large proportion of the contract management/transactional processing in respect of POD continues to be provided by the same employees that were responsible for this at NHSE, but they are now hosted through the NEL POD hub. However, as outlined within the MoU, there are a number of responsibilities that sit within the ICB including:

- 9.1 To identify a lead officer(s) to attend and, with sufficient authority, contribute to the POD Commissioning Oversight Group.
- 9.2 To discharge their financial responsibilities as set out in paragraph 12 of this MOU.
- 9.3 To appropriately discharge their responsibility under their Delegation Agreement and inform the development of pan London strategies for the development/transformation of POD services as referred to in paragraph 8.1.9 in respect of:
- 9.3.1 Legal duties to involve patients and the public in shaping the provision of POD services, including by working with local communities, under-represented groups and those with protected characteristics under the Equality Act 2010; and
- 9.3.2 Considering how they can address health inequalities in performing their obligations with input from Dental Public Health.
- 9.4 To be responsible for the management of, and response to, Freedom of Information (FOI) requests in respect of POD services as required by their Delegation Agreement.
- 9.5 To manage the complaints process for POD, appropriately liaising with the POD Commissioning Team.
- 9.6 To cascade information as appropriate within their individual ICB. The lead POD officer referred to in paragraph 9.1 shall themselves, or identify a named individual who will provide the interface between their ICB and the POD Commissioning Team between the meetings of the POD Commissioning Oversight Group, supporting the POD Commissioning Team in the operational delivery of its functions.
- 9.7 To make decisions relating to the commissioning of POD services in a timely way in compliance with its own ICB Governance Framework, engaging appropriately with other ICBs at the POD Commissioning Oversight Group, where such decisions impact across ICB borders or more widely across London, and to present all POD commissioning and contracting decisions at the POD Commissioning Oversight Group.
- 9.8 To work with the other four ICBs and the POD Commissioning Team to co-develop POD commissioning plans across London, having regard to paragraphs 8.1.9, 9.3.1 and 9.3.2.
- 9.9 To ensure that appropriate and transparent reporting and accountability mechanisms are put in place within each ICB in relation to POD.

Current year findings

3 The ICB depends on a small number of employees for overseeing POD delegation

Control design

Finding rating

Rating	Medium

Finding and root cause

- 9.10 To manage the engagement of various local individual ICB teams such as the infection control team and communications team where such engagement is necessary with the POD Commissioning Team or Regional Medical Advisors and/or Consultants in Dental Public Health.
- 9.11 To work with the POD Commissioning Team, regional clinical advisors and Consultants in Dental Public Health (in terms of health protection) to manage local stakeholder engagement and communications, should this be necessary.
- 9.12 To liaise as appropriate with the Local Representative Committees, the LPC, LDC and LOC, keeping the POD Commissioning Team appropriately informed.
- 9.13 To establish appropriate contractual arrangements with acute providers to commission acute dental services in collaboration with the POD Commissioning Team (see paragraph 7.1.4).
- 9.14 To be responsible for any necessary internal audit of expenditure within its ledger and associated actions, with the appropriate support of the POD Commissioning Team (see paragraph 7.1.15).
- 9.15 To lead any liaison with the local Fraud team as necessary in relation of expenditure within its ledger and associated contracts, with appropriate support of the POD Commissioning Team (see paragraph 7.1.15).

However, the ICB does not have any additional dedicated resourcing to deliver on these responsibilities. The Director of Strategic Commissioning & Procurement oversees the dental and optometry components of POD but this provides little scope for strategic planning or detailed operational management as per finding one. Pharmacy activity has largely been integrated into the existing medicines management structure (see finding three for further details) but this is creating a resource pressure and this risk was to be added to the IMOC risk register with the ICB now responsible for the oversight of hundreds of pharmacies. Financial oversight is provided by the Director of Finance for Primary Care and the Finance Team is holding regular meetings with the POD to educate itself on the drivers of the activity and explanations for financial variances.

Moving forward, the demand on ICB time is likely to increase as strategic planning for these services increases alongside management of operational issues. The experience from the previously delegated primary care commissioning also shows that it would be sensible for the ICB to begin to identify dedicated resource that can upskill in the operational contract management for POD should there be a further allocation of responsibilities in the future.

Current year findings

3 The ICB depends on a small number of employees for overseeing POD delegation

Control design

Finding rating

Rating	Medium

Potential implications

The ICB may not have sufficient resources to deliver on the expectations of the ICB responsibilities based on the MoU. This risk is likely to increase as the arrangement embeds as the focus turns towards strategic commissioning for these services.

Recommendation

The ICB should consider:

- Reviewing the resources in place to oversee the expected roles and responsibilities under POD delegation and whether further capacity is needed to meet both operational management expectations and to create sufficient capacity for future strategic commissioning of the services.

Evidence required: A roles and responsibility matrix that clearly maps out the ICB's responsibilities, cross references these to specific individuals within the ICB, and ensures that they have appropriate capacity to support the delivery of the POD delegation.

Management action plan

Actions agreed.	Responsible person/title:
	Sarah Mansuralli / Deputy Chief Executive and Chief Strategy & Population Health Officer and Sarah McDonnell-Davies / Executive Director of Place
	Target date:
	30 June 2024

Current year findings

4 There are gaps in the governance and reporting for overseeing the POD services

Control design

Finding rating

Rating	Low

Finding and root cause

We considered the governance arrangements in place at the ICB to oversee the delegated POD services. Our starting point for this was to request a copy of the ICBs governance structure that clearly outlines for each service the key groups/committees in place and how they interact with the wider POD hub and the POD Commissioning Oversight Group (that includes all five ICBs). However, the ICB was unable to provide us with this governance structure.

Through our interviews conducted and wider documentation shared, we are aware of the following governance structure and reporting that occurs for each component of POD:

<u>All</u>

- A POD Commissioning Oversight Group has been established. The purpose of the meeting is to provide oversight of the delegation of POD Services at a Pan London level under the MoU, focusing in particular on oversight of the commissioning activity they undertake on behalf of ICBs under the direction of the MoU, and the commissioning advice they provide to ICBs.
- There are monthly national POD finance meetings named Primary Care Finance Group (PCFG) meetings, which pick up on the financial management and monitoring concerns across London.
- There are POD Delegation Finance Leads Meetings between the five ICBs every four to six weeks.

<u>Pharmacy</u>

- Pharmacy information has been integrated into the existing Medicines Management structure of the ICB. This is overseen by an Integrated Medicines Oversight Committee (IMOC) with the following purpose:
  - a) Provide oversight and assurance on the ICB's statutory functions on medicines;
  - b) Provide oversight and assurance on medicines to ensure:
    - Safe and clinically effective use of medicines;
    - Improved clinical outcomes;
    - Best value of medicines use;
    - The promotion of proper use of medicines;
    - Safe and consistent access to medicines in the context of care pathways which cross multiple providers;
  - c) Oversee the development and implementation of the ICB's medicines management strategy and procedures;
  - d) Ensure co-operation and consistency of approach to medicines optimisation across the NCL Integrated Care System;
  - e) Oversee the arrangements for sponsorship and/or joint working with the pharmaceutical industry.

(continued on the next page)

Current year findings

4 There are gaps in the governance and reporting for overseeing the POD services
Control design

Finding rating

Rating	Low

Finding and root cause (cont'd)

However, there is no formal dedicated reporting occurring between the POD hub and IMOC that captures details on the performance of community pharmacies. Our discussions with the ICB highlighted that this information may become increasingly important moving forward as strategic decisions are taken relating to commissioning of community pharmacy and performance management of this. Our good practice section in the Executive Summary also highlighted how the IMOC has received a seminar in January 2024 providing greater understanding on the ICB role in relation to community pharmacy.

Optometry

- There is no formal governance arrangements or direct reporting into the ICB established to oversee optometry. This, in part, reflects that relatively straightforward nature of the service being commissioning, which is NHS eye tests predominantly delivered by private providers.
- The ICB benefits from a General Ophthalmic Services (GOS) Contract Assurance exercise. 5% of Mandatory and Additional Services providers are selected randomly across each 5 ICB areas to complete and return a Quality in Optometry (QiO) self-declaration. A maximum of 20 are then selected for a validation practice visit by an Optometric Adviser and a member of the commissioning team.

Dental

- A Dental Collaboration Group (DCG) has been established. The Terms of Reference (ToR) for the DCG are in draft at the time of our review and outline its roles and responsibilities as:
  - Providing a forum for all partners involved in supporting Dental Services in NCL to come together to discuss challenges and plan solutions as well as provide updates on progress.
  - To provide a forum for sharing updates including those arising from Local Authority colleagues within the remit of Oral Health Promotion.
  - To provide a link between the work underway within NCL and the wider London footprint and ensure consistency of approach as well as to share best practice.

Risk management

We reviewed minutes and papers across the above governance meetings. Our review highlighted that risk management/the identification of risks is not being consistently incorporated as an agenda item.

Financial performance

Regarding the detailed breakdown of financial performance, we were informed that for delegated primary care commissioning there is a dedicated committee, the Primary Care Committee, that receives and scrutinises the financial performance. However, there is no equivalent reporting/committee in place for the delegated POD arrangements.

Current year findings

4 There are gaps in the governance and reporting for overseeing the POD services

Control design

Finding rating

Rating	Low

Potential implications

A lack of a clearly documented and understand governance structure may result in information not being captured or reported and ineffective scrutiny and challenge over decision making. A failure to ensure that risk management is integrated across the governance structure may also prevent the timely identification of risks and result in risks materialising that may otherwise have been mitigated,

Recommendation

The ICB should consider:

1. Producing a diagram that clearly maps out all relevant ICB/wider committees/groups in relation to POD and the reporting lines for clarity.
2. Whether a formal group or a clear reporting line is required to oversee optometry.
3. Finalise the Terms of Reference for the Dental Collaboration Group.
4. Ensure risk management is included as a regular agenda item across the governance structure and reporting related to POD.
5. Developing formal reporting on the performance of community pharmacies into the IMOC.
6. Identifying a dedicated committee/group where a more granular financial report could be reported for POD to enable this to be reviewed, scrutinised and challenged in a consistent manner with the primary care commissioning delegated responsibilities.

Evidence required: A copy of the governance structure established for overseeing the POD arrangements. The finalised Terms of Reference for the Dental Collaboration Group. Evidence of consideration being given for the a) the appropriateness of the optometry governance arrangements/reporting b) the need for greater reporting on community pharmacy and c) more granular financial reporting on POD expenditure. Evidence of risk management being more formally embedded across the governance structure.

Current year findings

4 **There are gaps in the governance and reporting for overseeing the POD services**
Control design

Management action plan

Actions agreed.	Responsible person/title: Katherine McNaughton / Head of Devolved Commissioning and Louise Coughlan / Deputy Chief Clinical Officer & ICS Chief Pharmacist Target date: 30 June 2024

Finding rating

Rating	Low

Current year findings

5 The MoU needs to be supplemented with checklists or aide-memoires to clarify roles and responsibilities

Control design

Finding rating

Rating	Low

Finding and root cause

The MoU provides a basis for the arrangement between the NEL ICB POD Hub Team and the fives ICBs that utilise their services. However, the MoU does not go into specific scenarios that may arise whilst managing POD services that may require support from the Hub and the ICB to resolve.

Our discussions with the ICB highlighted that operational matters are arising, such as a recent business continuity issue within pharmacy, and there isn't always clarity on which roles and responsibilities fall on the ICB and which fall on the Hub to take forward.

Potential implications

A lack of clearly allocated roles and responsibility may lead to efforts being duplicated between the ICB and the Hub or gaps in responding to operational matters.

Recommendation

The ICB should consider:

- Capturing the roles and responsibilities for operational contract management matters arising under the POD arrangements. This can then form as a template to help guide both ICB and the Hub staff moving forward to minimise duplicated efforts and ensure there are no gaps in response.

Evidence required: A copy of a checklist/aide memoires developed to supplement the MoU.

Management action plan

Actions agreed.	Responsible person/title:
	Mark Eaton / Director of Strategic & Delegated Commissioning
	Target date:
	30 June 2024

Appendices

Appendix A: Basis of our classifications

Individual finding ratings

Critical

A finding that could have a:

- **Critical** impact on operational performance, e.g. resulting in inability to deliver core activities; or
- **Critical** monetary or financial statement impact; or
- **Critical** breach in laws and regulations that could result in material fines or consequences; or
- **Critical** impact on the reputation or brand of the organisation which could threaten its future viability.

High

A finding that could have a:

- **Significant** impact on operational performance e.g. resulting in significant disruption to core activities; or
- **Significant** monetary or financial statement impact; or
- **Significant** breach in laws and regulations resulting in significant fines and consequences; or
- **Significant** impact on the reputation or brand of the organisation.

Medium

A finding that could have a:

- **Moderate** impact on operational performance e.g. resulting in moderate disruption of core activities or significant disruption of discrete non-core activities; or
- **Moderate** monetary or financial statement impact**;** or
- **Moderate** breach in laws and regulations resulting in fines and consequences; or
- **Moderate** impact on the reputation or brand of the organisation.

Appendix A: Basis of our classifications

Individual finding ratings

Low

A finding that could have a:

- **Minor** impact on the organisation's operational performance e.g. resulting in moderate disruption of discrete non-core activities; or
- **Minor** monetary or financial statement impact; or
- **Minor** breach in laws and regulations with limited consequences; or
- **Minor** impact on the reputation of the organisation.

Advisory

A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

Report classifications

The report classification is determined by allocating points to each of the findings included in the report.

Findings rating	Points
Critical	40 points per finding
High	10 points per finding
Medium	3 points per finding
Low	1 point per finding

Report classification	Points
Low risk	6 points or less
Medium risk	7 – 15 points
High risk	16 – 39 points
Critical risk	40 points and over

Appendix B: Terms of reference

Background and audit objectives

On 1st April 2023 the delegated responsibility for commissioning Pharmacy, Optometry and Dentistry (POD) services transferred from NHS England to Integrated Care Boards (ICBs). As part of this transition, nine 'early adopter' ICBs took on the commissioning responsibility in July 2022, ahead of the rest of the UK. The NHS Confederation recently published a report on the progress made by these nine ICBs, and highlighted the main challenges as:

- The difficulty of managing and monitoring the quality of the service being provided;
- Having access to the right data to effectively manage the services at an ICB level, and appropriate resource levels to support the subsequent processing requirements in relation to this data; and
- The impact that logistical and governance challenges relating to contract change is having on ICBs potential to transform.

The ICB was not one of the 'early adopter' organisations, and as such took on responsibility for the POD function from 1st April 2023. Ahead of this transition, the ICB undertook the pre-delegation assessment framework response as required by NHSE and established the POD Delegation Steering Group, bringing together leads from primary care, medicines, contracts, finance, quality and governance. The ICB refreshed its response to the delegation assessment framework in February 2023, highlighting areas requiring further work in order to support the incoming services, including creating a clear governance structure, consideration of how best to engage with Local Dentistry Networks and the public and the development of SOPs to support decision making.

The scale of the POD services in scope across NCL are 4,500 providers, ranging from significant specialist trusts to high street providers, and equating to approximately £200m per year (February 2023 Board papers). In early 2023/24 there was a risk on the ICB'S Board Assurance Framework (BAF): Failure of the Integrated Care Board in effectively managing the risks of devolution for Dental, Optometry and Pharmacy Services from April 2023 Onwards.". This risk was previously rated 16, but in July 2023 following to signing of the National Delegation Agreement, National Delegation Agreement and Memorandum of Understanding this fell to a rating of 12 - which is below the threshold for the ICB BAF.

Our review has considered whether due diligence was performed ahead of the transfer of commissioning responsibility to the ICB as well as whether the outcomes of this activity has been followed up, with any potential risks appropriately mitigated. We will also consider whether the ICB has implemented clear governance arrangements to support the services and ensure that efficient management reporting, oversight and decision making is taking place, and whether data requirements have been clearly outlined in order to enable effective oversight of services and decision making.

Scope and limitations of scope

1. Pre-delegation activities
2. Governance
3. Use of data
4. Risk management and reporting

Our scope was limited to the areas above. Our work was performed on a sample basis.

Internal audit work was performed in accordance with PwC's Internal Audit methodology which is aligned to the Public Sector Internal Audit Standards. As a result, our work and deliverables were not designed or intended to comply with the International Auditing and Assurance Standards Committee (IAASB), International Framework for Assurance Engagements (IFAE) and International Standard on Assurance Engagements (ISAE) 3000.

Appendix B: Terms of reference

Scope

We will review the design and operating effectiveness of key monitoring controls in place relating to the auditable unit during the period 1 April 2023 to the time of our review (unless otherwise stated).

The sub-processes, risks and related control objectives included in this review are:

1. Pre-delegation activities

Objectives

- A pre-contractual assessment framework was completed in advance of the transfer of commissioning responsibility for POD services to the ICB. This assessment was reviewed regularly, with the results, updates and associated actions being escalated internally as appropriate.
- Due diligence was performed on the services to be transferred ahead of the 1 April 2023 and:
    - The results of this exercise were reviewed and approved by an appropriate party;
    - The results and sign-off of this exercise have been documented; and
    - The risks emerging from this exercise were assessed on a timely basis, with any requiring mitigating action recorded, assigned an owner and due date and progress against these is monitored regularly.
- Processes have been put in place to continue to monitor identified risks post-delegation, which are correctly recorded with details on mitigating controls in the Corporate Risk Register.

Risks

- If the ICB did not assess it's readiness to take on the delegated services, there is a risk that core aspects of oversight, management and/or responsibility requiring additional action may not have been identified on a timely basis.
- Although the transfer of commissioning responsibilities for POD services was directed by NHSE, the completion of sufficient due diligence would enable the ICB to identify key risks associated with the delegation in order to mitigate these down to an acceptable level. If this diligence is not performed, core risks may not be actioned on a timely basis.

Appendix B: Terms of reference

2. Governance

Objectives

- A clear scheme of delegation is in place in relation to the delegation of POD services. This scheme of delegation includes:
    - Key roles and responsibilities;
    - Clear levels of delegated authority; and
    - An outline of key reporting structures to support the POD services, for example relevant steering groups.
- Oversight mechanisms and controls are in place to address key matters (such as financial and clinical risk) post-delegation, with sufficient management and clinical time being allocated within the ICB to manage the ongoing needs of POD services.
- All relevant ICB committees been identified and briefed about the impact of POD delegation, with Terms of Reference being updated to clearly reflect their role in POD services.
- Governance and oversight arrangements have been further developed and strengthened since delegation to reflect emerging challenges and the experience of being accountable for services.
- External reporting (scope, regularity, distribution) from the POD hub satisfies ICB governance and audit requirements.

Risks

- If there is no clear scheme of delegation in place, there is a risk that the ICB is unable to effectively manage the delegated POD services.

Appendix B: Terms of reference

3. Use of data

Objectives

- The ICB has a clear understanding of the data required to effectively manage the POD services, and has implemented core controls to ensure that this data is accessible on a timely basis, is of a sufficient quality and is consistent to enable efficient service management. Examples of data may include financial, activity and quality metrics.
- Data has been identified, is available and is being deployed effectively to manage the ongoing risks of delegation.
- Sufficient information and data (soft & hard) was sought, received, scrutinised as part of the delegation process and associated due diligence.
- The ICB has scrutinised and reflected on the information and data (soft & hard) post delegation, with action plans being put in place to address any issues identified.
- The ICB is clear on where data resides that it has access to and arrangements are in place to ensure control and accountability is exercised effectively. Where gaps in the data have been identified action plans have been put in place to address any issues identified.

Risks

- If the data requirements related to the transition of services are not clear, there is a risk that the ICB does not have access to the data it requires to effectively manage the delegated POD services.

Appendix B: Terms of reference

4. Risk Management and Reporting

Objectives

- There is a clear, documented process in place for the identification, reporting, management and monitoring of risks relating to the POD delegation.
- Key risks relating to the delegation have been incorporated into the ICB risk register where relevant, and are reviewed on a regular basis. The ICB gains assurance on a regular basis that all relevant risks have been captured on this or other relevant risk register(s).
- When relevant, risks relating to the delegation are reported to the ICB Board, including:
    - Details of any mitigations planned and/or in place; and
    - Where it is decided that action is not to be taken to address a risk, why the decision was made, by whom and when.
- Ongoing risks to POD services have been identified and recorded on the Corporate Risk Register, with arrangements in place to manage them effectively with controls and mitigating actions being identified and tracked where required.
- The ICB has considered new risks post delegation and where changes to the risk profile are required (e.g. around capacity, reputation) mitigating actions have been identified.

Risks

- If risks are not identified on a timely basis, this will impact the ICB's ability to react and mitigate these appropriately.
- If risks are not regularly monitored there is a risk that they may not be mitigated appropriately, increasing the residual risk score.

Limitations of scope

The scope of this review will be limited to the areas outlined within these scope tables. Our work will be performed on a sample basis. We will not be testing the completeness nor accuracy of the information provided nor reconciling figures back to source data. This review will not provide assurance that the ICB is compliant with its statutory responsibilities.

Internal audit work is performed in accordance with PwC's Internal Audit methodology which is aligned to the Public Sector Internal Audit Standards. As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Committee (IAASB), International Framework for Assurance Engagements (IFAE) and International Standard on Assurance Engagements (ISAE) 3000.

Appendix C: Limitations and responsibilities

Limitations inherent to the internal auditor's work

We have undertaken this review subject to the limitations outlined below:

Internal control

Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Future periods

Our assessment of controls is for the period specified only. Historic evaluation of effectiveness is not relevant to future periods due to the risk that:

- The design of controls may become inadequate because of changes in operating environment, law, regulation or other changes; or
- The degree of compliance with policies and procedures may deteriorate.

Responsibilities of management and internal auditors

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected.

Accordingly, our examinations as internal auditors should not be relied upon solely to disclose fraud, defalcations or other irregularities which may exist.

Thank you

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North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 May 2024

Report Title	2023 Staff Survey Report	**Date of report**	17 April 2024	**Agenda Item**	2.2
Lead Director / Manager	Sarah Morgan, Chief People Officer	**Email / Tel**		Sarahlouise.morgan@nhs.net	
Board Member Sponsor	Sarah Morgan, Chief People Officer				
Report Author	Dr Rhia Gohel, Head of Organisational Development	**Email / Tel**		r.gohel@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Not applicable.			
Report Summary	This report provides a high-level overview of the 2023 national Staff Survey results for NCL ICB and compares our performance both with the 40 other ICBs in England who participated in the survey (41 in total) and also drills down into our comparison with our London counterparts. Although we have made some headway in some key areas, the results are indicative of an organisation whose staff do not consistently have a good experience. This has been amplified by, but not fully a result of, the significant organisational change we have undergone throughout the past year and this theme is felt throughout the analysis. Our completion rate was 54.7%, indicating that we are the ICB with the lowest response rate this year. This is incredibly disappointing and although we took a decision not to promote the Staff Survey during the change programme, as it was felt that it would be insensitive, it is clear by looking at the significantly worsened staff morale score, it is more likely to be indicative of our current levels of engagement across the organisation. Key findings The staff survey results are analysed against the nine categories – the seven elements of the People Promise[1] which form a key part of the NHS People Plan plus staff engagement and staff morale. It is disappointing to note that the ICB is below average against all the themes.				

[1] https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/

	In terms of identifying where we want to focus our attention in 2024, we are honing in on the key areas where staff have fed back, we need to significantly improve - which are: • We are always learning • Staff engagement • Staff Morale We are also utilising the thematic feedback from the Staff Network safe space conversations to ensure we are hearing from staff in multiple forums. It is worth highlighting that there are areas of improvement, which are attributed to line management and team behaviours. We have seen an improvement since we implemented the Core Skills for managers programme in 2022 and almost and almost 80 managers went through the 8-week programme, 8 participants then went on to undertake the UCLH Leadership Development Programme. However, we acknowledge that there is a lot more to do, particularly with reference to bullying and harassment for all staff and supporting people to develop both personally and professionally. Our key findings are set out below. **<u>Improved</u>** • Our most positive result is the **improvement of colleagues feeling their teams deal with disagreements constructively**; a score that has improved by 5%. This is in line with broader trends that indicate that relationships between colleagues and colleagues and managers have improved year-on-year. • We have also seen some **improvements in the line manager/staff member relationship**, including improved scores around colleagues feeling more involved in decision making around their work (3% improvement), and managers taking a positive interest in colleagues health and wellbeing (4% improvement). This continues the trend that we saw in 2022, of where there has been an ongoing thematic improvement in the relationship between our colleagues and their line managers. **Declined** • Some of our most declined scores appear as if they may be directly, or indirectly related to the change management programme. Out of our most declined scores, 3 questions specifically related staff considering leaving the organisation. • This has not been a surprise given all ICBs have had the same Running Cost Allowance (RCA) reduction challenge and so is not unique to NCL, however the scale of the organisational change programme that we have undertaken, has been more significant than many other ICBs nationally and may have had a more adverse impact on how staff view and experience the organisation. • It is worth noting that the Voluntary Redundancy Scheme was launched around the same time as the launch of the Staff Survey. There is therefore a reasonable chance that this could have adversely impacted the scores for this year's Staff Survey. For this reason, we re-analysed the data and looked at the next set of **lowest scoring** questions that were considered to not be because of the organisational change programme. These

questions highlighted that **access to the right learning and development opportunities, fair opportunities for career progression and the organisation taking positive action on health and wellbeing were highlighted**. For example, the data indicates that indicates staff are not feeling as if the organisation is investing in their learning and development in comparison to the ICB organisation average (a difference of 17%).

- A more **concerning decline has been 'recommending the organisation as a place to work'**, with this year's data reporting 43%; a reduction of 14% on the 2022 data.

Our actions to date

Although we have been undergoing significant change, we have not been standing still in terms of starting to put in place actions to address the staff survey results. In July 2023 the Board approved the organisational OD plan, which is a three-year plan (2023 – 2026) to start to address the feedback in the 2022 staff survey. Although this was not in time to materially impact the 2023 staff survey, however as this is a multi-year plan we anticipate that the work undertaken should start to show some strides to improving staff experience in the organisation by the time of the 2024 survey.

Some of our key programmes of OD work are as follows:

- As part of the change programme, investment has been made to establish an **OD Team** in the People and Culture directorate to support the development of our culture. The OD Team will work in a consultative capacity alongside our leaders to support them in creating the right environment for their teams to thrive. It will also work at an organisational level, ensuring that we are able to provide the right resources and pathways for our vision and strategic goals to be achieved.

- Recognising that the **high performing teams** are the building block of our organisation we have invested in a High Performing Teams programme. This will enable all teams within the new organisational structure to identify new ways of working and support the development of an improved local culture to achieve our organisational objectives. This piece of work has already commenced, with 12 teams (made up of 174 staff) completing the programme in March. Phase One of the programme aims to complete in Summer 2024, and from there will be further developed by our OD Team to develop a continuous team development offer.

- Launched a **Senior Leadership Development Programme** in March 2024. This year long programme aims to invest in our most senior leaders to support them to navigate leadership in an environment that requires them to create the conditions for cultural change as well as to facilitate innovative systems leadership and thinking.

- Developing a **Leadership Competency framework** which provides an aspirational foundation and aims to support all leaders from across the organisation to invest in themselves and be the best leaders they can be.

- In response to the change programme EQIA, a full **Inclusive Recruitment (IR) Programme** has been developed to support the requirement for a fair and equitable process throughout our recruitment to roles within the different stages of the organisational change programme. Over 50 Inclusive Recruitment Advisors - representing all protected characteristics - have been trained and every single interview panel has included an IR

	Advisor to ensure a fair process, with a particular focus on the EQIA outcomes regarding the potential for race and age discrimination. • Currently undertaking a **Learning and Development Review** to identify the offer for staff. This will be end to end, starting with onboarding through to professional and personal development and career progression. A full **Training Needs Analysis**, is being undertaken as part of the Review to identify how we can best equip our staff with the right skills and experience to excel in the delivery of our vision for population health improvement and respond to the new challenges faced by our system and increasing requirements of our partners and regulators. • In early April we released for **recruitment** all vacancies that have not been considered suitable alternative employment for at risk staff to ensure we can start to stabilise our new organisational structure and support the wellbeing of our staff. • We are bringing all our staff together in April for our second **All Staff Away Day.** This is an in-person event that will enable our staff to connect with each other; reflect on the experience since the last away day in December 2022 and look forward to starting to deliver on our vision and the improvements we want to make for the benefit of our residents and patients in NCL. Improving the experience of our staff is a vital part of ensuring NCL is a great place to work. Although we have made a good start, there is more to do and embedding the new learning and development offer, upskilling managers, and creating the conditions for staff to thrive are a key part of our focus throughout 2024/25. The paper sets out the more detailed analysis and appendix 1 sets out the detail against the NHS People Promise.
Recommendation	The Board of Members is asked to **NOTE** the contents of this report.
Identified Risks and Risk Management Actions	The risks and risk management action associated with not improving our staff survey results are captured in the Board risk: PC1 Engage and motivate staff in order to retain a high performing workforce
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	Informal and Formal Joint Partnership Group. NCL ICB Executive Management Team. NCL ICB Senior Leadership Team. People & Culture Oversight Group.
Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010.

Report History and Key Decisions	Not applicable
Next Steps	This report is to be reviewed by the Board.
Appendices	Appendix 1 – Staff survey results breakdown against the People Promise

NHS
North Central London
Integrated Care Board

2023 Staff Survey Report

April 2024

1. Executive summary

This report provides a high-level overview of the 2023 national Staff Survey results for NCL ICB and compares our performance both with the 40 other ICBs in England who participated in the survey (41 in total) and also drills down into our comparison with our London counterparts.

Although we have made some headway in some key areas, the results are indicative of an organisation whose staff do not consistently have a good experience. This has been amplified by, but not fully a result of, the significant organisational change we have undergone throughout the past year and this theme is felt throughout the analysis.

Our completion rate was 54.7%, indicating that we are the ICB with the lowest response rate this year. This is incredibly disappointing and although we took a decision not to promote the Staff Survey during the change programme, as it was felt that it would be insensitive, it is clear by looking at the significantly worsened staff morale score, it is more likely to be indicative of our current levels of engagement across the organisation.

Our overall response rates are set out in *Figure 1* below.

Figure 1: Response rate

713 Staff (permanent & fixed term) were invited to complete the survey

390 Staff in total completed the survey

Agency workers and clinical leads are not invited to complete the survey.

55%

Response rate

11% **Reduction in our year-on-year data**

n = 442; 2022
n = 390; 2023

Real-terms decrease in respondents

Directorate	Respondents	Response Rate
Whole organisation	390	54.7%
Chief Nursing Officer	71	51.8%
Corporate Affairs	38	82.6%
Dev & Pop Health – Place	77	57.9%
Development & Population Health	50	49.0%
EMT & People & Culture	11	73.3%
Finance	33	61.1%
Performance & Transformation	103	50.5%

Key findings

The staff survey results are analysed against the nine categories – the seven elements of the People Promise[1] which form a key part of the NHS People Plan plus staff engagement and staff morale. *Figure 2* provides a summary by themes against the national ICB average and both best and worst performing ICBs across the country.

It is disappointing to note that the ICB is below average against all the themes. In terms of identifying where we want to focus our attention in 2024, we are honing in on the key areas where staff have fed back we need to significantly improve - which are set out in *Figure 3* and are:

- We are always learning
- Staff engagement
- Staff Morale

[1] https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/

We are also utilising the thematic feedback from the Staff Network safe space conversations to ensure we are hearing from staff in multiple forums.

It is worth highlighting that there are areas of improvement, which are attributed to line management and team behaviours. We have seen an improvement since we implemented the Core Skills for managers programme in 2022 and almost 80 managers went through the 8-week programme, 8 participants then went on to undertake the UCLH Leadership Development Programme. However, we acknowledge that there is a lot more to do, particularly with reference to bullying and harassment for all staff and supporting people to develop both personally and professionally.

Our key findings are set out below.

Improved

- Our most positive result is the **improvement of colleagues feeling their teams deal with disagreements constructively**; a score that has improved by 5%. This is in line with broader trends that indicate that relationships between colleagues and colleagues and managers have improved year-on-year.

- We have also seen some **improvements in the line manager/staff member relationship**, including improved scores around colleagues feeling more involved in decision making around their work (3% improvement), and managers taking a positive interest in colleagues health and wellbeing (4% improvement). This continues the trend that we saw in 2022, of where there has been an ongoing thematic improvement in the relationship between our colleagues and their line managers.

Declined

- Some of our most declined scores appear as if they may be directly, or indirectly related to the change management programme. Out of our most declined scores, 3 questions specifically related staff considering leaving the organisation.

- This has not been a surprise given all ICBs have had the same Running Cost Allowance (RCA) reduction challenge and so is not unique to NCL, however the scale of the organisational change programme that we have undertaken, has been more significant than many other ICBs nationally and may have had a more adverse impact on how staff view and experience the organisation.

- It is worth noting that the Voluntary Redundancy Scheme was launched around the same time as the launch of the Staff Survey. There is therefore a reasonable chance that this could have adversely impacted the scores for this year's Staff Survey. For this reason, we re-analysed the data and looked at the next set of **lowest scoring** questions that were considered to not be because of the organisational change programme. These questions highlighted that **access to the right learning and development opportunities, fair opportunities for career progression and the organisation taking positive action on health and wellbeing were highlighted**. For example, the data indicates that indicates staff are not feeling as if the organisation is investing in their learning and development in comparison to the ICB organisation average (a difference of 17%).

- A more **concerning decline has been 'recommending the organisation as a place to work'**, with this year's data reporting 43%; a reduction of 14% on the 2022 data.

Our actions to date

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we anticipate that the work undertaken should start to show some strides to improving staff experience in the organisation by the time of the 2024 survey.

Some of our key programmes of OD work are as follows:

- As part of the change programme, investment has been made to establish an **OD Team** in the People and Culture directorate to support the development of our culture. The OD Team will work in a consultative capacity alongside our leaders to support them in creating the right environment for their teams to thrive. It will also work at an organisational level, ensuring that we are able to provide the right resources and pathways for our vision and strategic goals to be achieved.

- Recognising that the **high performing teams** are the building block of our organisation we have invested in a High Performing Teams programme. This will enable all teams within the new organisational structure to identify new ways of working and support the development of an improved local culture to achieve our organisational objectives. This piece of work has already commenced, with 12 teams (made up of 174 staff) completing the programme in March. Phase One of the programme aims to complete in Summer 2024, and from there will be further developed by our OD Team to develop a continuous team development offer.

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- In response to the change programme EQIA, a full **Inclusive Recruitment (IR) Programme** has been developed to support the requirement for a fair and equitable process throughout our recruitment to roles within the different stages of the organisational change programme. Over 50 Inclusive Recruitment Advisors - representing all protected characteristics - have been trained and every single interview panel has included an IR Advisor to ensure a fair process, with a particular focus on the EQIA outcomes regarding the potential for race and age discrimination.

- Currently undertaking a **Learning and Development Review** to identify the offer for staff. This will be end to end, starting with onboarding through to professional and personal development and career progression. A full **Training Needs Analysis**, is being undertaken as part of the Review to identify how we can best equip our staff with the right skills and experience to excel in the delivery of our vision for population health improvement and respond to the new challenges faced by our system and increasing requirements of our partners and regulators.

- In early April we released for **recruitment** all vacancies that have not been considered suitable alternative employment for at risk staff to ensure we can start to stabilise our new organisational structure and support the wellbeing of our staff.

- We are bringing all our staff together in April for our second **All Staff Away Day.** This is an in-person event that will enable our staff to connect with each other; reflect on the experience since the last away day in December 2022 and look forward to starting to deliver on our vision and the improvements we want to make for the benefit of our residents and patients in NCL.

Improving the experience of our staff is a vital part of ensuring NCL is a great place to work. Although we have made a good start, there is more to do and embedding the new learning and development offer, upskilling managers, and creating the conditions for staff to thrive are a key part of our focus throughout 2024/25. The further actions we plan to take are set out in Section 5: Next Steps.

2. People Promise Scores

ICB comparison data

The staff survey results are analysed against the nine categories – the seven elements of the People Promise[2] which form a key part of the NHS People Plan plus staff engagement and staff morale. *Figure 2* provides a summary by themes against the national ICB average and both best and worst performing ICBs across the country.

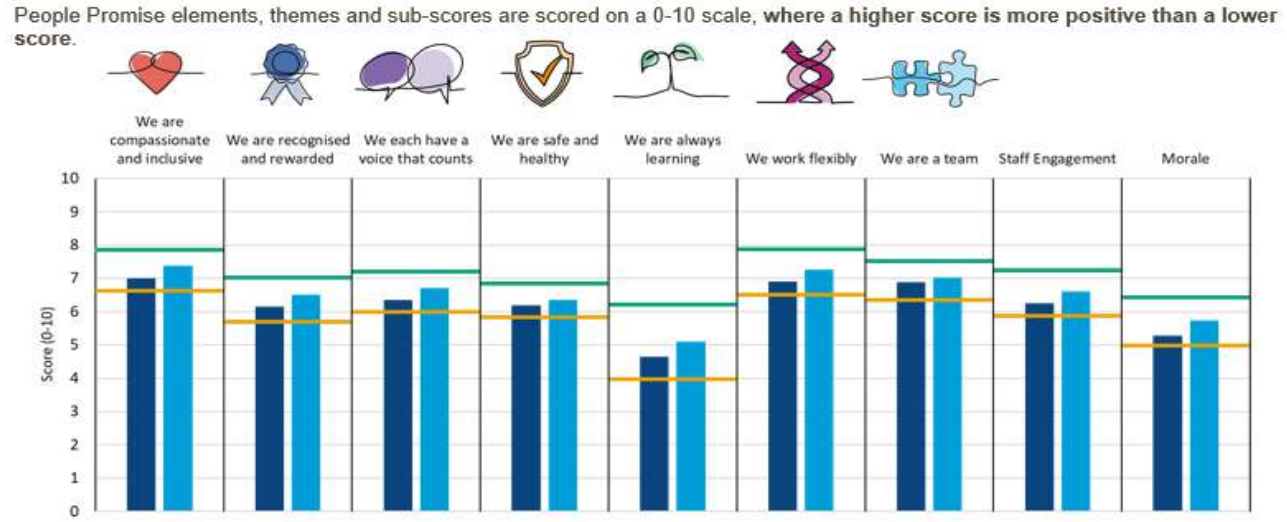
It is disappointing to note that the ICB is below average against all the themes. We are particularly focused on the key areas where staff have fed back we need to significantly improve - which are set out in *Figure 3* and are:

- We are always learning
- Staff engagement
- Staff Morale

For a more detailed breakdown the full report can be accessed here.[3]

It is also important to note that this is the first year that data on sexual safety in the workplace has been collated, which will enable organisations to build a better picture of unwanted behaviour that our colleagues may experience in the workplace. We do not have 100% of staff telling us that they have not experienced this (98%) and so we do need to ensure that all staff are protected from unwanted behaviour of a sexual nature from patients/service users, their relatives, members of the public, as well as colleagues.

Figure 2: 2023 NCL ICB People Promise Scores compared to other ICB organisations



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Our org	7.01	6.15	6.35	6.19	4.64	6.90	6.88	6.25	5.28
Best result	7.85	7.03	7.19	6.84	6.20	7.87	7.52	7.24	6.43
Average result	7.38	6.51	6.71	6.34	5.10	7.26	7.03	6.61	5.74
Worst result	6.63	5.70	5.98	5.82	3.96	6.50	6.35	5.87	4.99
Responses	389	390	386	388	366	390	389	390	390

[2] https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/
[3] https://cms.nhsstaffsurveys.com/app/reports/2023/QMJ-benchmark-2023.pdf

Figure 3: 2023 NCL ICB People Promise Scores areas of statistically significant change

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	7.24	441	7.01	389	Not significant
We are recognised and rewarded	6.37	440	6.15	390	Not significant
We each have a voice that counts	6.57	440	6.35	386	Not significant
We are safe and healthy	6.36	441	-	-	-
We are always learning	5.08	425	4.64	366	Significantly lower
We work flexibly	7.01	439	6.90	390	Not significant
We are a team	6.91	441	6.88	389	Not significant
Themes					
Staff Engagement	6.67	442	6.25	390	Significantly lower
Morale	5.70	442	5.28	390	Significantly lower

Appendix 1 sets out the detailed findings of the staff survey mapped against the People Promise Indicators

Comparison of London ICBs

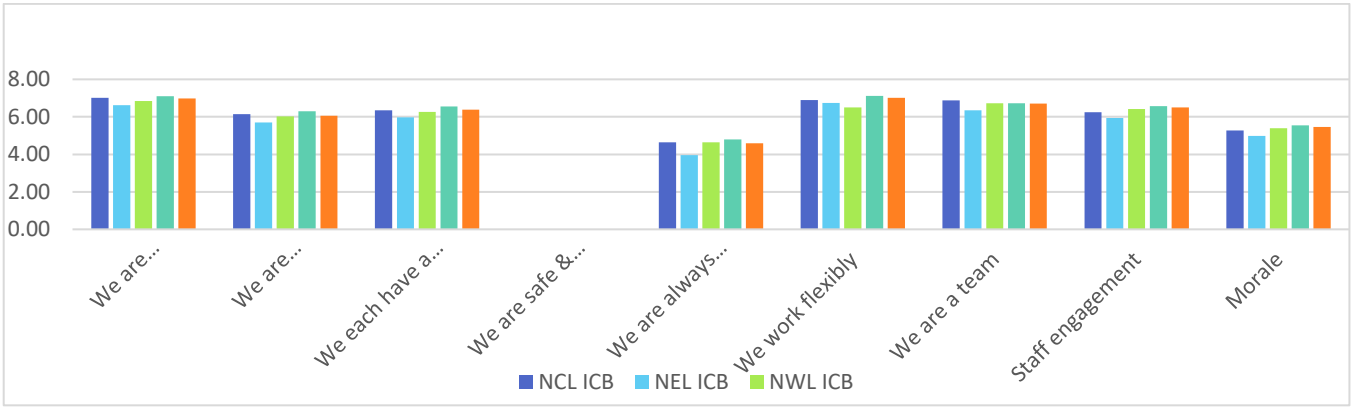
Ensuring that we remain an employer of choice is vitally important to our success. To ensure that our staff experience is equal or better that other ICBs in London is a crucial part of retaining the best talent. Although all London ICBs are just below national average against all the People Promise themes, NCL does perform higher in some areas, however staff morale remains a concern.

As part of our talent development approach, we will be aiming to significantly improve our performance against the other ICBs in London.

NCL performance compared to London ICBs:

- We Are a Team - NCL performed the best out of all the London ICBs
- Compassionate and Inclusive and Always Learning - NCL performed above average
- Recognised and Rewarded, Each Have a Voice That Counts, and Work Flexibly - NCL performed around average
- Staff Morale - NCL was below average.

Figure 3: 2023 People Promise theme scores for London ICBs



	We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
NCL ICB	7.01	6.15	6.35	n/a	4.64	6.90	6.88	6.25	5.28
NEL ICB	6.63	5.70	5.98	n/a	3.96	6.74	6.35	5.94	4.99
NWL ICB	6.85	6.03	6.27	n/a	4.64	6.50	6.72	6.41	5.40
SEL ICB	7.10	6.29	6.56	n/a	4.79	7.12	6.73	6.58	5.55
SWL ICB	6.99	6.06	6.39	n/a	4.59	7.01	6.71	6.51	5.47

**Please note, data for 'We are Safe and Healthy' is currently not available. This is because a problem was identified with the quality of the data. For this reason, the benchmarking reports for each organisation have not been updated at this time, but revised results are expected to be published at the end of May 2024.*

3. Equality data

The below sections outline the organisation's performance for Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) scores, taken from the 2023 Staff Survey data. Please note that a more comprehensive report showing the ICB's performance against the specific WRES and WDES indicators and key priorities will be considered by the Board in July 2024 as part of the suite of Equalities papers.

Workforce Race Equality Standard (WRES)

The WRES data shows an increase in staff from a BAME background reporting experiencing bullying and harassment from patients/service users and staff and a decline in experience of staff from a white background in these areas. There has however been a reduction of staff from a BAME background reporting feeling discrimination from mangers, team leaders or colleagues. White staff members however have reported an increase in experiencing discrimination from a colleague, team leader or manager.

There has been a decline in both staff from a white and BAME background feeling that the organisation acts fairly with regards to career progression opportunities.

Figure 4 sets out the staff survey questions which are used to assess NHS organisations performance against some of the Workforce Race Equality Standards (WRES). The table below shows the areas that the ICB has improved/declined in comparison to the 2022 results.

Our OD plan includes a planned Civility and Respect and microaggressions programme for all staff to improve the experience of all staff within the organisation. We are also utilising the thematic feedback from the Staff Network safe space conversations to ensure we are hearing from staff in multiple forums and gaining more detailed and better insights into their experience.

Figure 4: WRES 2023 Staff Survey Data

The results highlighted in red show a decline in positive results in comparison to the 2022 results.
The results highlighted in green show an increase in positive results in comparison to the 2022 results.

WRES Staff Survey Questions	2022		2023	
	White	BAME	White	BAME
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from…Patients / service users, their relatives or other members of the public	7.9%	5.3%	7.6%	6.7%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	22.8%	22.7%	19.4%	24.1%
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	49.2%	34.5%	41.1%	32.3%
In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / team leader or other colleagues	7.5%	18%	11.1%	14.9%

**Number of responses did not meet the suppression threshold to publish the response to this question*

Workforce Disability Equality Standard (WDES)

Figure 5 for Workforce Disability Equality Standards (WDES) sets out the staff survey questions that are used as the WDES indicators. As the nature of the question has changed, there is no comparable data available to measure whether there has been an increase or decrease in the number of staff with a disability experiencing harassment, bullying or abuse from patients, managers or colleagues.

However, there has been an improvement in the numbers of staff with a disability that reported harassment, bullying or abuse. This could be attributed to the frequent disability/long term conditions awareness events that are run by the Disability, Long Term Conditions and Carers Staff Network, and the roll out of the workplace adjustment passport in 2021.

Nevertheless, there has been a worsening of the number of staff with a disability feeling pressure to come into work when they do not feel well enough to and a worsening in the number of staff with a disability reporting that the provides equal opportunities for career progression or promotion. There has also been a decrease in the number of staff reporting that they are satisfied to the extent of which their organisation values their work.

Figure 5: WDES 2023 Staff Survey Data

WDES Staff Survey Questions	2022		2023	
	No LTC	With LTC	No LTC	With LTC
Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients, managers or colleagues	*	*	22.0%	32.1%
Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	44%	38.5%	39.6%	39.4%
Percentage of disabled staff compared to non-disabled staff believing that their trust provides equal opportunities for career progression or promotion	43.8%	36.2%	37.7%	32.4%
Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	18%	23.2%	12.0%	25.8%
Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	51.6%	37.1%	45.8%	32.1%
Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	*	74.1%	*	70.7%

**indicates no comparable data from previous year*

4. Progress against our three-year OD plan

The design of our organisational change programme contained 3 key strands: Organisational Design, Ways of Working and Organisational Development. As part of the OD strand, the 2023-26 OD Plan was approved by the Board in July 2023 with the agreement that this would form the overarching organisation level staff survey action plan.

The OD plan is based on best practice in the form of the evolved Culture and Leadership Programme[4], developed by Professor Michael West and sponsored by NHSE. This focuses on 6 key pillars: Vision and Values, Goals and Performance, Learning and Innovation, Support, Compassion and Wellbeing, Equity and Inclusion and Team and System Working. Work has already begun to meet some of the objectives in these 6 areas. This includes:

- As part of the change programme, investment has been made to establish an **OD Team** in the People and Culture directorate to support the development of our culture. The OD Team will work in a consultative capacity alongside our leaders to support them in creating the right environment for their teams to thrive. It will also work at an organisational level, ensuring that we are able to provide the right resources and pathways for our vision and strategic goals to be achieved.

- Recognising that the **high performing teams** are the building block of our organisation we have invested in a High Performing Teams programme. This will enable all teams within the new organisational structure to identify new ways of working and support the development of an improved local culture to achieve our organisational objectives. This piece of work has already commenced, with 12 teams (made up of 174 staff) completing the programme in March. Phase One of the programme

[4] https://www.england.nhs.uk/culture/culture-leadership-programme/the-evidence-base/

aims to complete in Summer 2024, and from there will be further developed by our OD Team to develop a continuous team development offer.

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- Developing a **Leadership Competency framework** which provides an aspirational foundation and aims to support all leaders from across the organisation to invest in themselves and be the best leaders they can be.

- In response to the change programme EQIA, a full **Inclusive Recruitment (IR) Programme** has been developed to support the requirement for a fair and equitable process throughout our recruitment to roles within the different stages of the organisational change programme. Over 50 Inclusive Recruitment Advisors - representing all protected characteristics - have been trained and every single interview panel has included an IR Advisor to ensure a fair process, with a particular focus on the EQIA outcomes regarding the potential for race and age discrimination.

- Currently undertaking a **Learning and Development Review** to identify the offer for staff. This will be end to end, starting with onboarding through to professional and personal development and career progression. A full **Training Needs Analysis**, is being undertaken as part of the Review to identify how we can best equip our staff with the right skills and experience to excel in the delivery of our vision for population health improvement and respond to the new challenges faced by our system and increasing requirements of our partners and regulators.

- In early April we released for **recruitment** all vacancies that have not been considered suitable alternative employment for at risk staff to ensure we can start to stabilise our new organisational structure and support the wellbeing of our staff.

- We are bringing all our staff together in April for our second **All Staff Away Day.** This is an in-person event that will enable our staff to connect with each other; reflect on the experience since the last away day in December 2022 and look forward to starting to deliver on our vision and the improvements we want to make for the benefit of our residents and patients in NCL.

5. Next steps

A review of the progress from the first year of the OD plan will be considered by the Board in July, along with the suite of Equalities papers that are indicators of our progress. As we come to the end of the design element of our change programme, our focus will shift to the organisational development and ways of working workstreams. A high-level overview of some of the areas of focus, which will be discussed in more detail at the July Board include:

Organisational Development

- Launching our Big Conversation around our identity, goals, values and strategic objectives, which will start at the All Staff Away Day and build momentum from there.
- A values redesign and relaunch through the Big Conversation, leading to the development of a values and behaviours framework which will underpin a more comprehensive overhaul of the appraisal process in 12 months time
- Formalising the establishment of our OD offer to the organisation; working in alignment with colleagues from HR and senior leadership to support the whole organisation to mature and develop in line with our strategic objectives
- Supporting our directorates to improve their staff experience and engagement through the development of localised OD Action Plans

- Wellbeing conversations toolkit for line managers and staff members, to better support our staff in having effective wellbeing conversations with their senior leaders that create a culture we can be proud of
- Investing in our Staff Networks and developing our Network Chairs
- Continuation of our Team Development and High Performing Teams work
- Scoping and launch of a staff engagement tool to test the temperature of the organisation and receive feedback on a more regular basis than the annual staff survey
- Formally launching our Learning and Development offer to the organisation to ensure that all staff have equitable access to high quality learning and development opportunities
- Launching a formalised approach to supervision for our staff to enable them to learn from real examples in their work
- Introduction of a restorative Just & Learning Culture into HR Practices
- Taking forward the actions associated with pledging to the National Sexual Safety Charter
- Continuing to recruit to our vacancies as quickly as possible to ensure we can stabilise the organisation and improve staff wellbeing

Ways of working

- Continuing to support the safe transition of work, which underpins our new operating model
- Progressing at pace the automation committed to as part of the organisational design in the first three key areas of Finance, HR and Complex Care
- Continuing the work to streamline and improve our systems and processes to support staff to have a better experience of work and reducing the need for work arounds and levels of approval.
- Finding new and better ways for staff to collaborate, learn from each other and our partners and improve their sense of belonging in the workplace

6. Conclusion

We acknowledge that the staff survey results are disappointing as they reflect that our staff do not currently feel they have a good experience of working in the organisation. There are however some green shoots, particularly in terms of line management support and team identity that we will continue to build from. The comprehensive organisational development plan coupled with the directorate localised staff survey (OD) action plans, should enable us to make significant progress over the next year.

Although the timing of the staff survey was challenging from an organisational change perspective, we are not going to use that as an excuse and remain committed to listening to our staff and moving forward to ensure that NCL ICB becomes a great place to work and receive treatment.

Appendix One

North Central London
Integrated Care Board

2023 Staff survey results mapped against the People Promise Indicators

1. Our key themes

People Promise themes

North Central London
Integrated Care Board

We are compassionate & inclusive

Compassionate leadership: There has been a slight increase in all 4 questions related to compassionate leadership including: colleagues feeling like their immediate manager works with them to come to an understanding of problems, listening when describing challenges faced, caring about concerns and manager taking effective action to help me with any problems they face.

Compassionate Culture: There has been a decline in all 5 questions related to a compassionate culture, including care of patients/service users is my organisation's top priority, my organisation acts on concerns raised by patients/service users and I would recommend my organisation as a place to work. This is in line with the national average.

Diversity and Equality: Our data shows us that there has been a decline in the number of staff feeling as if the organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age. This is notable as it is close to the worst reported result (our org 36.69%; worst result 33.53%). The ICB also has performed poorly around experiencing discrimination at work from a manager/team leader or other colleagues, with a 6.08% difference in comparison to the average ICB result.

Inclusion: The ICB has seen a slight increase in the number of staff reporting that they feel valued by their team (2.09% increase), bringing it just under the ICB average score in this area. However, there has been a slight decrease in the number of people reporting that they have a strong personal attachment to their team, that the people they work with are understanding and kind to one another and the people they work with are polite and treat each other with respect, putting the ICB below the national average in each of these 3 areas.

We are recognised & rewarded

Recognition for good work: There has been a decline in the number of staff reporting that they get recognition for good work. This is in line with the ICB Average trend, however the organisation has performed 7.38% worse than the national average.

Organisation values my work: In line with the national trend, the organisation's scores on staff feeling as if the organisation values their work has reduced year on year. The ICB has performed 2.63% less than the national average.

Level of pay: The data shows that the ICB has had a slight increase in the number of staff feeling satisfied with their level of pay, however it is still 3.44% below the national average.

Showing appreciation to one another: In line with the national trend, the number of staff reporting that the people they work with show appreciation to one another has reduced year-on-year, with the ICB performing 4.55% below the national average.

Immediate manager values work: Our year-on-year data shows that there has been a 2.75% reduction in the number of staff feeling like their immediate manager values their work.

1. Our key themes

People Promise themes

North Central London
Integrated Care Board

We each have voice that counts

Autonomy and control: In each of the questions that measures feelings of autonomy and control, staff have reported a decline on year-on-year data. This is broadly in line with national trends. In every question, the reported data has also been below the national average.

Raising concerns: In line with the national trend, the organisation's scores on staff feeling secure in raising concerns have declined year-on-year, however it is important to note that the ICB is performing below the national average.

We are safe and healthy

Health and safety climate: In 3 of the questions (Q3g. I am able to meet all the conflicting demands on my time at work; Q3h. I have adequate materials, supplies and equipment to do my work and Q3i. There are enough staff at this organisation for me to do my job properly) the ICB has moved closer to the national average score than in previous years, however there has been a decline in Q3g and Q3i across the board. Most notably, there has been a significant decline in staff feeling as if the organisation takes positive action on health and wellbeing, with a 9.54% year-on-year reduction. This is also 8.36% less than the national average.

Burnout: In line with the national trend, there has been an increase in the number of staff experiencing burnout in the workplace. For all questions measuring burnout, staff scores have increased which indicates that more staff are experiencing exhaustion from work. The ICB is particularly close to the worst reported result for Q12g. (How often, if at all, do you not have enough energy for family and friends during leisure time), with the ICB reporting 31.11% and the worst reported result at 32.02%.

Negative experiences: In line with the general national trend, there has been a decrease in the number of staff reporting they have experienced MSK issues as a result of work activities, however, there has been an increase in the number of staff reporting that they have felt unwell as a result of work related stress and coming into work despite not feeling well enough to perform duties. Staff have also reported an increase in experiencing bullying and harassment in the workplace from other colleagues, although experiencing this from managers has slightly declined.

Unwanted sexual behaviour: No staff who took part in the survey reported they have been the target of unwanted sexual behaviours in the workplace from patients/service users, however 2.32% of our staff reported that they have been the target of unwanted sexual behaviour in the workplace from staff/colleagues.

We are always learning

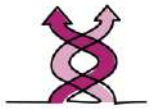
Development: In each of the questions that measures development, there has been a decrease in the number of staff feeling as if the organisation invests in development. This is broadly in line with the national trend. It is important to note that the ICB year-on-year data for each question has also reduced for each area, most notably in q24b there are opportunities for me to develop my career in this organisation, which has seen just over a 10% year-on-year decrease.

Appraisals: There has also been a decrease in the number of staff reporting that they have had an appraisal, however for those staff that did, there has been a slight increase in the number of staff feeling that their appraisal helped them to improve how they do their job.

1. Our key themes

People Promise themes

North Central London
Integrated Care Board



We work flexibly

Support for work-life balance: There has been a year-on-year reduction in the number of staff feeling that they achieve a good work life balance, which is broadly in line with the national trends.

Flexible working: There has been a slight reduction in the number of staff reporting that they are satisfied with the opportunities for flexible working patterns, approximately a 1% decrease year-on-year.

We are a team

Team working: Overall, there has been a reduction in the number of staff reporting that they feel they have a set of shared objectives, that they meet often to discuss the team's effectiveness, and that they receive the respect they deserve from colleagues at work, with the organisation performing below the national average. There has been a slight increase in team members feeling that they understand each other's roles and that they enjoy working with their team, bringing the organisation roughly in line with the national average for these two areas,

Line management: For each of these areas there has been a slight increase in staff reporting positive improvements in their line manager providing encouragement, clear feedback and asking for their opinion before making decisions that affect their work, bringing the ICB broadly in line with the national average. There has also been a 4.04% year-on-year increase in the number of staff reporting that their immediate manager takes a positive interest in their health and wellbeing.

Staff engagement

Motivation: For all areas measuring motivation, there has been a significant decrease in staff looking forward to going to work, feeling enthusiastic about their job and that time passes by quickly when they are working. This is broadly in line with the national trend, with the ICB performing worse in every question in comparison to the national average and just being 1% above the worst reported result for q2b, I am enthusiastic about my job (NCL ICB: 48.97%).

Involvement: For all areas measuring involvement, there has been a decrease in the number of staff reporting that they feel involved in work. This is in line with the national trend, with the ICB performing worse in every question in comparison to the national average.

Advocacy: There has also been a decrease in each of the 3 questions that measure involvement, with this being in line with the national trend. The ICB has performed worse in every question that measures engagement in comparison to the national average.

Morale

Thinking about leaving: In each of the questions that measures thinking about leaving, there has been an increase in the number of staff reporting this. The ICB had the worst result across the national data for q26b (I will probably look for a job at a new organisation in the next 12 months), scoring 48.71%, an increase in 14.62%

Work pressure: The ICB has scored broadly in line with the national average for work pressure.

Stressors: The ICB has noted a decline in each of the 7 areas that measure stressors, and is performing below the national average in all 7 questions.

Our key themes

Staff Survey Free Text analysis

105 **free text comments** were received from staff that completed the staff survey. Out of these comments, 5 were positive and 100 were negative. The themes of the negative experiences are also consistent with themes raised by staff through our trade unions, staff network 'safe space' conversations and our workforce performance data.

It is important to note that the change programme has heavily influenced the discussion at these forums and has ultimately impacted the experience of our staff over the last year. Our OD Plan, approved by the Board in July 2023, aims to address the issues that have been raised and work has already begun in improving these areas.

NHS
North Central London
Integrated Care Board

Super theme 1: Our wellbeing, development and experience

- Health and wellbeing not considered
- Lack of psychological safety
- Bullying culture
- Personal circumstances not considered
- Lack of learning and development opportunities
- In vs Out group
- Poor values and behaviours
- Discrimination
- Blame culture

Super theme 2: The way we work

- Change programme
- Financial impact on staff
- Issues with staff survey
- Ways of working
- Change programme – negative impact
- Financial constraints affecting quality of work
- Disengaged staff
- Disengagement from role
- No resources to do role

Super theme 3: Our managers

- Manager does not trust me
- EMT not connected to the organisation
- No Autonomy in workload

Super theme 4: The good parts

- Like the culture
- Good development
- Colleagues supportive

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 May 2024

Report Title	NCL ICS People Strategy Annual Report 2023/24	**Date of report**	28 April 2024	**Agenda Item**	2.3
Lead Director / Manager	Sarah Morgan, Chief People Officer	**Email / Tel**		Sarahlouise.morgan@nhs.net	
Board Member Sponsor	Sarah Morgan, Chief People Officer				
Report Author	Michael Cleary, ICS Workforce Programme Senior Manager	**Email / Tel**		Michael.cleary2@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Not applicable.			
Report Summary	The North Central London ICS People Strategy was approved by the NCL ICB Board in May 2023. The strategy is a companion strategy to the overarching Population Health and Integration Strategy, published in April 2023, and delivers on the aim of achieving a high quality, sustainable care delivery. The first year focussed on laying the foundations and developing the three pillars of Workforce Supply, Development and Transformation into a set of interventions that would start to shift the dial on some of the challenges facing the NCL health and care system. This annual report highlights what has been achieved across the system over the past year and starts to articulate the ambitions and priorities for future years. **Our NCL People Strategy Vision and Mission** NCL ICS Population Health Outcome Framework centres on the life course with Start Well, Live Well, and Age Well. Within these aims we have developed a North Central London ICS vision for our residents and community to receive high quality health and care services delivered by a representative and diverse workforce, where people are supported to achieve their full potential in an inclusive and compassionate environment, free from racism or other discrimination. Our mission is to support NCL health and social care organisations to: • be excellent employers, developing and supporting the wellbeing of existing staff and attracting new people to live and work in North London. • plan workforce and its development needs, to deliver new care models in new settings, including in integrated care systems.				

- be socially responsible organisations, using our influence and decision making to best serve the interests of our communities and to reduce inequalities.

Our analysis shows that the predicted needs of our population will require a larger health and social care workforce and that without intervention to support recruitment and retention, the workforce gap could increase from roughly 12% to 17%. We have started to make inroads into this within our first year, however a focus on innovation and digital transformation will be required over the coming years to improve the efficiency and effectiveness of our care delivery model.

Over the past year people strategy has been transformed into a programme of work, under the three pillars of the strategy – Workforce Supply, Development and Transformation. These are set out in the main body of the report, however some key achievements include:

Supply

- Our NCL Health and Social Care Academy have supported 160 residents into roles within our local health and care organisations
- Over 450 international nurses have found a new home and career in North Central London through our dedicated recruitment programme
- Reduction in nursing turnover from 13.5% in 2020 to 6% in February 2024
- Our Workforce Management Service have placed local residents into over 1,000,000 hours of healthcare work in the past two years.
- One of ten national pilots supporting young people leaving care into roles within healthcare. In the past year, over forty young people have engaged with the programme with a 25% success rate of an employment outcome.

Development

- As a priority, trained over 230 staff to be better equipped to support children and young people with their mental health needs to improve their care and treatment when they are in hospital.
- As part of our talent programme, we offered a positive action Future Leaders programme for Aspirant Executives from a Black, Asian and Minority Ethnic background across all our providers. 30% of whom have secured Executive roles already.
- Over 100 operational leaders from all disciplines have participated in 5 cohorts of a system leadership development programme to connect operational activity in our health and care organisations to our wider system priorities
- 30 nursing and midwifery Clinical Fellows have undertaken a development programme with a system placement to develop broader skills and experience

Transformation

- Over 1,000 primary care staff have been trained in our new Long Term Conditions model, which will better support our patient outcomes
- Development and launch of the 'Waiting Room' app to provide signposting and support for children and young people on the Child and Adolescent Health Services (CAMHS) waiting list
- Piloting of Artificial Intelligence (AI) solutions to support clinicians efficacy and productivity such as supporting clinical note taking with a voice technology pilot at Great Ormond Street.

The system has had a focussed effort on addressing the challenges of recruitment and retention and whilst there is a great deal of work still to be done, we are beginning to see positive impacts across several areas when comparing the 2024 position to 2023.

	Those areas where green shoots of improvement have been seen over the past year include: • NHS has seen a reduction in turnover rate of 3.5% from 15.6% in May 2023 to 12.1% in March 2024 • NHS has seen a reduction in absence rate from 4.5% in May 2023 to 4.2% in March 2024 which is below London (4.8%) and national (5.3%) averages • Mental Health has seen a 9.7% increase in substantive workforce linked to the national Mental Health Investment Standard (MIS) in the past year to stabilise the quality of the service and reduce reliance on bank and agency • Social care increased their filled posts by 1,000 and reduced their turnover rate by 3.2% in the last 12 months • NHS vacancy rate has dropped from 9% to 8.6% across NCL over the past 12 months From 2024, the NCL Integrated Care Board (ICB) have invested in a small permanent resource to lead on the delivery of the people strategy priorities and to develop the initiatives to start to accelerate the change. This report sets out the detailed achievements of our 'Laying the Foundations' year 2023/24 and outlines our intentions for our first year of 'Accelerating the Change' in 2024/25.
Recommendation	The Board of Members is asked to **DISCUSS** the contents of this report and **APPROVE** as progress against the Year 1 delivery plan.
Identified Risks and Risk Management Actions	The risks and risk management action associated with not delivering on our people strategy are captured in the Board risk: PC3 Failure to ensure sufficient workforce to deliver against increasing demand
Conflicts of Interest	This paper was written in accordance with the Conflicts of Interest Policy.
Resource Implications	National funding is expected to be attached to the delivery of the Long Term Workforce Plan and other initiatives. Any further investment would require an investment business case.
Engagement	NCL ICS People Board (virtual). NCL ICS Delivery Boards (Supply, Development, Transformation) virtual.
Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	Not applicable.
Next Steps	Once approved the report will be sent to be transferred into the new ICS branding and published on the website as the annual report.
Appendices	None.

North Central London
Integrated Care System

NCL ICS People Strategy

Annual Report

2023/2024

May 2024

Foreword

I am delighted to present the results of the first year of delivery of our NCL ICS People Strategy.

We have made great strides over the past year against a backdrop of a challenging financial and waiting list recovery position coupled with unprecedented levels of industrial action. This is a testament to the hard work and dedication of our staff and partners across the entire health and care system.

This has been a true system effort, and I have been impressed by the commitment shown to the shared ambitions of our people strategy as part of the delivery our population health and integration strategy.

There are a number of achievements set out in this report and I would like to draw attention to a few that, quite rightly, we are most proud of.

- Supported 160 residents into roles within our local health and care organisations
- Over 450 international nurses have found a new home and career in North Central London through our dedicated recruitment programme
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- One of ten national pilots supporting young people leaving care into roles within healthcare. In the past year, over forty young people have engaged with the programme with a 25% success rate of an employment outcome.

The publication of the NHS Long Term Workforce Plan on 30 June 2023, gave further ambition to our plan, particularly regarding building a sustainable supply of workforce. As the national plans crystalise over the coming year we are well placed to accelerate the requirements across NCL.

Our collective achievements are amongst many that we can be rightfully proud of and that we look to build upon as we move forward. Thank you to those whose work has brought us to this point. I hope that you enjoy reviewing the year's progress.

Phill Wells, Chief Executive Officer

NHS North Central London Integrated Care Board

Executive Summary

The North Central London ICS People Strategy was approved by the NCL ICB Board in May 2023. The strategy is a companion strategy to the overarching Population Health and Integration Strategy, published in April 2023, and delivers on the aim of achieving a high quality, sustainable care delivery.

The first year focussed on laying the foundations and developing the three pillars of Workforce Supply, Development and Transformation into a set of interventions that would start to shift the dial on some of the challenges facing the NCL health and care system.

This annual report highlights what has been achieved across the system over the past year and starts to articulate the ambitions and priorities for future years.

Our NCL People Strategy Vision and Mission

NCL ICS Population Health Outcome Framework centres on the life course with Start Well, Live Well, and Age Well.

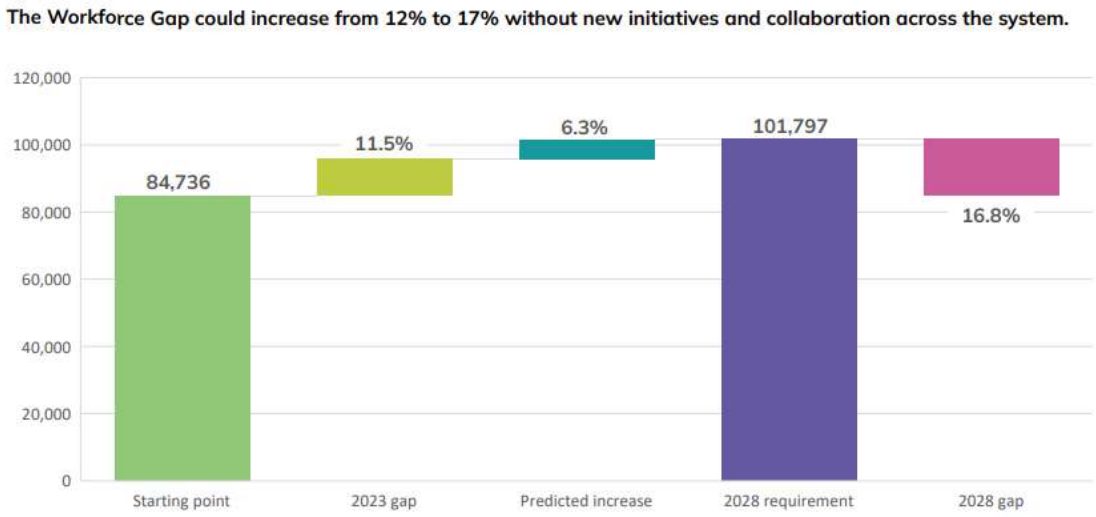
Within these aims we have developed a North Central London ICS vision for our residents and community to receive high quality health and care services delivered by a representative and diverse workforce, where people are supported to achieve their full potential in an inclusive and compassionate environment, free from racism or other discrimination.

Our mission is to support NCL health and social care organisations to:

- be excellent employers, developing and supporting the wellbeing of existing staff and attracting new people to live and work in North London.
- plan workforce and its development needs, to deliver new care models in new settings, including in integrated care systems.
- be socially responsible organisations, using our influence and decision making to best serve the interests of our communities and to reduce inequalities.

Our analysis shows that the predicted needs of our population will require a larger health and social care workforce and that without intervention to support recruitment and retention, the workforce gap could increase from roughly 12% to 17%. We have started to make inroads into this within our first year, however a focus on innovation and digital transformation will be required over the coming years to improve the efficiency and effectiveness of our care delivery model.

Figure 1 The workforce gap as set out in the NCL ICS People Strategy 2023-2028



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- NHS has seen a reduction in turnover rate of 3.5% from 15.6% in May 2023 to 12.1% in March 2024
- NHS has seen a reduction in absence rate from 4.5% in May 2023 to 4.2% in March 2024 which is below London (4.8%) and national (5.3%) averages
- Mental Health has seen a 9.7% increase in substantive workforce linked to the national Mental Health Investment Standard (MIS) in the past year to stabilise the quality of the service and reduce reliance on bank and agency
- Social care increased their filled posts by 1,000 and reduced their turnover rate by 3.2% in the last 12 months
- NHS vacancy rate has dropped from 9% to 8.6% across NCL over the past 12 months

From 2024, the NCL Integrated Care Board (ICB) have invested in a small permanent resource to lead on the delivery of the people strategy priorities and to develop the initiatives to start to accelerate the change.

This report sets out the detailed achievements of our 'Laying the Foundations' year 2023/ 24 and outlines our intentions for our first year of 'Accelerating the Change' in 2024/25.

Introduction

NCL is one of the most complex Integrated Care Systems in England, with eleven core providers, including the highest number of specialist trusts in London. These include Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH), Royal National Orthopaedic Hospital (RNOH), Moorfields Eye Hospital NHS Foundation Trust and The Tavistock and Portman NHS Foundation Trust.

As well as our strong NHS secondary care sector, we have over 180 GP practices, five Local Authorities who contract with over 200 care homes and numerous domiciliary care providers, several highly regarded academic institutions and a strong and vibrant Voluntary and Community Sector (VCS).

This gives us a fantastic opportunity to develop innovative solutions to our complex problems, however to do this well and to support the effective leveraging of our assets for the benefit of our patients and our population, we have to have a strong emphasis on collaborative working and a commitment to our shared ambition.

The first year of the delivery of the people strategy has truly demonstrated the benefit of bringing together all the different parts of the system, with their different perspectives, skills, experience and resources to partner in new and different ways to achieve our ambition of a sustainable health and care system.

An excellent example of collaborating differently has been the close working relationships that have been formed over the past year between VCS organisations, health and employment teams across the ICS. This closer working has been particularly forged through the development of a support offer to bring employment and health closer together with a particular focus on those residents who have a long-term condition or mental health problems, to help overcome the barriers to work. This is part of our 'live well' population health outcome and also our commitment to develop our broader social and economic contribution – the fourth test of an ICS.

This is of particular importance as within our five Boroughs, three (Haringey, Enfield and Islington) have a higher unemployment rate (working age population claiming out of work unemployment benefit) than the England average, with Haringey being the highest in London with almost double the rate. We also know that in terms of employment across the sector, North Central London has one of the lowest rates of population within employment, with the ICB area tracking below the England average, and four boroughs having higher levels of economic inactivity than the England average. This presents a real opportunity for the health and care system to support as anchor[1] organisations and provide social and economic opportunities for our residents.

[1] Anchor institutions are large organisations that are unlikely to relocate and have a significant stake in their local area. They have sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development, and buildings and land use. (King's Fund 8 September 2021) https://www.kingsfund.org.uk/insight-and-analysis/long-reads/anchor-institutions-

As a vital part of our strategy, we continue to develop our partnerships with academic institutions. One of our key successes in 2023/2024 was the NCL Nursing and Midwifery Clinical Academic Nexus (NCL CAN) established at Middlesex University. This is a partnership to establish an environment where clinical and academic colleagues from health and care can collaborate, share and co-produce. Our aim is to increase the availability of advanced clinical practice; research and a range of other opportunities to both retain our most talented nurses and midwives at all stages of their career and inspire a future generation.

The purpose of NCL CAN is to generate and sustain a professional culture that helps attract and retain a sustainable nursing and midwifery workforce, who are ready and capable to support the overall ICS aims.

The four priorities for the NCL CAN are to:

1. Prepare and successfully transition future nurses & midwives through pre-registration academic and practice learning, delivered by skilled educators and practice facilitators
2. Develop and advance practice for registered nurses & midwives from preceptorship to early career and onwards
3. Develop clinical academic working, to transform practice through research and innovation
4. Develop and embed restorative practices to sustain safety critical professional

Year one of our strategy focussed on Laying the Foundations so that we were building our progress on strong collaborations and system working. This has taken quite a lot of time and effort to establish, however the governance is now in place and the partnerships are in a good position to start to accelerate delivery.

The next section of the report will set out our progress over the past year.

and-peoples-health#:~:text=Anchor%20institutions%20are%20large%20organisations,stake%20in%20their%20local%20area.

Laying the Foundations - Our year one progress

In May 2023, we set out a plan for our year one aims. It has been a challenging year as the partners across the system have been focussed on trying to reduce the waiting list backlog and many have been adversely affected by the different periods of industrial action that have been experienced throughout the year.

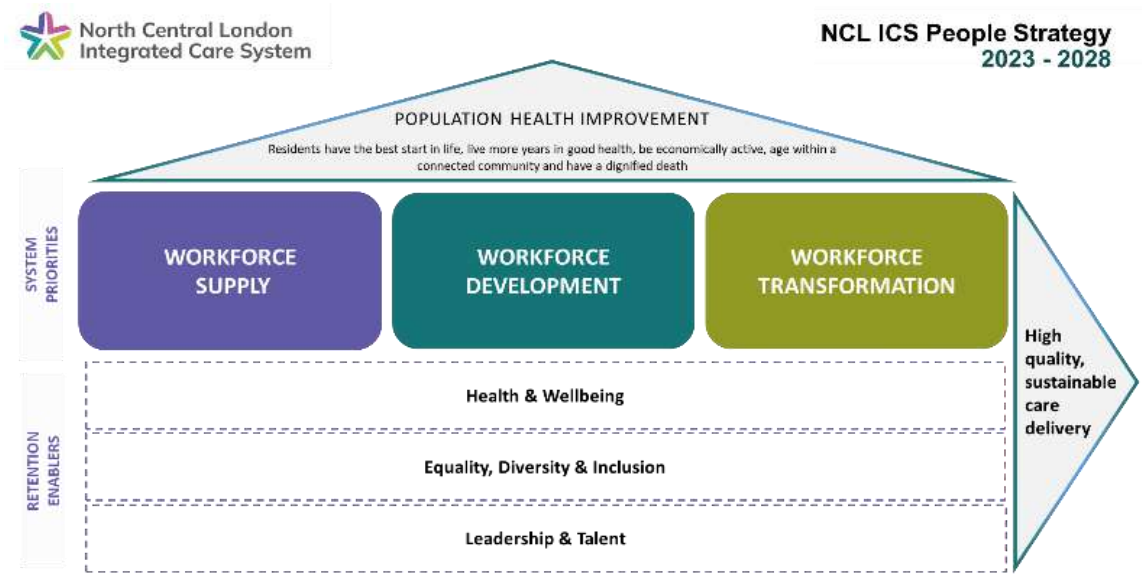
The People Strategy is a companion strategy to deliver the Population Health and Integration Strategy and this remains core to what we are trying to achieve. Our approach for developing a high quality, sustainable care system is through the development of 'one workforce' across primary, secondary care; social care; voluntary, community and social enterprise sector delivering joined-up, preventative and person-centred care for North Central London.

Our aims for one workforce are to:

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

We believe that through achieving the above we can positively contribute to population health improvement. *Figure 3* demonstrates how the two strategies fit together.

Figure 3 NCL ICS People Strategy at a glance



Each pillar of the strategy has been carefully considered in terms of the contribution it makes to the overall delivery of the strategy. There are interdependencies and overlaps between each pillar, however each plays a vital part in ensuring we are delivering across the right areas of focus.

- **Workforce Supply** – Optimising the volume of staff with the right skills and values to achieve our population health improvement outcomes across NCL, sustainably.
- **Workforce Development** – Continuously improving staff, systems and processes to maximise the talent and assets we have across North Central London
- **Workforce Transformation** – Utilising technology to drive productivity and efficiency improvements, and further connect our workforce with advanced data and analytics.

Strategic Retention Enablers

Future workforce supply, development and transformation are only possible with a stable workforce. Recognising the local and national challenges presented by high turnover and the difficulty in retaining skilled staff, we identified 3 key strategic enablers within our strategy that we felt would make a tangible difference to the employee experience and therefore overall retention of the workforce.

These enablers are;

- **Equality Diversity and Inclusion –** recognising and celebrating the strengths of our diverse workforce and committing to ongoing work to support, empower and protect our staff. Supporting and reaching into our communities to increase the diversity of our workforce.
- **Leadership and Talent –** building strong compassionate and inclusive leadership skills. Supporting career progression at all levels and developing the talent present within our systems to support our ongoing growth.
- **Health and Wellbeing –** supporting our workforce to look after their physical and mental health. This also includes job design and ways of working to improve the wellbeing of our staff.

As we have started to implement the delivery, it has become increasingly clear that these remain the right pillars to be focussed on. In June 2023, the NHS Long Term Workforce Plan[2] was published. This was a welcome document, backed with investment and a national plan to deliver. We mapped the three pillars of the LTWP of train, retain and reform against our pillars and it maps across well. We acknowledge that the LTWP is an NHS workforce plan and therefore only part of the overall solution. We remain committed to our one workforce approach across all our sectors. As the national requirements and funding crystallise, we will continue to map this into our Delivery Boards to ensure we are well placed to deliver.

[2] https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/ (NHS England 30 June 2023)

Overall, despite the challenges faced by our partner organisations across the system, we have largely been on track with delivery this year. The Delivery Boards (Supply, Development and Transformation) were all successfully established within three months of the approval of the strategy and these have multi-professional, multi partner membership from across the ICS. Rather than have separate workstreams, each delivery board also has responsibility and oversight for a strategic retention enabler. This enables us to ensure that the enablers remain core to our delivery programme. These are:

- ✓ Supply – equality, diversity and inclusion
- ✓ Development – leadership and talent
- ✓ Transformation – health and wellbeing

Progressing as far as we have in a short space of time has been a truly system-wide effort. To bring to life some of the achievements we have made collectively over the past year, the next section outlines these in more detail against each of the pillars as set out in our year 1 commitments.

Year 1 Progress - Laying the Foundations

WORKFORCE SUPPLY

SUPPLY ROUTES	Scope out opportunities to develop high-impact approach to apprenticeships across North Central London.	Completed the mapping of apprenticeship opportunities and status across the Trusts, primary and social care	In development is an apprenticeship framework in preparation for the Long Term Workforce Plan.	To inform a marketing campaign, commissioned research into the appeal of the NHS as employer to young people
	Identification of routes into health and social care careers. Focus on increasing opportunities for school and care leavers.	One of ten successful pilots for the Care Leavers Covenant in the NHS. Supporting care experienced young people into roles in healthcare.	Developed and strengthened relationships with Health & Social Care Academies, North London Partners Shared Services, Prince's Trust, Job Centre Partners and borough employment leads	Implementation of the NCL Healthcare Support Worker programme, working with partners to recruit to roles locally (Generation, Ingeus, Prince's Trust)
DATA	Develop in-depth understanding of local labour markets; demographics and profiles to better target training and employment	Discovery phase to understand the local labour markets in the five Boroughs to target interventions	Partnership with employability contacts across the system to develop an employment and health partnership linked to Long Term Conditions	Strengthened links with Local Authority employment hubs and OHID colleagues to improve data insights
	Scope enhanced data analytics with system partners to determine the data sharing, quality and access requirements needed to	Established collaboration forum with NHS England Workforce Transformation & Education and other London ICBs	Development of a dashboard of data insights and metrics across NCL shared with the People Board and local partners	Integrated Planning pilot to determine alignment of workforce, activity and finance completed in CAMHS and elective care

WORKFORCE DEVELOPMENT

ENHANCED CAPABILITY

Partner with higher-education institutions to develop staff upskilling and training programmes aligned to system priorities

- Collaboration with higher education partners through the NCL ICS People Board and Delivery Boards
- Launch of a training pilot to support staff to deescalate challenging behaviour in acute settings.
- Development of the NCL Nursing and Midwifery Clinical Academic Nexus. A partnership between NCL ICB and Middlesex Universitv.

Identification of high impact roles that could unlock care delivery i.e., poly-potential, generalist or advanced clinical practice

- Development of Advanced Practitioner pathway in NCL
- Nationally funded Trainee Health Psychologist hosted by Tavistock and Portman.
- Over 100 operational leaders participated in the system leadership development programme
- NCL Training Hub leading on the development of a supervision approach
- NCL Education Faculty supporting subject expertise as Communities of Practice
- NCL Education Faculty developing educators with monthly Multi-Professional Educator Groups across all 5 boroughs, supported by an NCL Teach-the-teachers group.

FLEXIBILITY

Development of an approach to flexible employment to support portfolio or blended careers to further attract and retain staff.

- Training Hub providing fellowship opportunities for newly qualified and early career GPs and General Practice Nurses and nurses new to practice, to support career development.

System-wide mapping of requirements for the development of an ‘NCL passport’ to support enhanced staff portability.

- NHS London staff movement agreement (staff passport) extended to include Trusts and primary care.
- Improved outcomes and retention from the self-roster and flexible working pilot at Royal Free London NHS FT
- Adoption of the London-wide development of a HCSW clinical skills passport

WORKFORCE TRANSFORMATION

WAYS OF WORKING

Integrated Neighbourhood Workforce model defined to realise the ambitions of the Fuller Review of Primary Care

Workforce deep dive undertaken at the Primary Care Committee

Participated in London Region led deliberations on the Future of Primary Care, including feedback and interviews with Londoners and patient groups.

Development of the workforce model to support the implementation of the Long-Term Conditions management in Primary Care

100% GP practices signed up to the new LTC management model and 1,000 staff trained

Partnership working between employment leads, primary care, local authority partners, ICS workforce and the training hub to scope the employment and health offer

INNOVATION

Identify, develop and support the delivery of the change management requirements for the NCL digital strategy.

Supporting the development of the workforce elements of the NCL digital strategy

Piloting of Artificial Intelligence (AI) solutions to support clinicians efficacy and productivity

Focus on current workforce digital transformation such as Virtual Wards

Identify opportunities to accelerate, enhance and scale innovation across the system.

Contributing to the London People Board Digital Workforce Group to share learning

Scoping for a pilot to develop an innovative approach to zero touch HR

Early work on the identification of the impact of digital on workforce productivity

STRATEGIC RETENTION ENABLERS

EQUALITY, DIVERSITY, AND INCLUSION	Recognising, celebrating and supporting our diverse workforce.	Inclusivity audit of NCL shared recruitment service to ensure inclusive recruitment practice is taking place	North Central London ICB, GOSH and RFL participated in the NHS cohort of the Greater London Authority Workforce Integration Network anti racism programme	NCL ICB Diversity and Inclusion Book, Film & Music Club expanded across the ICS and plans in development to roll out across London
HEALTH AND WELLBEING	Ensuring our workforce are supported to remain mentally and physically healthy.	System-wide Health and Wellbeing offer created to support the workforce with psychological support hosted through the shared occupational health service and reaching into primary care	Wellbeing bus supporting health checks for social care and primary care staff, with a particular focus on cardiac health	
TALENT AND LEADERSHIP	Building on the talent in the system to develop system-wide leadership.	Future Leaders positive action programme for BAME staff who are aspiring directors. 14 participants and 5 have been promoted in the past year	System Leadership Clinical Fellow programme for nurses and midwives with 30 participants in cohort 1	Increasing the number of Professional Nurse Advocates to support the profession and increase retention

Celebrating and Recognising our Success

HELOA Awards 2023

Best Practice Collaboration

NCL Training Hub and Middlesex University

Nursing Times Awards 2023

Care of Older People award

Moorfields' Eye Envoy programme

Nursing Times Workforce Awards 2023

Winner for Best Recruitment Experience

NCL ICS – Graduate Guarantee Programme

Shortlisted for Best Workplace for Learning and Development

NCL ICS – CPEP Project: expansive learning in practice

RCN Nursing Awards 2023

Nurse Researcher of the Year

Roxanne Crosby-Nwaobi from Moorfields

Accelerating the Change

Whilst we are proud of the great work delivered in year 1, we know there is much more to do, particularly in the development and transformation pillars.

In years 2 and 3 (2024 – 2026) the focus will be on accelerating the change, so continuing to identify and expand on the work happening across the system and seeking opportunities for scaling up.

This brings the focus to delivering system efficiency and productivity benefits via targeted initiatives that close the supply and demand gap, upskill staff and provide workforce portability.

People Strategy Priorities Year 2 and 3 (2024-2026)

Below are some initial areas of focus that we have identified for future delivery. However, the People Strategy has been developed in partnership and we know that strong engagement needs to take place in order to refine these Year 2/3 priorities. We will continue to build on and embed the learning from year one, whilst supporting new opportunities as they emerge.

The opportunities include the expectations of the Long Term Workforce Plan and also the commitments regarding employment and health made in the Spring Budget 2023 to support residents to remain or obtain employment through an improvement in their health. These will be two significant programmes of work to deliver across all elements of the strategy.

Finally, we will continue to support efforts to meet the staffing requirements of social care providers, recognising the vital role that our social care workforce have in meeting the needs of the population and preventing the need for more intensive support. We will welcome the Long Term Workforce Plan for social care when it is published.

Set out below are a summary of our key priorities, with further work to do to flesh out the details.

Workforce Supply

Data:
There will be an acceleration of work to build data modelling capability including system-wide metrics and benchmarks to drive service efficiency and workforce productivity. Data will be utilised effectively to identify workforce pressures, understand the number of people living and working across the system and identify opportunities for further growth.

Supply Route:
Ongoing use of workforce data intelligence will assist in reviewing workforce gaps and opportunities for rotational placements across sector boundaries. This will support future diversification of skills and training models. Through sustained cross sector partnership, there are strategic opportunities to link with existing resources and address workforce supply. It is anticipated that year 2/3 priorities will develop new, innovative and or trail blazing opportunities to enable NCL a great place to work. This will be achieved by:

- Understanding barriers faced by people living across our local communities. Subsequently, strategic plans will be formulated to further collaborate and invest in providing 'good work' for people in NCL.
- Enhanced engagement, positive promotional and marketing campaigns to communicate health and care jobs across the system. Health and Care Academies, Local Authority Hubs and other job networks are required to partner and develop cross boundary models of working to promote routes into health and social care careers.
- Co-create high impact long term plan with schools and colleges to diversify entry roles into the health and social care sector, for example apprenticeships, T-Level pathways.

Career Promotion and Support:
Our current biggest workforce gap is in healthcare science and allied health professionals. We will focus on promoting careers, outlining plans to engage schools and showcase careers to young people in particular lesser-known roles, apprenticeship routes and STEAM (Science, Technology, Engineering, Arts and Mathematics) careers into the sector.

There is scope to develop a school engagement strategy as part of the Primary Care Anchors Network (PCAN) working with our Allied Health Professional (AHP) Faculty and Apprenticeship programme led by NCL Training Hub. This strategy will take forward an approach to ensuring young people start to consider careers in the NHS and the broader health and care system. We will work across the system to support in key areas such as National Apprenticeship week, multi-disciplinary approach to Work Experience, Volunteering and National Careers week to start to develop a marketing campaign.

Workforce Development

Flexibility:
Expanding collaborative staffing mechanisms and existing centralised corporate services to support sharing of staff including in the areas of demand, vacancy management and internal recruitment. This could include areas like the collaborative bank and shared recruitment services.

Enhanced Capability:
Redesigning People processes to reflect policies supporting workforce flexibility and portability in the system, through mechanisms such as cross-organisational flexible working policies that can improve retention and staff satisfaction. Building upon the work to date on Just and Restorative culture to continue to enhance the practice of our staff and enable them to deliver to a high standard.

The Long-term Workforce Plan sets out ambitions for systems to grow their workforce, which will not only require significant expansion to entry routes but also increasing education and training to meet this demand. To realise this ambition, we will work closely with our NCL Higher Education Institution colleagues to develop an Educator Framework which describes the knowledge, skills and behaviours required to be an effective teacher, learning facilitator, supervisor and role model and defines clear, high standards which will be achieved by students within their supervision.

Learning and Development
Building on successful initiatives within the system to upskill and develop staff to better understand and develop their roles, bringing cross-discipline expertise together to shape and deliver the education offer, define the system learning needs analysis and interventions with a one workforce vision.

We will build on the existing work of the Education Faculty, its Multi-Professional Educator Groups and Subject Expert Groups with the Education faculty supporting subject expertise as Communities of Practice with new groups in development for Personalised Care, Sustainability and Wellbeing.

Following the success of the two System Leadership Development Programmes delivered in 2023/24, we will seek to re-commission a further cohort, inviting leaders to apply from across NCL health and care organisations. Those that have successfully graduated from the programme will be invited to join a faculty of alumni, enabling health and care leaders to come together to discuss and define system priorities.

Additionally, discussions are underway to define what the next iteration of the positive action Future Leaders programme could look like, and how we might scale this up to a London level.

We will work up a Talent Strategy to pull these strands together and advance the work needed to enhance the leadership and talent opportunities in NCL and to ensure there is a sustainable pipeline of leaders to enable system-wide succession planning.

Workforce Transformation

Innovation:
Development of a funded innovation pipeline that allows the system to test and learn, developing processes that can be used across the system and establishing clear partnerships with enablers in Education & Industry.

Ways of working:
Developing and mobilising a programme of digital upskilling to the Health and Social Care workforce across the system to support new ways of working and build on existing pilot initiatives.

A discovery exercise has been underway to further develop Year 2-3 Workforce Transformation priorities. This has identified the need to focus on innovation adoption and change management, the role of leadership in supporting digital workforce transformation, and the need for systematic processes to interrogate workforce models to support new ways of working. In ensuring a system-wide collaborative there is a Workforce Transformation workshop planned which to crystalise Year 2-3 deliverables linked.

Early work towards our priorities has already begun. This includes exploring productivity initiatives, such as workforce modelling and the use of AI to improve rostering and access to self-rostering. The development of Digital Strategy is underway which considers the digital skills required. Furthermore, case studies on digital group clinic models in primary care and the implementation of virtual wards are supporting us to interrogate traditional ways of working and opportunities for spread and scale.

Conclusion

As this annual report sets out, much has been achieved by partners working across the system. The projects, programmes and initiatives set out in this report only scratch the surface of all the great work that is happening within our numerous organisations as it focuses on the visible, collective work.

As we progress over the years of this strategy, our ambition is to collate a better understanding of all the work that is contributing towards a sustainable health and care system through the effective recruitment and retention of a highly talented ‘one workforce’ across North Central London, caring for our patients and our residents day in day out.

Ensuring we continue to think of good work as a population health intervention and support as many people as possible into meaningful work as part of our population health intervention is core to our people strategy. This is, and continues to be shared ambition, and collective endeavour to ensure we can make NCL a great place to live and work.

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 May 2024

Report Title	2024/25 Financial Planning Update	**Date of report**	15 April 2024	**Agenda Item**	2.4
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** Work continues on the ICB plan. The expectation is that the ICB will report a **£10.6m** surplus. To achieve this there are a number of risks and targets built into the ICB position that will require in-year management, this includes: • Use of non-recurrent funding - **£10.6m** • Full achievement of CIP targets - **£26.1m** • Full achievement of running cost reductions - **£4.8m** • Cost pressures of **£4.7m** • The assumption that all risks will be mitigated in year. These currently stand at **£81.4m**, risk adjusted to **£34.1m**			
Report Summary	The ICBs continues to work on the financial plan for 2024/25, which covers the period 1 April 2024 to 31st March 2025. A draft plan was submitted to NHS England on **21 March 2024**, with a final plan submission due on **2 May 2024**. The ICB draft plan approved by the ICB Board is a **£10.6m surplus**. This plan is subject to change as planning is still underway. To achieve this surplus, the ICB is required to **fully deliver £41.5m of efficiencies** being: • Cost Improvement Programme (CIP) of **£26.1m**, • Reduction in running costs as part of the 20% required by all ICBs. This totals **£4.8m**, • Use of non-recurrent measures of **£10.6m**. During the planning process the ICB has identified a number of cost pressures totalling **c£4.7m.** These pressures have been funded within the plan and will be held centrally to be drawn upon as required.				

	Also included within the plan are potential risks of **£34.1m** (risk adjusted). Financial planning assumes that these risks can be **fully mitigated** in year.
Recommendation	The Board of Members is asked to **NOTE** the contents of this report.
Identified Risks and Risk Management Actions	As part of the planning process the ICB has identified c£34.1m of potential risks (risk adjusted). These risks will be managed via the implementation of an in-year Financial Recovery Plan.
Conflicts of Interest	This paper was written in accordance with the Conflicts of Interest Policy.
Resource Implications	The report highlights the allocations for the ICB.
Engagement	This report is presented to the Board.
Equality Impact Analysis	This report has been written in accordance with the provisions of the Equality Act 2010.
Report History and Key Decisions	None.
Next Steps	This report is to be reviewed by the Board and **NOTE** the contents of the financial plan.
Appendices	None.

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2024/25 Financial Planning Board Report

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Financial Planning for 2024/25

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The ICBs continues to work on the financial plan for 2024/25, which covers the period *1st April 2024 to 31st March 2025*. A draft plan was submitted to NHS England on **21st March**, with a final plan submission due on **2nd May**.

The ICB draft plan approved by the ICB Board is a **£10.6m surplus**. This plan is subject to change as planning is still underway. To achieve this surplus, the ICB is required to **fully deliver £41.5m of efficiencies** being:

- Cost Improvement Programme (CIP) of **£26.1m** (*please see slide 6*),
- Reduction in running costs as part of the 20% required by all ICBs. This totals **£4.8m**,
- Use of non-recurrent measures of **£10.6m**.

During the planning process the ICB has identified a number of cost pressures totalling **c£4.7m.** These pressures have been funded within the plan and will be held centrally to be drawn upon as required.

Also included within the plan are potential risks of **£34.1m** (risk adjusted). Financial planning assumes that these risks can be **fully mitigated** in year. *Please see slide 7.*

The following slide details some of the key assumptions included in the plan.

Financial Planning for 2024/25

North Central London
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Key Planning Assumptions:

- The ICB is planning on delivering a **£10.6m surplus.** This is subject to change as planning is still underway.
- There is a **0.8% Net Uplift** applied to Programme costs service areas except CHC (**5.5%**) and Prescribing (**5.0%**),
- Primary Care Co-commissioning aligned to the published allocation of **£467m** (*including Dental, Ophthalmic & Pharmacy*),
- Running Costs aligned to the published allocation of **£26m**,
- **0.6% Capacity** funding has been provided for within Acute Services. Capacity Funding aims to relieve pressures on hospitals and help cut waiting lists,
- A **Mental Health reserve** has been created to ensure the ICB meets its Mental Health Investment Standard (MHIS) line with allocation growth,
- **Better Care Fund (BCF) budgets have been increased by 5.66%** in line with published minimum contribution,
- The next slide details expected uplifts by service area.

Financial Planning for 2024/25

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Planning Assumptions 2024/25	Price	Activity	Efficiency	Net Uplift
Acute Block (Intra)	1.90%	0.00%	-1.10%	**0.80%**
Acute Block (Inter)	1.90%	0.00%	-1.10%	**0.80%**
Acute Block (LAS)	1.90%	0.00%	-1.10%	**0.80%**
Acute Services - Independent / Commercial Sector	1.90%	0.00%	-1.10%	**0.80%**
Acute Services - Other Non - NHS	1.90%	0.00%	-1.10%	**0.80%**
Acute Services - Other Net Expenditure	1.90%	0.00%	-1.10%	**0.80%**
MH Block (Intra)	1.90%	0.00%	-1.10%	**0.80%**
MH Block (Inter)	1.90%	0.00%	-1.10%	**0.80%**
MH Services - Independent / Commercial Sector	1.90%	0.00%	-1.10%	**0.80%**
MH Services - Other Non - NHS	1.90%	0.00%	-1.10%	**0.80%**
MH Services - Other Net Expenditure	1.90%	0.00%	-1.10%	**0.80%**
Community Health Services - Block (Intra)	1.90%	0.00%	-1.10%	**0.80%**
Community Health Services - Block (Inter)	1.90%	0.00%	-1.10%	**0.80%**
Community Health Services - Other	1.90%	0.00%	-1.10%	**0.80%**
Continuing Care Services	6.60%	0.00%	-1.10%	**5.50%**
Funded Nursing Care (FNC)	6.60%	0.00%	-1.10%	**5.50%**
Prescribing	6.10%	0.00%	-1.10%	**5.00%**
PC - Other	1.90%	0.00%	-1.10%	**0.80%**
Primary Care Co-Commissioning	0.00%	3.75%	0.00%	**3.75%**
Primary Care DOP	0.00%	2.39%	0.00%	**2.39%**
Other Programme Services	1.90%	0.00%	-1.10%	**0.80%**
Running Cost	-18.04%	0.00%	0.00%	**-18.04%**

Net uplifts are expected to be 0.8%, with the exception of the below services;

- 5.50% for CHC/FNC
- 5.00% for Prescribing
- 3.75% for PC Co-Commissioning
- 2.39% for PC DOP
- 18.04% Reduction in Running Costs

ICB Recurrent Published Allocations

North Central London
Integrated Care Board

NCL ICB Published Recurrent Allocations 23/24 to 25/26

Service Area	Recurrent Allocations			Recurrent Increase	
	2023/24 £m	2024/25 £m	2025/26 £m	2024/25 £m	2025/26 £m
Programme	2,852	2,973	3,067	120.9	94.2
Primary Care Delegated Commissioning	294	307	319	12.9	11.9
Primary Care Dental, Ophthalmic & Pharmacy	156	160	163	3.3	3.5
Running Costs	30	26	22	(4.0)	(3.6)
Total	**3,333**	**3,466**	**3,572**	**133.1**	**105.9**

Published Recurrent Allocations 23/24 to 25/26

The table above details the expected increase in NCL ICB's recurrent allocations for 2024/25 and an estimate for 2025/26. The ICB is expecting an increase of c£133m in core funding in 2024/25, representing an increase of c4%.

In addition to the above recurrent funding, the ICB is expecting additional non-recurrent allocations of **c£174m** in 2024/25;

- **£73.1m** – Additional Elective Recovery Funding
- **£57.1m** – SDF funding
- **£28.5m** – Community Diagnostics Centres
- **£8.8m** – Overseas Visitors
- **£4.3m** – Ambulance Capacity Funding
- **£2.3m** – Covid Testing
- **£2.2m** – Long Testing
- **-£1.3m** – Microsoft Licence Funding Transfer (NHS Trusts)

The above is subject to change.

Cost Improvement Programme (CIP) Update

North Central London Integrated Care Board

Service Area	24/25 Recurrent CIP Target	23/24 Recurrent CIP Target
	£m	£m
Chief Nursing Officer	(10.0)	(9.7)
Corporate Affairs	(0.0)	(0.1)
Chief Medical Officer & Place	(12.4)	(11.1)
Finance	(0.3)	(0.7)
Performance & Transformation	(1.1)	(0.5)
Strategy & Population Health	(2.2)	(3.5)
People & Culture	0.0	(0.0)
	(26.1)	**(25.6)**

Cost Improvement Programme (CIP)

The 24/25 CIP target is £26.1m. This equates to c5% of ICB controllable spend.

This CIP target does not assume any use of non-recurrent measures or cost avoidance schemes and is assumed as fully delivered in the financial plan. This target is in addition to the running cost allocation reduction.

The ICB target has also not been applied against;

- NHS Contracts
- Mental Health
- Pay budgets
- Primary Care Co-Commissioning
- Running Costs

2024/25 Risk & Mitigations

North Central London
Integrated Care Board

Risk Summary

Directorate	£'000 Risk value £'000	% RAG rating	Rag Rating	£'000 Risk adjusted value £'000
RISKS				
Performance & Transformation	(1,388)	58%		(807)
Finance	(11,168)	26%		(2,892)
Strategy & Population Health	(9,391)	71%		(6,705)
CMO & Place	(23,633)	37%		(8,842)
CNO	(33,277)	39%		(12,883)
People & Culture	(1,728)	83%		(1,441)
Corporate Affairs	(850)	65%		(553)
TOTAL RISKS	**(81,435)**	**42%**		**(34,121)**
MITIGATIONS				
Financial Recovery Plan	81,435	42%		34,121
TOTAL Mitigations	**81,435**	**42%**		**34,121**
NET RISK POSITION	**0**			**0**
Mitigations required	*0*			*0*
REPORTED RISK POSITION	**0**			**0**

Risks & Mitigations

As part of the planning process the ICB has identified c£81.4m of potential risks reported outside of the financial plan, which has been risk adjusted to £34.1m based on the likelihood of risks materialising.

Of the risk adjusted position of £34.1m, c£11.7m (c34%) relates to CIP delivery risk.

If required there will be an in-year recovery programme to identified mitigations as risks arise to ensure the ICB is able to achieve a breakeven position against plan. Noting that the use of non-recurrent measures to cover recurrent pressures will have an adverse effect on the ICBs Underlying Position.

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North Central London ICB
Board of Members Meeting
7 May 2024

Report Title	Integrated Performance and Quality Report	**Date of report**	17 April 2024	**Agenda Item**	3.1
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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. Given the last board meeting was held 26 March 2024, there have only been some metrics published and updated in this time. Areas of note are set out below: Areas of progress: • 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 quarterly 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, 51% of NCL patients received a same day appointment, which is above the national average of 44% recorded for February 2024. Ongoing challenges and further work: • 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 - the latest position for March 2024 continues the improving trend shown over Q4, despite trajectories not being met. Work in the NCL System continues to deliver the step change towards the national performance ambition of 78% of patients seen within 4 hours, by March 2025. • At NMUH UEC performance against the exit criteria remains below agreed trajectories since Q2 of 2023/4. Delivery on the ambulance handover target has been particularly challenged and remains a key focus into 2024/25. A recent trial of diverting patient postcodes normally associated to NMUH, to other sites has not resulted in material improvements to performance highlighting the importance of internal work on flow in parallel. • 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. • Industrial action has continued across the NHS throughout 2023 and into 2024. Whilst there has been no further action since February 2024, and no further dates beyond this announced yet, the Junior Doctor's Mandate is in place for 6 months until September 2024, therefore further action is possible. Previous action has 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. The impact of industrial action is still being seen in some of the performance figures which are published in arrears.
Recommendation	The Board of Members is asked to **NOTE** the key issues set out in the paper for escalation and the actions in place to support improvement.
Identified Risks and Risk Management Actions	Key risks identified are detailed in the BAF and listed below: • PERF5: Failure to deliver Cancer 62-day waiting time standard (Threat).

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

NHS
North Central London
Integrated Care Board

NCL ICB Integrated Performance & Quality Report

March 2024

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:

- Quality Update (slide 3)
- Operational planning for 2024/25 (slide 4)
- Primary Care (slide 5)
- Mental Health Services (slide 6)
- Community Health Services (slide 7)
- Urgent and Emergency Care (UEC) (slides 8 and 9)
- Electives (slide 10)
- Diagnostics (slide 11)
- Cancer Services (slide 12)

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 13)
- 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 work towards elective activity targets, improve bed capacity to enhance A&E performance trajectories, and the efficient use of mental health beds to reduce the reliance on out of area placements. Planning for 2024/25 is in progress in the NCL System, ahead of final submission of plans to NHSE in May 2024.

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.

Overview of Quality

North Central London
Integrated Care Board

NMUH – Care Quality Commission (CQC) Well-led Inspection Report

The CQC inspected core medical services in September 2023 under the 'Well-led' domain. These services were rated as ''Requires Improvement' for providing safe, responsive and well led care, and good in the domains of effectiveness and caring. The overall rating of the Trust remains the same, "Requires Improvement". The full report can be accessed here: Trust - RAP North Middlesex University Hospital NHS Trust (28/03/2024) INS2-18615927045 (cqc.org.uk)

The ICB's Director of Quality, and Director of Performance and System Oversight are working collaboratively with the Trust and supporting their improvement plans across ED and maternity services. At the beginning of April 2024, NMUH invited the Emergency Care Improvement Support Team (ECIST) at NHSE to undertake a diagnostic visit to allow expert review of ED and UTC 'front door' processes that affect flow. ECIST have provided feedback to NMUH on areas that require focus, such as reviewing criteria to admit, and discharge processes. ECIST were complimentary of the paediatric ED facility. The ICB are also working with all acute providers across NCL on Sustainable Discharge as part of the Flow Strategy.

Martha's Rule

Dr Adain Fowler, NHSE Director of Patient Safety wrote to CEOs, Medical Directors and Chief Nurses at all NHS Trusts and Foundation Trusts in April 2024, inviting NHS providers of acute adult and/or children and young people's inpatient care, with an existing on-site 24/7 critical care outreach team (CCOT) or paediatric critical care outreach team (PCCOT) infrastructure, to formally submit expressions of interest to participate in the first phase of the programme throughout 2024/25, as part of the process to recruit the first 100 sites to implement Martha's rule https://www.england.nhs.uk/long-read/marthas-rule-expression-of-interest-regulation/

Across NCL, three acute providers with 24/7 CCOT and/or PCCOT have submitted an expression of interest (RFL all sites, UCLH and the NMUH), along with GOSH and the North London Mental Partnership NHS Trust. UCLH and GOSH have been working on local approaches to support patients, families and carers to escalate their concerns and have their views acted upon.

Publication of the Cass Review

NHSE commissioned Dr Hillary Cass to undertake an independent review of gender identity services for children and young people. The purpose was to make recommendations on how to improve NHS gender identity services and ensure that children and young people who are questioning their gender identity, or experiencing gender dysphoria, receive a high standard of care that meets their needs, is safe, holistic and effective. The final report was published in early April 2024: https://cass.independent-review.uk/home/publications/final-report/

NCL Operational Planning 2024/25

North Central London
Integrated Care Board

NCL Operational Planning 2024/25

NCL ICB led the development of a system-level operational plan for activity, finance, performance, and workforce for 2024/25 plans and trajectories. The overall priority in 2024/25 remains the recovery of core services and productivity following the Covid-19 pandemic. To improve patient outcomes and experience, systems were required to plan to:

- Maintain the collective focus on the overall quality and safety of services, particularly maternity and neonatal services, and reduce inequalities in line with the Core20PLUS5 approach.
- Improve ambulance response and A&E waiting times by supporting admissions avoidance and hospital discharge, and maintaining the increased acute bed and ambulance service capacity that systems and individual providers committed to put in place for Q4 of 2023/24.
- Reduce elective long waits and improve performance against the core cancer and diagnostic standards.
- Make it easier for people to access community and primary care services, particularly general practice, and dentistry.
- Improve access to mental health services so that more people of all ages receive the treatment they need.
- Improve staff experience, retention, and attendance.

The draft NCL Operating Plan for 2024/25 was submitted to NHSE in March 2024, with the final submission to be made in early May 2024. The NCL plans met the national ambitions as known at the time, for improving A&E performance, maintaining bed capacity, reducing long waits for elective care, improving 62-day and faster diagnosis standards for cancer, as well as mental health access and quality improvements underpinned by the Long-Term Plan.

With the final national planning guidance now officially published, NCL ICB is working with providers to refresh draft plans based on the guidance where these do not align with nationally set ambitions. Feedback on the draft submission has been received from NHSE, and NCL stakeholders are currently working to iterate plans, making amendments where necessary.

The NCL System is using a robust planning structure to work with providers to build 2024/25 plans that triangulate between workforce, activity and finance, ensuring that efficiencies are expressed, and testing the level of productivity improvement built into plans. Individual provider meetings have been held between Executive Teams to establish and review key lines of enquiry, related to expected challenges and risks for 2024/25.

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 658,000 appointments per month, which is an increase of 36,000 a month on 2022/23 activity levels. NCL practices continue to exceed the national target of providing 90% of appointments within 2 weeks, and continues to offer a high proportion of same day appointments. Overall core appointments have increased since the expected dip over Christmas.

Digital tools play am important 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. Practices are in the process of transitioning to the "modern general practice" operating model as described in PCARP, which underlines the importance of balancing digital, telephone and in-person access to meet patient need.

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 in October 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.

	Dec '23	Jan '24	Feb '24
Core primary care appointments	578,058	733,709	697,494
% same day appointments	53%	52%	51%
% appointments within 2 weeks	92%	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 indicators** include health checks, care planning, patient experience, CQC ratings and complaints.
- **Activity and appointments indicators** include provision and uptake of General practice services.
- **Workforce indicators** include clinical and admin FTE, and uptake of the Primary Care network Additional Roles Reimbursement Scheme (ARRS).

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

Overview of Mental Health Services

North Central London
Integrated Care Board

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. As of January 2024, NCL achieved the 6 and 18 week wait targets (75% and 95%) but failed to meet the recovery target of 50%.

The North London Mental Health Partnership (NLMHP) has been working with system colleagues to achieve the ambition of zero **Out of Area Placements (OAP)** by year-end. The NLMHP has embedded the 10 mental health actions for discharge planning across the system, aiming to reduce length of stay and improve flow by focusing on 3 key workstreams – preadmission , inpatients and discharge. While there has been a notable reduction in the number of OAPs throughout 2023/24, NCL is reporting 173 bed days in January 2024 against the zero target.

The NCL **CYP Access +1** target for 2023/24 is 20,579, which was achieved in January 2024. NCL ICB continues to monitor progress, recruitment, and activity from 2023/24 investment schemes via highlight reports and sit-reps 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) – NCL will see an increase from 16 to 19 MHST later in 2024/25, and alongside further Mental Health Investment Standard schemes in year, they will support achievement of next year's access and waiting time targets.

Memory services in NCL are developing plans to ensure delivery of the **Dementia** diagnosis rate ambition of 67% is maintained throughout 2023/24 and into 2024/25. 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 January 2024, NCL is meeting one of the three measures relating to the use of inpatient facilities for patients with **Learning Disability/Autism**. Limited capacity in social care and community support services for individuals is contributing to higher admission rates, particularly among adults and specialised commissioning cases. Delays in early intervention and support services for CYP with learning disabilities has resulted in escalated health issues, necessitating inpatient care. NCL is enabling early intervention programs, with key worker support for CYP to address their needs proactively, potentially mitigating the need for inpatient care and thus reducing admissions.

	Nov '23	Dec '23	Jan '24
TT Access (YTD) *[Jan YTD Target: 36,958; 23/24 Y/E Target: 44,350]*	23,151	25,421	28,981
OAPs (in month) *[23/24 Target: 0]*	198	424	173
CYP Access (12MR) *[23/24 Y/E Target: 20,579]*	22,172	22,738	23,143
Dementia Rate *[Diagnosis Target: 67%]*	68%	68%	68%

	Nov '23	Dec '23	Jan '24
LD/Autism Inpatients (ICS) *[23/24 Y/E Target: 22]*	19	18	15
LD/Autism Inpatients (NHSE) *[23/24 Y/E Target: 16]*	23	23	33
LD/Autism Inpatients(<18yrs) *[23/24 Y/E Target: 5]*	9	7	11

Overview of Community Health Services

North Central London
Integrated Care Board

The **Children and Young People (CYP)** waiting list consistently met operating plan trajectories in 2023/24. The percentage of CYP waiting 18 weeks or less increased to 68% in January 2024 against the locally agreed target of 66%, while those waiting over 52 weeks reduced from 683 to 230 following a data validation exercise at NMUH.

Due to the increasing demand for autism referrals, a Task and Finish Group carried out an analysis of NCL demand and capacity. The group developed a core standardised pathway to provide pre-diagnostic support for autism/ADHD patients both over and under 5. The analysis highlighted variation across NCL boroughs and has recommended actions to mitigate differences and reduce waiting times - these include targeted investment and capacity to the northern boroughs within NCL and commissioning a systematic review of CYP therapy services. Implementation of the standardised pathway is expected in April 2024, with an additional £1m planned to be allocated in 2024/25 to manage the additional capacity. To date, 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 carried out around 1,000 additional CYP assessments on top of NCL core capacity.

The **Adults'** community waiting list trajectory was achieved in January 2024 - musculoskeletal (MSK), podiatry, and physiotherapy services remain key contributors to those currently waiting. The percentage of adults waiting 18 weeks or less remains stable at 80% in January 2024. At Whittington Hospital, backlog reductions have been seen in MSK since October 2023 as recruitment reached full staffing establishment levels, to help maintain capacity and service performance. In addition, extra weekend lists scheduled through February and March 2024 saw 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.

To finalise the financial envelope and approve relevant Project Delivery Plans (PDPs) during April 2024, work has continued regarding the NCL CYP Community Core offer for 2024/25. In addition to autism and therapy services, the 2024/25 priorities include services in respect of asthma, bowel and bladder, hospice provision, and 'Early Language Support for Every Child'.

For adult community services, the shortlisted PDPs include 2-hour urgent community response capacity and enablers, stroke rehabilitation at home, NHS Pathway 1 and 2 discharge schemes, Enhanced Community Neurorehabilitation, as well as speech and language therapy provision. The NCL CYP Transformation Group and the Adult Community Collaborative Programme Group will oversee the evaluation of these PDPs.

	Nov '23	Dec '23	Jan '24
Waiting Times % <18 weeks (CYP) *[23/24 Target: 66%]*	65%	61%	68%
Waiting Times >52 weeks (CYP)	548	683	230
Waiting Times % <18 weeks (Adults)	81%	80%	80%
Waiting Times >52 weeks (Adults)	12	14	21

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

North Central London
Integrated Care Board

Attendances to NCL EDs continue to increase, with March 2024 seeing 2,300 attendances more than March 2023. Sustained increase in demand from highly acuity patients, delays in discharges, increased complexity of patients' social needs with stretched capacity within community services, and infection control issues have all lead to the A&E 4-hour performance remaining below the 76% standard. However, there has been some recent improvement, with performance of 71% in March 2024, which is the highest return since August 2023.

In February 2024, NCL undertook a gap analysis across acute, community and mental health providers to assess the system position against the 'Five Priority ED Improvement Initiatives' set out by NHSE. All NCL providers have made some progress towards implementing the priority initiatives, but there remains some areas requiring further improvement. Action plans to address the gaps have been developed and progress against these will be monitored via the NCL Flow Operational Group with escalation to the NCL Flow Board.

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

1. Streaming and redirection,
2. Rapid Assessment and Treatment,
3. Maximising the use of Urgent Treatment Centres (UTC),
4. Improving ambulance handovers,
5. Reducing the time spent in department.

Action plans put renewed focus on:

- Maximising alternate care pathways including Urgent Care Response, Silver triage, Ambulatory Care and SDEC.
- Discharge improvements, via implementation of the SAFER discharge bundle, optimising virtual ward use, and working collaboratively with local authorities to focus on daily management of patients with no criteria to reside.
- Use of the GP hub service, alongside UTCs to separate patients requiring primary care services away from ED.
- Improved focus on maximising the use of SDEC units for medicine, surgery , and other specialties as appropriate, and a continued review of flows within Acute Medical and Frailty Assessment Units to ensure that patients are only admitted when necessary. This work is being further enhanced through a recently initiated Site Peer Review programme.

	Jan '24	Feb '24	Mar '24
A&E 4-hour Waits *[23/24 national target – 76%]*	68%	69%	71%
A&E 12 Hours in Department* [From a decision to admit]	2,514	1,845	2,056
Ambulance Handover Delays (>30 minutes) *[National target – 5%]*	2,888	2,714	2,680
Ambulance Handover Delays (>60 minutes) *[National target – 0]*	418	305	461
NHS 111 – Calls Abandoned *[National target <3%]*	13%	14%	TBC
Long Lengths of Stay (>21 days) *[23/24 Target – 455]*	589	582	559

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

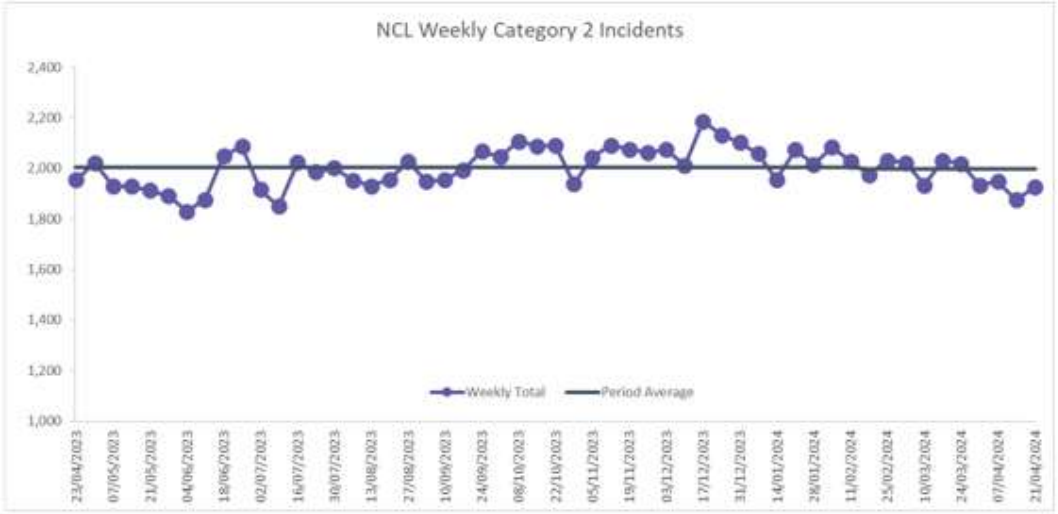
North Central London
Integrated Care Board

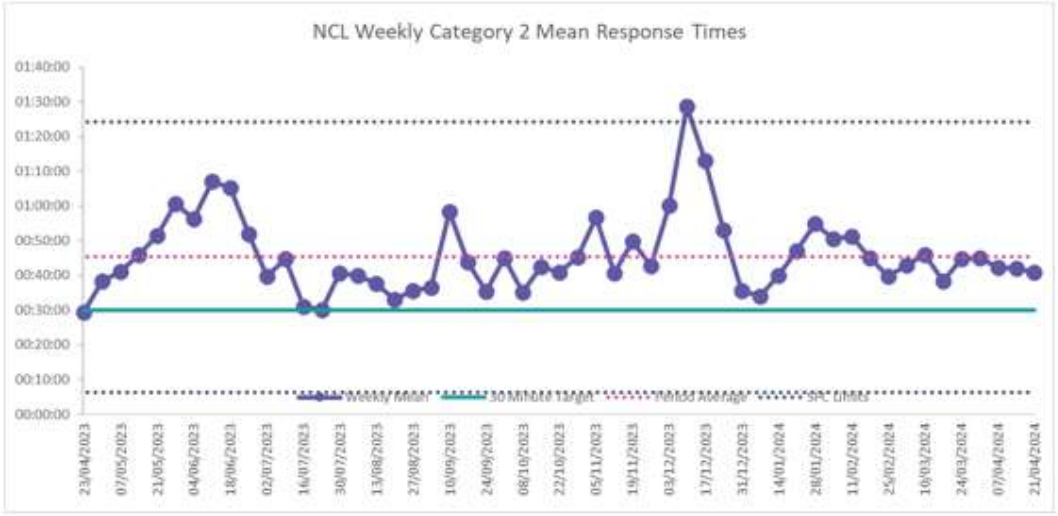
London Ambulance Service (LAS)

LAS ambulance handover performance remains challenged, with the number of handovers taking over 30 minutes remaining very high. In February 2024, there were 700 more handovers taking longer than 30 minutes than in February 2023, however, since the implementation of the pan-London LAS 45-minute handover protocol in summer 2023, there has been fewer handovers taking longer than 60 minutes, more than halving from February 2023 (720) to February 2024 (305). Handovers within 45 minutes averaged 85% in March 2024. 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 from 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 4 minutes, and a call abandonment rate of 14%, in February 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 staff retention and absence. A series of support and improvement initiatives are in place, including a national resilience partner (Vocare) supporting up to 20% of calls received, (in place until the end of 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. An improvement trajectory plan is in place with weekly system meetings to track performance recovery.





Overview of Elective Services

North Central London
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The Referral to Treatment programme has focussed on reducing the number of long waiting patients across admitted and non-admitted pathways, to eliminate waits over 78 weeks by the end of March 2024. NCL acute providers have increased activity levels during periods of no industrial Action (IA) but have experienced reduced elective activity by 20-30% and outpatient activity by 10-20% for each strike day. This covers 36 days in 2023 and 6 in 2024. The recent ballot indicates that IA will potentially continue to disrupt normal elective services during 2024.

NCL providers have shown good service resilience and have realised service efficiencies that have helped deliver the required 78 week wait reductions despite recurrent IA. The strikes have had a significant impact on the waiting list, as clinically urgent and the longest waiting patients have been prioritised, but the usual mixed attrition of shorter waiting patients has not occurred. This will impact the elective capacity requirements since greater numbers of patients are on the waiting list, albeit for a shorter time. The majority of the longest waiting patients are attributed to capacity constraints across surgery and within the specialised and complex paediatric services.

The focus for 2024/25 is to eliminate all patient waits over 65 weeks by the end of September 2024. NCL providers have undertaken demand and capacity modelling to assure that this plan is achievable, with a highlight on those areas needing assistance through mutual aid, waiting list initiatives, or with referral management.

NCL ICB will continue to support with key interventions to reduce waiting times:

- 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.

	Jan '24	Feb '24	Mar '24
RTT Waiting List *[23/24 Target – 259,133]*	264,509	268,618	*281,745**
RTT 65ww *[23/24 Target – 0]*	2,529	2,177	*1,699**
RTT 52ww *[23/24 Target – 3,088]*	8,377	8,373	*9,255**

	Dec '23	Jan '24	Feb '24
Electives YTD vs 19/20 baseline *[Inpatients + Day Cases]*	111.0%	111.0%	111.6%
Outpatient FU YTD vs 19/20 baseline *[Excluding OPPROC]*	107.5%	107.7%	108.2%

** 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 February 2024, NCL remains the top-performing ICB in England, with 9.0% of patients waiting over 6 weeks for a diagnostic test. NCL providers are reporting 6.2% for the same period. 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 continues across the system to focus on modality hotspots where the highest volumes are recorded and progress actions to help achieve this target.

The latest unvalidated data for March 2024 suggests that the NCL diagnostic backlog has increased to 11.4%, although this figure is expected to drop after all providers complete their validation exercises and publish their final position. Recovery plans remain in place to reduce backlogs, with additional capacity at NCL providers, and more utilisation of Community Diagnostic Centres (CDC) as mutual aid for imaging modalities.

March 2024 unvalidated data shows that the imaging backlog contributed to 45% 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 specialised 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. Endoscopy procedures have mutual aid in place with UCLH and WH, although some of the cohort are complex patients that require general anaesthetic, so are not suitable for mutual aid.

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.

	Jan '24	Feb '24	Mar '24
Diagnostic Waiting List	41,595	45,124	*49,012**
Diagnostic Waits > 6 weeks %	8.5%	6.2%	*11.4%**
Diagnostic Waits > 6 weeks	3,543	2,788	*5,567**
Diagnostic Waits > 13 weeks	549	577	TBC
Diagnostic Activity *[% of 2019/20)*	123%	126%	TBC

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

Overview of Cancer Services

North Central London
Integrated Care Board

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 March 2024 to 566, following a Q3 peak of 716 in January 2024. Faster Diagnosis Standard (FDS) performance for February 2024 recorded the highest value for NCL for all of 2023/24 so far.

Cancer waiting times (CWT) performance standards have now been simplified to three from the previous ten, and the FDS and 62-day performance have become priority standards, replacing the 62-day backlog standard. At the end of March 2024, NHSE published the 2024/25 planning objectives which are to improve performance against the 62-day standard to 70% by March 2025, improve performance against the FDS to 77% by March 2025 towards the 80% ambition by March 2026, and increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

NCL faces a challenge in meeting the 2024/25 performance trajectories - aggregating the standards will result in a small increase in 62-day performance and a greater impact on performance from screening referrals and consultant upgrades. Shifting focus onto the 62-day standard will require a wider focus, as the standard covers exclusively patients with confirmed cancer. Two pathways whose profiles are expected to increase as a result are breast and lung.

Working with primary care, providers and the NCL Cancer Alliance (NCLCA), NCL has submitted an operational performance delivery plan for 2024/25 to NHSE. Highlights include a series of provider business cases to increase capacity to close the gap where it is outstripped by demand, and to build resilience to potential future industrial action and peaks in demand. NCL will continue to oversee outliers across the previous 10 standards, and the 104-day backlog to avoid the risk of losing sight of key cohorts.

Four transformational projects provide an opportunity to close the performance gap through efficiencies, avoiding the high-risk strategy of doing more of the same in an environment characterised by a workforce shortfall. New pathways in breast, skin, gynaecology and multi-disciplinary team meetings (MDTM) present an opportunity to deliver better and more efficient services. The NCLCA will lead NCL in implementing these pathways, including investment in the workforce where operational bandwidth has been a barrier to implementing new pathways in the past.

	Jan ’24	Feb ’24	Mar ‘24
Cancer Waits 62-Day Backlog *[23/24 Target - 515]*	692	553	566
Cancer Diagnosis Standard (FDS) *[23/24 Target – 75%]*	68.2%	73.5%	TBC Data is reported 6 weeks in arrears

NCL Providers (as of 31st March 2024)	Cancer Backlog as % of Waiting List
Royal National Orthopaedic	11.5%
North Middlesex	9.7%
Whittington Health	9.3%
Royal Free London	8.7%
University College London	6.2%
England Average	**7.5%**

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 or Q4. While AE 4-hour targets have not been achieved, 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 (SDEC) pathways and virtual wards utilisation can be maximised.

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 from Q3 onwards and ended the year with 282 patients waiting – 18 more than plan. Clearance rates have been impacted by recent industrial action in Q3 and Q4, with urology, breast, and lower GI remaining the most challenged pathways.

Faster Diagnosis Standard (FDS) improvements had been seen against the revised plan for Q3, but trajectories have been missed in January and February of 2024. Early indications for March 2024 data suggest an expectation for performance to meet the FDS 75% in month target. Endoscopy capacity for complex patients has been an ongoing issue at RFL, and possible opportunities will be explored here in order to achieve sustainable improvements for patients into 2024/25.

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. Cancer performance for March 2024 shows that NMUH finished the year ahead of trajectory with 83 patients against a plan of 85 – driven by recent improvements in lower GI and urology. FDS achievement has remained challenged throughout 2023/24, but the February 2024 value of 72.6% was the highest recorded in year. The FDS has been impacted by endoscopy delays affecting overall performance but should ease with additional capacity from 3 extra clinics into 2024/25.

UEC performance against the exit criteria remains below agreed trajectories since Q2 of 2023/4.

Delivery on the ambulance handover target has been particularly challenged and remains a key focus into 2024/25. A recent NCL system trial of diverting patient postcodes normally associated to NMUH, to other sites has not resulted in material improvements to performance highlighting the importance of internal work on flow which complements ongoing support from the system around attendances.

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. NMUH have established their ‘hot’ and ‘cold’ SDEC pathways and have also focussed on improved streaming and the ability to divert patients away from A&E much earlier in the pathway e.g. to an urgent treatment centre.

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. Meetings will now move from monthly to quarterly during 2024/25.

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. The live patient list has now transferred to GOSH as part of 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. As of April 2024, this framework is in place.

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. – they have also commissioned an external independent review of adult gender services.

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

North Central London
Integrated Care Board

Appendices

Appendix 1 – NCL Balanced Scorecard

North Central London
Integrated Care Board

NCL ICS Level Scorecard (16-04-24)

	Key Performance Indicator	Target	Reporting Period	Current Performance	Trend	Year-End Forecast	Notes
ICS Finance	Bottom line (YTD)	(£21.8m)	YTD M11	(£40.9m)		(£0.0m)	*The system FOT is breakeven as of M11*
	Efficiency delivery (YTD)	£257.9m	YTD M11	£211.8m		£274.7m	*Providers are currently behind on CIP delivery and the forecast is less than plan by £11m*
	Agency Spend (YTD)	£86.4m	YTD M11	£101.7m		£110.0m	*YTD overspend on agency against 2023/24 plan and a straight line extrapolation would indicate that NCL will exceed the 2023/24 NHSE agency cap.*
	Capital (YTD)	£155.0m	YTD M11	£146.8m		£184.3m	*YTD underspend to plan reported at M11*
	Cash (YTD)	n/a	YTD M10	£740.4m		£726.7m	*YTD cash position is a net £453m increase in cash balances, equivalent to a net increase of 34 days (612%) cash in hand from 56 days to 90 days*
	ERF	n/a	YTD M7	£6.7m		n/a	*As of M7, NCL ICB has paid £6.7m of ERF overperformance to the 7 providers within NCL.*
Performance & Quality	Elective Activity (% of 19/20)		YTD M11	111.6%	Steady		*Value represents NCL provider aggregate*
	Total Waiting List Size	Mar '24 <259,133	w/e 31/03/24	281,745	Declining	off target	*The NCL waiting list has increased through Feb & Mar-24 with referral delays arising from industrial action; there is a potential that the closure of the RSS too has contributed to this rise.*
	RTT 65ww	Mar '24 <2,390	w/e 31/03/24	1,699	Improving	on target	*Trusts across NCL have reviewed demand and capacity and plans are progressing to assure in areas of pressure.*
	Cancer Backlog	Mar '24 <515	w/e 31/03/24	566	Declining	off target	*The NCL backlog position is largely driven by urology (188), lower GI (104) and breast (81). Material reductions have been seen from the end of Jan-24 into Mar-24 in urology, gynaecology, and skin pathways.*
	Cancer Backlog - % of PTL	6.4%	w/e 31/03/24	6.7%	Declining	off target	
	Cancer FDS	Feb'24 >75.0%	Feb '24	73.5%	Improving	off target	*NCL FDS performance remains challenged throughout all of 2023/24*
	Diagnostic % >6 weeks	Mar '24 <9.8%	w/e 31/03/24	11.4%	Declining		*Based on validated data, NCL ICB is still England's best performing ICB, with 9% over 6+ww performance in Feb-24.*
	MH - Talking Therapies Access	M11 YTD - 40,654	YTD M11	32,026	Steady		*Underperformance seen across all NCL boroughs*
	MH - Out of Area Placements	Q4 - 0	Q4	173	Improving		*The numbers of Out of Area Placements is exceeding anticipated target at both BEH and C&I.*
	CAMHS Access	M10 (12MR) - 20,579	M10 (12MR)	23,143	Improving		*NCL performance on plan due to additional activity reported from MHST function 1cases.*
	Never Events	0	Feb-24	0			*Represents NCL providers' total count*
	Serious Incidents	0	Feb-24	13			*Represents NCL providers' total count*
	HCAI - *C.Diff*	12 month rolling - 297	Feb-24	271			*Represents NCL ICB total cases*
	HCAI - MRSA	0	Feb-24	24			*Represents NCL ICB total cases*
Efficiency/ Workforce	Staff in Post v Plan	Op Plan	M11	4%			*Values are based on the 2023/24 Operating Plan submission*
	Vacancy Rate	n/a	M11	7.9%			
	Sickness Rate	c4%	M7	4.2%			*The overall NCL sickness rate has remained steady over recent reporting periods.*
	Theatre Productivity	85%	4 wks to 24/03/24	77.0%			*Value represents 'capped utilisation'.*
	Daycase as a % of Elective	85%	Jan '23	87.4%			*MEH,NMUH and RFL are currently meeting the target.*
	Outpatient FU Reduction	75%	YTD M11	108.2%			*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 23/24 - Q1	2023/24			TARGET 23/24 - Q2	2023/24			TARGET 23/24 - Q3	2023/24			TARGET 23/24 - Q4	2023/24	
			April	May	June		July	August	September		October	November	December		January	February
Summary of Monthly Measures	IAPT access	11,088	2,990	6,055	9,045	22,175	11,915	14,665	17,310	33,263	20,080	23,151	25,421	44,350	28,981	32,026
	IAPT recovery rate	50.0%	47.0%	51.0%	49.0%	50.0%	47.0%	48.0%	49.0%	50.0%	46.0%	47.0%	49.1%	50.0%	48.0%	48.0%
	IAPT first treatment 6 weeks finished course rate	75.0%	85.3%	85.0%	87.0%	75.0%	87.0%	86.0%	87.0%	75.0%	89.0%	90.0%	91.0%	75.0%	87.0%	85.0%
	IAPT first treatment 18 weeks finished course rate	95.0%	98.0%	98.0%	99.0%	95.0%	98.0%	98.0%	99.4%	95.0%	98.0%	99.0%	99.0%	95.0%	99.0%	99.0%
	CYP access - One contact	16,822	20,080	20,153	20,467	18,075	20,749	21,228	21,504	19,327	21,714	22,022	22,578	20,579	22,983	23,241
	Dementia diagnosis rate 65+	67.0%	66.3%	67.2%	68.0%	67.0%	67.9%	67.9%	68.0%	67.0%	68.2%	68.2%	68.2%	67.0%	67.5%	67.5%
	EIP entering treatment - treatment received <2wks	60.0%	69.0%	69.0%	78.0%	60.0%	77.0%	85.0%	80.0%	60.0%	75.0%	72.0%	48.0%	60.0%	54.0%	TBC
	Number of inappropriate OAP days (YTD by quarter)	578	221	390	594	392	241	377	683	155	420	618	1,042	0	173	TBC
	1 hour response time %	95.0%	96.8%	96.8%	97.2%	95.0%	95.8%	96.3%	95.3%	95.0%	94.1%	93.4%	94.6%	95.0%	94.3%	TBC
	24 hour response time %	95.0%	98.2%	96.8%	95.5%	95.0%	97.1%	97.5%	97.4%	95.0%	97.4%	97.3%	98.0%	95.0%	97.7%	TBC
	Women accessing perinatal mental health (PMH)	275	351	498	612	550	709	771	851	948	944	1,040	1,135	1,347	1,257	1,355

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	TARGET 23/24 - Q4	Q4
Summary of Quarterly Measures	Children and young people (CYP) eating disorders - urgent	95%	43.6%	95%	54.1%	95%	57.1%	95%	75.0%	95%	100.0%	95%	100.0%	95%	100.0%	95%	100.0%
	Children and young people (CYP) eating disorders - routine	95%	25.4%	95%	27.2%	95%	28.1%	95%	34.0%	95%	82.8%	95%	87.9%	95%	97.4%	95%	95.5%
	People accessing individual placement and support (IPS)	285	308	570	400	855	494	1,141	767	355	331	711	441	1,066	585	1,421	765
	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	14,028	14,507
	Adult Community Access	16,795	15,200	17,825	14,985	18,555	14,945	19,887	14,805	16,627	23,474	18,248	24,567	19,870	25,487	21,491	TBC
	Learning disabilities - annual health checks	12.4%	17.0%	29.4%	37.4%	49.2%	59.5%	75%	90.3%	12%	14.4%	29%	32.6%	49%	52.8%	75%	78.1%
	Learning disabilities - adult inpatients (ICS Commissioned)	26	27	24	20	22	18	22	22	23	25	23	25	23	18	23	TBC
	Learning disabilities - adult inpatients (NHSE Commissioned)	19	16	19	18	16	17	16	18	17	22	16	24	15	23	14	TBC
	Learning disabilities - CYP inpatients	5	6	5	8	5	9	5	5	8	5	7	7	6	7	5	TBC

Appendix 4 – NCL Acute Dashboard

North Central London
Integrated Care Board

NCL - Selected Acute Services		2022/23	2023/24										
		March	April	May	June	July	August	September	October	November	December	January	February
UEC	*4-Hour AE performance target*	*95.0%*	*70.1%*	*70.5%*	*71.9%*	*72.7%*	*73.8%*	*74.8%*	*75.6%*	*76.0%*	*74.9%*	*75.7%*	*77.3%*
	4-Hour AE performance	68.4%	71.3%	70.6%	72.8%	73.8%	72.7%	69.7%	69.4%	66.9%	65.4%	67.9%	68.8%
	12 hour waits	1,586	1,054	1,614	1,343	1,078	1,493	1,387	1,924	2,028	2,059	2,514	1,845
	LAS handovers	6,451	6,589	6,381	6,111	7,099	7,082	6,892	7,086	6,678	6,917	7,277	7,228
	Ambulance handovers 30 min+	2,542	2,183	2,191	2,065	1,894	1,996	2,207	2,311	2,145	2,578	2,888	2,714
	Ambulance handovers 60 min+	889	589	753	613	210	117	124	201	156	310	418	305
RTT	*New RTT pathways (clockstarts) plan*	*54,751*	*52,262*	*60,400*	*58,575*	*58,005*	*58,678*	*57,657*	*61,019*	*59,905*	*49,061*	*58,297*	*54,288*
	New RTT pathways (clockstarts)	69,287	55,756	63,559	64,858	62,169	61,821	61,972	65,237	65,655	53,430	64,402	65,283
	RTT incompletes plan	*247,754*	*259,555*	*261,219*	*261,938*	*261,127*	*260,675*	*259,771*	*259,978*	*259,218*	*259,109*	*259,404*	*259,249*
	RTT incompletes	259,535	262,516	264,929	267,490	267,358	269,450	271,572	268,969	265,640	266,991	264,509	268,618
	52+ waits plan	*7,186*	*5,962*	*6,624*	*6,392*	*6,088*	*6,297*	*6,182*	*5,546*	*4,910*	*4,208*	*3,840*	*3,368*
	52+ waits	6,289	6,710	7,048	7,170	7,717	7,748	8,197	8,600	8,684	8,429	8,377	8,373
	65+ waits plan	*n/a*	*2,379*	*2,728*	*2,473*	*2,365*	*2,526*	*2,267*	*1,874*	*2,231*	*2,219*	*2,276*	*2,333*
	65+ waits	1,231	1,250	1,391	1,527	1,611	1,964	2,167	2,269	2,162	2,495	2,529	2,177
Diagnostics	*Imaging plan*	*57,740*	*48,306*	*54,129*	*51,967*	*52,436*	*52,435*	*55,555*	*57,582*	*58,814*	*49,800*	*55,640*	*53,758*
	Imaging activity	68,236	57,313	63,721	67,854	64,511	63,917	64,169	68,021	70,219	62,532	69,947	66,234
	Endoscopy plan	*3,966*	*4,004*	*4,481*	*4,167*	*4,604*	*4,197*	*4,206*	*4,434*	*4,577*	*3,863*	*4,218*	*4,198*
	Endoscopy activity	4,651	3,889	4,036	4,489	4,194	4,073	4,347	4,823	4,954	4,250	4,584	4,472
	Total diagnostic 6+ weeks	3,503	4,596	4,467	4,447	3,997	4,534	4,395	3,744	3,154	3,713	3,543	2,788
	Total diagnostic 6+ weeks achievement	91.3%	88.5%	89.4%	89.4%	90.4%	88.6%	89.6%	91.2%	92.6%	90.8%	91.5%	93.8%
Cancer	*62+ backlog plan*	*488*	*748*	*725*	*701*	*679*	*651*	*637*	*609*	*592*	*578*	*559*	*541*
	62+ backlog	665	752	742	723	691	763	802	788	691	675	692	553
	104+ waits plan	*n/a*	*340*	*346*	*324*	*307*	*291*	*271*	*256*	*241*	*237*	*230*	*211*
	104+ waits	345	341	330	345	355	332	313	354	336	350	310	349
	28-day FDS plan	*75.0%*	*69.8%*	*72.1%*	*72.2%*	*74.3%*	*75.1%*	*76.0%*	*77.6%*	*73.0%*	*72.5%*	*73.9%*	*75.0%*
	28-day FDS achievement	73.1%	69.8%	66.9%	67.9%	71.2%	69.9%	70.1%	69.0%	69.6%	71.6%	68.2%	73.5%
Beds	*Average G&A beds occupancy plan*	*93.9%*	*95.8%*	*95.4%*	*95.3%*	*95.7%*	*95.4%*	*95.7%*	*95.9%*	*96.4%*	*96.2%*	*96.8%*	*96.3%*
	Average adult G&A beds occupancy	94.6%	91.8%	92.6%	92.4%	89.5%	90.4%	90.9%	91.9%	93.5%	90.3%	91.5%	92.3%
	Average adult CC beds occupancy plan	*79.5%*	*79.8%*	*79.3%*	*79.8%*	*80.3%*	*79.7%*	*79.3%*	*79.8%*	*79.3%*	*79.7%*	*82.7%*	*81.3%*
	Average adult CC beds occupancy	80.9%	78.6%	82.4%	77.0%	79.6%	81.8%	72.9%	78.2%	82.1%	82.2%	82.1%	83.8%
	Length of stay 21+ plan	*n/a*	*541*	*548*	*529*	*520*	*516*	*507*	*512*	*470*	*474*	*532*	*488*
	Length of stay 21+	576	591	578	553	548	566	565	593	605	571	589	582

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 May 2024

Report Title	Board Assurance Framework ('BAF') Report	**Date of report**	19 April 2024	**Agenda Item**	3.2
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 reports;
- BAF Register. This is the full BAF risk register should Board members require further detail on each risk and the risk plans to control the risks (including controls, gaps in controls and actions). The full version of the BAF risk register is here.

Risk Overview

There are 10 risks in total on the BAF:

- 4 are ICB only risks;
- 1 is an ICB risk generated from risks or issues in other organisations;
- 5 are system risks;
- 4 of the 10 risks are below the BAF threshold but included for information.

There are no new risks.

Two risks have decreased:

- Perf8- Failure to deliver clearance of Referral-To-Treatment ('RTT') Long Waiting Patients across the 104, 78 and 65 week wait cohorts (Threat). Decreased from 16 to 12. This risk will continue to be overseen by the Quality and Safety Committee. This risk has reduced following the publication of the Operating Plan as the parameters for delivering the national RTT targets have changed and the time given for delivery has been extended;
- Fin29- Failure of North Central London Integrated Care Board ('ICB') to remain within its Running Cost Allowance ('RCA') 2024/25 and 2025/26 (Threat). Decreased from 12 to 9 as many of the mitigating actions have been put in place and they are successfully mitigating the risk.

One risk has closed:

- Fin16- Failure to Deliver the ICB's 2023-24 Financial Plan (Threat). This risk has closed as it has been fully mitigated;

4 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);
- 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>
The ICB has met its 2023-24 financial plan and any risks has been fully mitigated. In addition, the ICB is expected to remain within its Running Cost Allowance for Financial Years 2024-25 and 2025-26 with many of the mitigating actions that have been put into place successfully controlling the risk. A risk for the ICB's 2024-25 financial plan is being overseen by the Finance Committee and has a Current Risk Score of 12.

<u>Performance</u>
There remains significant risk to the clearance of Referral To Treatment ('RTT') long waiting patients across the 104, 78 and 65 week wait cohorts. Industrial action has caused delays in patients receiving treatment and caused waiting lists to grow significantly.

Whilst targeted action is being undertaken across providers to address this NCL tip in rates into the 52 week wait and 65 week wait cohorts have increased since January 2024. This is a long-term risk to sustaining the progress made with clearance of the 78 week wait cohort into 2024/25.

Great Ormond Street Hospital ('GOSH') Paediatric Dentistry remains a key risk to the system's delivery of June 78 week wait clearance target. To mitigate this risk, supported by NHS England, NCL ICB is facilitating an insourcing arrangement between Guy's and St Thomas' ('GSTT') and GOSH, with consultant and the

	required clinical staff being provided by GSTT to transfer across to provide operational capacity to GOSH. A routine mutual aid establishment is scheduled to run through Quarter 1 at University College London Hospital, and GOSH have recruited an additional Paediatric Dentistry Consultant who will be joining the Trust in June 2024. However, whilst the risk to patients remains high the risk to the ICB delivering the required national targets has reduced from 16 to 12 (see Perf8) following the publication of the Operating Plan. This is because the parameters for delivering the RTT targets has changed and the time given for delivery has been extended. **Looking Forward** The ICB's approach to risk management continues to evolve with oversight by the Audit Committee. A review of all Target Risk Scores is underway to ensure Target Risk Scores are realistic and achievable. In addition, all risk owners are assessing when they estimate each Target Risk Score will be achieved and this will be added to the risk register.
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	Committee	Risk description	Strategic update	2023 - 2024 Current Risk Score JULY	OCT	MAR	APRIL	Movement From Last Report	Target Risk Score
System Risks reducing to below the BAF threshold											
PERF8	Failure to deliver clearance of Referral-To-Treatment ('RTT') Long Waiting Patients across the 104, 78 and 65 week wait cohorts (Threat).	Richard Dale - Executive Director of Performance and Transformation	Strategy and Development Committee	**CAUSE:** If the ICB is unable to ensure adequate capacity and operational resilience to effectively manage waiting times due to winter pressures, industrial action impacts on capacity, and the requirement to prioritise patients with the greatest clinical need as well as low volume, high complexity long waiting patients within specialised services requiring treatment remaining on acute/tertiary waiting lists, **EFFECT:** There is a risk to operational delivery & elective waiting list management and that the system will not meet the national ambitions around RTT Long Waiting Patient clearance. **IMPACT:** This may result in the ICB missing the national expectations for long waits, poor patient outcomes and experience and adversely impact on SOF segmentation.	NHS England ('NHSE') have engaged with systems nationally to complete the annual Operating Plan process for 2024/25. Two of the key priority deliverables are 78 week wait clearance by the end of June 2024, and 65 week clearance by the end of September 2024. British Medical Association industrial strike action held throughout 2023/24 has had a significant adverse impact on elective capacity and long waiting patient recovery. Industrial action, most recently held in February 2024, 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 has led to increases to 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+ weeks. 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 Quarter 1 of 2024/25 if they remain unscheduled; • 78 week patient waits clearance to June end. • Booking and rescheduling 65+ week waits to sustain cohort growth • A reduction in 52+ week waits where possible throughout 2024/25; • Constituted diagnostic backlog recovery across imaging and endoscopy in line with provider operating plan trajectories. Great Ormond Street Hospital ('GOSH') Paediatric Dentistry remains a key risk to the system's delivery of June 78 week wait clearance target. To mitigate this risk, supported by NHSE, NCL ICB is facilitating an insourcing arrangement between Guy's and St Thomas' ('GSTT') and GOSH, with consultant and the required clinical staff being provided by GSTT to transfer across to provide operational capacity to GOSH. A routine mutual aid establishment is scheduled to run through Quarter 1 at University College London Hospital, and GOSH have recruited an additional Paediatric Dentistry Consultant who will be joining the Trust in June 2024. NCL tip in rates into the 52 week wait and 65 week wait cohorts has increased since January, and is a long-term risk to sustaining the progress made with clearance of the 78 week wait cohort into 2024/25. This risk has been reviewed and revised following the publication of the Operating Plan. As the parameters for delivering the national RTT targets have changed, as well as the time given for delivery extended, the initial, current and target risks have all reduced.	16	16	16	12	↓	9
Continuing System Risks											
PERF29	Failure to achieve the 4 hour A&E wait standard (Threat).	Richard Dale - Executive Director of Performance and Transformation	Strategy and Development Committee	**CAUSE:** If the ICB fails to ensure adequate capacity and operational resilience to affectively manage the flow of patients through the Emergency Department ('ED') and the hospital, **EFFECT:** there is a risk that patients will not be seen within the expected 4 hours and receive sub-optimal care, which may have an adverse effect on their health outcomes. **IMPACT:** this may result in the ICB missing the national expectation that 76% of patients are seen within 4 hours of arrival to the ED, increasing waiting times and increasing the potential risk of harm and adversely impact on System Oversight Framework segmentation.	Some progress has been made on improving 4 hour performance, with recent performance averaging 70%. While the ICB remains below the 76% trajectory, there have been signs of improved performance, however this is yet to be maintained. Operational plans for 2024/25 have been refreshed, particularly in relation to performance improvement trajectories together with underpinning actions to deliver. For Urgent and Emergency Care ('UEC'), these reflect national priorities such as the UEC Recovery Plan and the 5 priority improvement initiatives. Providers are maximising alternate care pathways including Urgent Care Response, Silver triage, Ambulatory Care and Same Day Emergency Care and utilisation and streaming to alternative care pathways. Providers are working with the local authority partners to improve discharges including reducing long stays for homeless patients, increasing the utilisation of discharge lounge capacity and discharge improvements via implantation of the 'SAFER' discharge bundle (Senior review, All patients, Flow of patients, Early discharge, Review of long stay patients), optimising use of virtual wards and focussing on daily management of those patients with no criteria to reside. Additional system actions to support performance improvement include use of the GP hub service, alongside the urgent treatment centre to separate patients requiring primary care services away from the main Emergency Department, and a continued review of flows within Acute Medical and Frailty Assessment Units to ensure that patients are only admitted to base wards when necessary. The continued review of flow is being further enhanced through a recently initiated Site Peer Review programme.	16	16	16	16	→	12
PC3	Strikes by NHS staff (Threat).	Sarah Morgan - Chief People Officer	NCL People Board	**CAUSE:** If industrial action taken by various Unions within healthcare, due to pay and working conditions disputes, continues without resolution, **EFFECT:** There is a risk that services will face significant reduction, cancellations of elective activity, and a reduced ability for London Ambulance Service ('LAS') to respond to non-life and limb patients during the time of industrial action. **IMPACT:** This may result in an increase in negative patient experience and negative patient outcomes, and a reduction in the quality of service delivered and capacity. This may also result in a disengaged workforce, and may exacerbate exiting system-wide workforce challenges.	This risk has emerged from national industrial action taken by unions and NHS staff regarding pay and working conditions disputes. Since the last update, the consultant's have a ccepted a revised pay deal and the junior doctors within the BMA voted in favour of continuing strike action which has now resulted in a further 6 months mandate. We are currently awaiting to hear when the next strikes will take place. The NCL People Board reviewed this risk at its last meeting on 19th February 2024 and held the Current Risk Score at 20.	20	20	20	20	→	15
FIN36	St Pancras Hospital Transformation Programme Funding (Threat).	Bimal Patel - Interim Chief Finance Officer	Finance Committee	**CAUSE:** If there is insufficient funding to deliver the complete St. Pancras transformation programme, **EFFECT:** There is a risk that the system will need to significantly 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.	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. A new finance resource was hired to review the overall programme finances and determine all costs to ensure confidence in the figures presented and allow the size of the funding shortfall to be confirmed. Project teams have been set-up to determine the costs for the various service relocations required to vacate the St Pancras site and decommission the buildings before the land sale. The shortfall is also dependent on the land sale value ('RLV'). In the meantime, the Finance and Business Case Group (28 November 2023) and Programme Board (12 December 2023) have approved a recommendation to pause work on the proposed Greenland Road development. This was referred to the C&I Trust Board in January 2023 for approval and may also require NHS England/Department of Health and Social Care approval. Other options to further reduce the pressure on the programme finances continue to be explored.			20	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	Finance Committee	**CAUSE:** If the ICS does not have sufficient capital allocation and the ICB does not effectively allocate the capital allocation, **EFFECT:** There is a risk that the ICS will not be able to deliver its strategic priorities whilst also addressing issues with key infrastructure. **IMPACT:** This may result in under delivery of ICS strategic priorities, some key estates becoming unusable or sub-par, a negative impact on population health and patient care and reputation damage.	The NCL ICS capital allocation for 2024/25 is approximately £178m. However, the current ICS strategic priorities, together with the list of urgent capital projects submitted by system partners, significantly 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 (approximately £330m per year) deficit.			20	20	→	15
ICB Risk arising from risks or issues in other organisations - below BAF threshold, but included for oversight											

PERF28	Failure of Primary Care patient access (Threat).	Sarah McDonnell-Davies - Executive Director of Place	Primary Care Committee	**CAUSE:** If the ICB fails to address patient and stakeholder concerns around timely and appropriate access to general practice, **EFFECT:** There is a risk 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 to Primary Care 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 be presented to the ICB public Board of Members meeting in March 2024. Further work is required to address access to Primary Care, including: • patient experience; • ease of access (including digital inclusion / exclusion); and, • contributing factors including workforce and patient needs and expectations. On average practices have witnessed a 15 to 30 % increase in appointments compared to before COVID-19. 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 and planning is underway to address this. This will be overseen by the Primary Care Committee.	12	12	12	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	Finance Committee	**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 11 financial position has a forecasted overspend, which continues to be driven by 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 bound 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) is to be refreshed with Local Authority re-engagement and sign-up. Additionally, the weekly joint funding reconciliation meetings are in place with the aim of closing historical reconciliation queries and processing the 2023/24 reconciliations with LA Finance/Commissioner leads. The 2023/24 NCL ICB Uplift Requests has only two cases outstanding, which is with the Provider for response and is expected in 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 and will end on 31 March 2024. The 2024/25 Invest to Save schemes are expected to be CHC Personal Health Budget Cost & Improvements and CIC Transition Service Stand-up.		16	16	16		→	9
Reducing ICB Only Risk below BAF threshold, but included for oversight												
FIN29	Failure of North Central London Integrated Care Board ('ICB') to remain within its Running Cost Allowance ('RCA') 2024/25 and 2025/26 (Threat).	Bimal Patel - Interim Chief Finance Officer	Finance Committee	**CAUSE:** If the ICB fails to mitigate any RCA overspend in Financial Years 2024/25, and 2025/26 due to the failure of the Organisational Design Programme to deliver the required efficiencies savings and/or due to the delayed implementation of new structures impacting on the delivery of 2024-25 RCA efficiencies, **EFFECT:** There is a risk that the ICB will be in breach of its statutory duty to stay within its RCA. **IMPACT:** This may result in the ICB being referred to the Secretary of State by its Auditors, with associated increased financial scrutiny and intervention from NHS England, and causing significant reputational damage.	As the organisational change programme progresses, there will be continual review of the controls and Running Cost Allowance ('RCA') impact on pay and non-pay costs to provide assurance on meeting required reductions. Financial modelling is currently forecasting achievement of the running cost reduction, noting that 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. The current risk score has dropped from 12 to 9 as many of the mitigating actions have been put in place and are successfully mitigating the risk.		12	12	9		↓	6
Continuing 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	Strategy and Development Committee	**CAUSE:** If the ICB fails to effectively manage the devolution of many specialist services to the ICB, and the opportunity to integrate pathways and tackle the underlying population health issues that are causing the growth in specialist activity and spend is lost, **EFFECT:** There is a risk that the expected improved health outcomes are lost and that provider services are destabilised and expertise is lost. There is also a risk that services are lost, particularly fragile services including Highly Specialised Services which, whilst not being devolved, could be destabilised if other related services experience issues. Changes to services and changes to the funding formula for specialised services could also lead to further provider and/or individual service pressures and resulting impacts on outcomes and performance. **IMPACT:** This may result in a negative impact on quality and equity of access, as well as, loss of workforce, increasing waiting times, significant cost pressures and the lost opportunity to improve outcomes.	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. The new programme director and is taking the lead on addressing the conditions for delegation and refreshing the Roadmap setting out the plan to delegation in April 2025. A first draft of this is now available but will require further refinement through 2024/25. The Delegated Services Board has agreed the recruitment of a permanent team to support delegated services (including Dentistry). The intention is that providers fund 50% of the overall cost through a recurrent reduction in their allocations. The proposal was ratified by the Executive Management Team and a recruitment plan is now being prepared. 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.	12	12	12	12		→	9
PC5	Failure to successfully implement the ICB Change Programme (Threat).	Phill Wells - Interim Chief Executive Officer	Executive Management Team Meeting	**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.	The ICB continues to manage the organisational change programme. The majority of the roles in the new structure have now been filled via internal processes in accordance with the ICB's Change Management Policy - slot in/ring-fence selection process. A number of staff left the ICB in January via voluntary redundancy and more staff will leave the ICB via voluntary redundancy on 31 March 2024. The ICB is now in the final phase of filling posts in the new structure via Suitable Alternative Employment ('SAE') for those staff that remain 'at risk' of redundancy and to minimise compulsory redundancies as far as possible. It is expected that this phase of the programme will conclude in early May 2024. Briefings and formal meetings have been held with staff that continue to be affected by change to explain the SAE process and the next steps should secure/not secure SAE, either within the ICB or with another NHS organisation. There are some delays with the final phase of the programme due to the complexity of managing and co-ordinating the SAE process in view of the number of posts available and also due to the February and Easter half term holidays. There will be a small element of double running into Q1 of 2024/25 for colleagues who have not managed to secure a role through the SAE process, however this will not be able to be quantified until the end of March 2024. The transition plan is underway with the detailed planning for each directorate now in development and a senior Director-led transition working group in place delivering the required changes. There are still risks associated with the gaps in resource, however this is being managed through agreed temporary resourcing support from Transformation Partners in Healthcare (TPHC) who are part of the Royal Free London Group.							

Risk Scoring Key

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

1. Overall Strength of Controls in Place

There are four levels of effectiveness:

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

2. Risk Scoring

This is separated into Consequence and Likelihood.

Consequence Scale:

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

Likelihood Scale:

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

3. Level of Risk and Priority Chart

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

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

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

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
7 May 2024

Report Title	Update to Committee Terms of Reference	**Date of report**	19 April 2024	**Agenda Item**	4.1
Lead Director / Manager	Ian Porter, Executive Director of Corporate Affairs	**Email / Tel**		Ian.porter3@nhs.net	
Board Member Sponsor	Mike Cooke, ICB Chair (Chair of the Strategy and Development Committee) Usman Khan, Non-Executive Member (Chair of Primary Care Committee) Dr Jonathan Levy, Partner Member- Provider of Primary Medical Services (Chair of Integrated Medicines Optimisation Committee)				
Report Author	Andrew Spicer, Assistant Director of Governance, Risk and Legal Services	**Email / Tel**		Andrew.spicer1@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** This paper supports the Integrated Care Board ('ICB') to effectively discharge its financial duties.			
Report Summary	As part of the annual review and the implementation of the Change Programme the Terms of Reference for a number of Board committees were reviewed. This is to strengthen the ICB's strategic approach to corporate governance, account for the impact of the ICB's Change Programme and ensure that we have suitable arrangements in place to assist the Board to effectively discharge its duties. Consequently, the Board is requested to approve the following proposed amendments to committee Terms of Reference: <u>Strategy and Development Committee</u> The proposed amendments to the Terms of Reference are: • An addition to the Committee's 'Purpose' to strengthen the Committee's focus on providing assurance to the Board of members that the ICB is discharging its statutory and strategic commissioning functions effectively; • An addition to the Committee's 'Purpose' to include oversight of the Local Care Infrastructure Delivery Board; • Including in the Committee's 'Role' a new responsibility as follows: *"Work together to provide system challenge and support, ensuring that decisions are made in the best interests of the system;"* • Update role titles in section 4.1 to reflect new job titles as part of the Change Programme; • To remove in section 5.1 the representative from Public Health as a Standing Participant and replace this with a representative from Adult				

	Social Care. This amendment is to better reflect the Committee's attendance; • To change the number of meetings per year from a minimum of 4 to 6. The Board of Members is asked to **APPROVE** the Terms of Reference for the Strategy and Development Committee. <u>Primary Care Committee</u> The proposed amendments to the Terms of Reference are: • The Standing Participants listed in section 5.1 be updated to reflect new job titles as a result of the Change Programme; • The Assistant Director for Primary Care Planning, Operations and Improvement and the Assistant Director for Primary Care Strategy and Change be added to the list of Standing Participants. The Board of Members is asked to **APPROVE** the Terms of Reference for the Primary Care Committee. <u>Integrated Medicines Optimisation Committee</u> The proposed amendments to the Terms of Reference are: • Additional wording under the 'Purpose' of the Committee to strengthen the Committee's clinical leadership role to read as "*Provide clinical leadership for the system and ensure co-operation and consistency of approach to medicines optimisation across the NCL Integrated Care System;"* • Role titles are updated in 4.1 and 5.1 to reflect the outcome of the Change Programme; • Two new Standing Participants have been added to reflect the scope of the Committee's work: o Director of Public Health or a Consultant in Public Health; o Lead for the National Tariff Excluded Drugs Function (high cost drugs). The Board of Members is asked to **APPROVE** the Terms of Reference for the Integrated Medicines Optimisation Committee. <u>Local Care Infrastructure Delivery Board</u> The proposed amendments to the Terms of Reference are: • To include the Chief Finance Officer in the membership; • Role titles in the membership section in 5.1 be updated to reflect new job titles as a result of the Change Programme. The Board of Members is asked to **APPROVE** the Terms of Reference for the Local Care Infrastructure Delivery Board. <u>Individual Funding Requests Panel</u> The proposed amendments to the Terms of Reference are: • Due to the infrequency of meetings these will be held on an as needed basis rather than scheduled monthly; • The Terms of Reference clarified so that notice of meetings and papers are sent out 5 working days (i.e. 7 days in line with standard ICB practice) in advance of a meeting. The Board of Members is asked to **APPROVE** the Terms of Reference for the Individual Funding Requests Panel. <u>Individual Funding Requests Appeals Panel ('IFR Appeals Panel')</u> The proposed amendments to the Terms of Reference are:

	• The IFR Appeals Panel reviews the process by which a decision was made and does not make decisions on Individual Funding Requests. Consequently, a change in the membership is proposed as follows: • A reduction in the number of clinicians from three to two; • Commissioning representative is removed from the membership. An IFR Specialist will continue to be a Standing Participant at IFR Appeal Panel meetings; • A representative from the Governance, Risk and Legal Services Team is added; • The Medicines Management Team representative is removed. However, regardless of this change a member of the Medicines Management Team will be invited to participate in meetings on an 'as needed' basis. The Board of Members is asked to **APPROVE** the Terms of Reference for the Individual Funding Requests Appeals Panel. <u>Functions and Decisions Map and other governance documentation</u> Any approved amendments to committee Terms of Reference will need to be reflected, as appropriate, in the ICB's Functions and Decisions Map and in other relevant governance documentation. The Board of Members is asked to **APPROVE** the amendments to the Functions and Decisions Map and the amendments to other governance documentation.
Recommendation	The Board of Members is asked to: • **APPROVE** the Strategy and Development Committee Terms of Reference; • **APPROVE** the Primary Care Committee Terms of Reference; • **APPROVE** the Integrated Medicines Optimisation Committee Terms of Reference; • **APPROVE** the Local Care Infrastructure Delivery Board Terms of Reference; • **APPROVE** the Individual Funding Requests Panel Terms of Reference; • **APPROVE** the Individual Funding Requests Appeals Panel Terms of Reference; • **APPROVE** the amendments to the Functions and Decisions Map and to other governance documentation.
Identified Risks and Risk Management Actions	The proposed amendments to the Terms of Reference will strengthen the Board and its committees ability to discharge their functions.
Conflicts of Interest	Conflicts of interest are managed in accordance with the ICB's Conflicts of Interest Policy.
Resource Implications	The proposed amendments to the Committee Terms of Reference will support the ICB is better using its resources.
Engagement	The draft Terms of Reference were shared with the respective committee members.
Equality Impact Analysis	This paper has been written in accordance with the provisions of the Equality Act 2010.

Report History and Key Decisions	A Governance Review paper was last presented to the Board on 7th November 2023.
Next Steps	If the ICB Board approve the recommendations the next step is to implement them.
Appendices	• Draft Strategy and Development Committee Terms of Reference; • Draft Primary Care Committee Terms of Reference; • Draft Integrated Medicines Optimisation Committee Terms of Reference; • Draft Local Care Infrastructure Delivery Board Terms of Reference; • Draft Individual Funding Requests Panel Terms of Reference; • Draft Individual Funding Requests Appeals Panel Terms of Reference.

NHS North Central London
Integrated Care Board
Strategy and Development Committee
Terms of Reference

1. Introduction

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

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

2. Purpose

2.1 The purpose of the Committee is to:

a) Oversee the development of the NCL system plans, the ICB's commissioning strategies and plans to ensure they:
   - Improve outcomes in population health and healthcare;
   - Tackle inequalities in outcomes, experience and access;
   - Enhance productivity and value for money;
   - Help the NHS support broader social and economic development;

b) Approve the commissioning of health services that deliver the NCL system plan, the ICB's commissioning strategies and plans;

c) Provide assurance to the Board of Members that the ICB is discharging its statutory and strategic commissioning functions effectively;

d) Ensure that all of the ICB's strategic commissioning priorities and plans are congruent and aligned across boroughs;

e) Oversee the Primary Care Committee, the Individual Funding Request ('IFR') Panel,the IFR Appeals Panel and the Local Care Infrastructure Delivery Board;

f) Oversee the development of service improvement strategies across the range of health services commissioned by the ICB.

3. Role

3.1 The Committee will:

a) Work together to provide system challenge and support, ensuring that decisions are made in the best interests of the system;

b) Provide clinical and senior management leadership for at scale and transformational strategic developments and service improvement strategies;

c) Oversee the development and implementation of the ICB's Population Health and Inequalities Improvement strategy and corresponding commissioning framework which supports delivery of the wider long-term objectives aligned to NHS policy direction/guidance;

d) Approve the ICB's annual plan and/or key national plan submissions to regulators as required;

e) Approve the development, recommissioning, de-commissioning and/or reconfiguration of system-wide healthcare services;

f) Oversee the development of collaborative, joint and/or delegated commissioning arrangements to support population health and inequalities improvements across North Central London;

g) Oversee and approve the ICB's approach to a) Digital and b) Estates;

h) Approve business cases, service specifications and authorise investment expenditure

from within the Committee's delegated authority limits;

i) Identify and ensure the delivery of strategic redesign work streams, including clinical input to these;
j) Monitor and review the effectiveness and the implementation of development or service improvement strategies, plans and redesign work streams;
k) Oversight of the annual contracting round;
l) Ensure that investments are affordable, value for money, sustainable and are underpinned by a robust and deliverable efficiency plans, where appropriate;
m) Make decisions on behalf of the ICB on recommendations from the System Delivery Board as appropriate;
n) Ensure place alignment with system-wide priorities and objectives;
o) Ensure that service development decisions reflect the ICB's patient and public and equality and diversity strategies;
p) Review performance issues that require a service improvement decision, service development and/or contract action and make decisions, provide advice and guidance or make recommendations to the Board of Members as appropriate;
q) Consider and act upon the commissioning implications of any issues referred by the Board of Members or any of its committee or sub-committee;
r) Determine arrangements to enable patients to make informed choices (for example, through the provision of relevant and timely information and where appropriate the development of personal budgets and care plans);
s) Provide assurance to the Board of Members that significant service development and improvement risks are being properly managed and agree remedial actions where necessary;
t) Make recommendations to the Board of Members and/or any of its committees as appropriate;
u) Consider Individual Funding Requests ('IFR') applications where the value exceeds the IFR Panel's financial authority limits (this is currently set at £50,000 per year per case);
v) Consider any matter referred from the Primary Care Committee;
w) Consider any matter referred from the Integrated Medicines Optimisation Committee;
x) Provide oversight and give due to regard to the Primary Care Strategy forum.

4. Membership

4.1 The Committee shall comprise of the following voting members:

a) ICB Chair;
b) Non-Executive Member;
c) Four Partner Members or three Partner Members and the UCL Health Alliance Member. One of the Partner Members shall be the Partner Member - Local Authorities;
d) Chief Executive;
e) Chief Finance Officer;
f) Chief Medical Officer;
g) Chief Nursing Officer;
h) Chief Strategy and Population Health Officer;
i) Executive Director of Place;
j) Executive Director of Transformation and Performance.

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

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

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

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

5. Participants and Observers

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

a) The ICB Chief People Officer;
b) A representative from Adult Social Care;
c) A representative from the GP Provider Alliance;
d) A representative from the VCSE Alliance;
e) A Community Participant.

5.2 Participants at Committee meetings are non-voting.

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

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

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

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

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

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

6. Chair

6.1 The Committee Chair shall be ICB Chair**.** The Chair may nominate a deputy to represent them in their absence.

7. Voting

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

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

8. Quorum

8.1 The Committee will be considered quorate when at least five voting members are present which must include:

a) ICB Chair;
b) Chief Executive or Chief Finance Officer;
c) Chief Medical Officer or Chief Nursing Officer;
d) A Partner Member or the UCL Health Alliance Member;
e) Chief Strategy and Population Health Officer or Executive Director of Place or Executive Director of Transformation and Performance.

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

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

9. Secretariat

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

10. Frequency of Committee Meetings

10.1 Committee meetings will be held s six times per year but may hold additional meetings as and when necessary. The Committee Chair may call additional meetings or cancel meetings as necessary.

11. Notice of Meetings

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

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

12. Agendas and Circulation of Papers

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

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

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

13. Minutes of Meetings

13.1 The minutes of the proceedings of a meeting shall be prepared by NCL ICB Governance and Risk Team and submitted for agreement at the following meeting.

14. Authority

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

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

15. Reporting Responsibilities

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

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

16. Delegated Authority

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

17. Virtual Meetings and Decision Making

17.1 Committee meetings may be held in person or virtually.

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

18. Sub-Committees

18.1 The Committee has four sub-committees with delegated functions and authorities which are:

a) The Primary Care Contracting Committee;
b) The Individual Funding Requests Panel;
c) The Individual Funding Requests Appeals Panel;
d) The Local Care Infrastructure Delivery Board.

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

19. Conflicts of Interest

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

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

20. Gifts and Hospitality

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

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

21. Standards of Business Conduct

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

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

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

22. Review of Terms of Reference

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

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

Date approved by the Board of Members:
Date of next review:

Schedule 1
List of Members

The voting members of the Committee are:

Position	Name
ICB Chair	
Non-Executive Member;	
Four Partner Members or three Partner Members and the UCL Health Alliance Member. One of the Partner Members shall be the Partner Member - Local Authorities;	
Chief Executive	
Chief Finance Officer;	
Chief Medical Officer	
Chief Nursing Officer	
Chief Strategy and Population Health Officer	
Executive Director of Place	
Executive Director of Transformation and Performance	

Committee Chair:

Position	Name
ICB Chair	

The standing participants are:

Position	Name
ICB Chief People Officer	
A representative from Adult Social Care	
A representative from the GP Provider Alliance	
A representative from the VCSE Alliance	
A Community Participant	

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

1. Introduction

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

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

2. Purpose

2.1 The purpose of the Committee is to:

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

3. Role

3.1 The Committee will:

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

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

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

4. Membership

4.1 The Committee shall comprise of the following voting members:
a) Two Non-Executive Members;
b) Chief People Officer;
c) Chief Medical Officer;
d) Chief Nursing Officer;
e) Executive Director of Place;
f) Director of Finance.

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

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

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

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

5. Participants and Observers

5.1 The following people shall attend Committee meetings as standing participants:
a) Director of Primary Care;
b) Assistant Director of Primary Care Contracting;
c) Assistant Director for Primary Care Planning, Operations and Improvement;
d) Assistant Director for Primary Care Strategy and Change;
e) Clinical Director for Primary Care;
f) A representative from the Quality Directorate;
g) A Director of Public Health;
h) Healthwatch Representative;
i) LMC Representative;
j) Community Participants;
k) VCSE Alliance Representative.

5.2 Participants at Committee meetings are non-voting.

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

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

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

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

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

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

6. Chair

6.1 The Committee Chair shall be a Non-Executive Member**.** The Chair may nominate a deputy to represent them in their absence.

7. Voting

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

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

8. Quorum

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

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

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

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

9. Secretariat

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

10. Frequency of Committee Meetings

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

11. Notice of Meetings

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

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

12. Agendas and Circulation of Papers

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

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

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

13. Minutes of Meetings

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

14. Meetings Held in Public

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

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

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

15. Questions from the Public and Deputations

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

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

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

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

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

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

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

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

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

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

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

16. Confidentiality

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

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

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

17. Authority

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

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

18. Reporting Responsibilities

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

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

19. Delegated Authority

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

20. Virtual Meetings and Decision Making

20.1 Committee meetings may be held in person or virtually.

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

20.3 In addition to the general authority set out in clause 20.2 above, due to the nature of primary care commissioning the Committee recognises that some urgent and immediate decisions may need to be made outside of Committee meetings and that the use of the protocol for virtual decision making is not appropriate. The Committee may therefore delegate urgent and immediate decisions that need to be made outside of Committee timescales in accordance with clauses 20.4 – 20.5 and 20.8 below.

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

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

20.5 Immediate decisions requiring a response within 2 weeks will be made at a Committee meeting where practicable or by the protocol for virtual decision making. Where this is not

practicable the following people or their nominated deputies will collectively make the decision:

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

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

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

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

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

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

21. Sub-Committees

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

22. Conflicts of Interest

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

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

23. Gifts and Hospitality

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

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

24. Standards of Business Conduct

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

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

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

25. Review of Terms of Reference

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

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

Date approved by the Board of Members:
Date of next review:

Schedule 1
List of Members

The voting members of the Committee are:

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

Committee Chair:

Position	Name
Non-Executive Member	

The standing participants are:

Position	Name
Director of Primary Care	
Assistant Director for Primary Care Contracting	
Assistant Director for Primary Care Planning, Operations and Improvement	
Assistant Director for Primary Care Strategy and Change	
Clinical Director for Primary Care	
A representative from the Quality Directorate	
A Director of Public Health	
Healthwatch Representative	
LMC Representative	
Community Participants	
VCSE Alliance Representative	

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

1. Introduction

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

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

2. Purpose

2.1 The purpose of the Committee is to:

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

3. Role

3.1 The Committee has two key areas of focus:

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

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

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

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

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

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

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

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

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

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

4. Membership

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

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

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

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

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

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

5. Participants and Observers

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

5.2 Participants at Committee meetings are non-voting.

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

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

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

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

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

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

6. Chair

6.1 The Committee Chair shall be the Non-Executive Member. The Chair may nominate a deputy to represent them in their absence.

7. Voting

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

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

8. Quorum

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

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

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

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

9. Secretariat

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

10. Frequency of Committee Meetings

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

11. Notice of Meetings

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

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

12. Agendas and Circulation of Papers

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

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

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

13. Minutes of Meetings

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

14. Authority

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

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

15. Reporting Responsibilities

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

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

16. Delegated Authority

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

17. Virtual Meetings and Decision Making

17.1 Committee meetings may be held in person or virtually.

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

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

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

a) The Committee Chair;
b) A Clinical member of the Committee;

c) Executive Director of Place.

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

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

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

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

18. Sub-Committees

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

19. Conflicts of Interest

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

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

20. Gifts and Hospitality

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

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

21. Standards of Business Conduct

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

f) The Conflicts of Interest Policy
g) The Counter Fraud, Bribery and Corruption Policy,
h) Any additional regulations or codes of practice relevant to the Committee.

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

22. Review of Terms of Reference

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

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

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

Schedule 1
List of Members

The voting members of the Committee are:

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

Committee Chair:

Position	Name
A Non-Executive Member	

The standing participants are:

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

NHS North Central London
Integrated Care Board
Local Care Infrastructure Delivery Board
Terms of Reference

1. Introduction

1.1 The Local Care Infrastructure Delivery Board ('Board') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a sub-committee of the Strategy and Development Committee.

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

2. Purpose

2.1 The purpose of the Board is to provide oversight, leadership and Governance for the delivery of the ICB's Local Care (Primary and Integrated Care) Estates programme.

2.2 The board will take its strategic direction from the Strategy and Development Committee and will focus on implementation, programme and project delivery and risk management.

3. Role

3.1 The Board shall:

a) Approve Primary and Integrated Care estates business cases in accordance with section 4.1 below;
b) Approve Primary and Integrated Care strategic estates investment pipeline, including evaluation criteria, with the involvement of Finance and Provider stakeholders;
c) Review the pipeline at least annually, to ensure it continues to reflect ICB priorities;
d) Oversee and ensure the strategic and operational delivery of the agreed priority Primary and Integrated Care estates pipeline, on time and budget. This programme will involve the reconfiguration of existing assets, investment into new facilities, and disposals. It will have a focus on enhancing the patient experience, access and health outcomes, reducing variation and tackling health inequalities;
e) Oversee and scrutinise the identification and securing of sources of capital or revenue funding, including the securing Section 106 and Community Infrastructure Levy funding, and build relationships with North Central London Local Authorities to promote estates development;
f) Scrutinise risks to estates development and support robust risk management in line with the ICB's Risk Management Strategy and Policy;
g) Align ICB strategy with that of the NHS London Estates and Infrastructure Board, London Estates Development Unit, London Primary Care Capital Panel and NHS England;
h) Communicate the need of estates within the ICB's response to the Fuller Stocktake, and ensure that the estate responds to the need of services.

4. Financial Approval Limits

4.1 The Board has no delegated financial approval limits. All decisions on approval to business cases or commitment to other expenditure made at Board meetings under section 3.1 above

shall be made by, and on the approval of, the ICB's Chief Finance Officer and the ICB's Executive Director of Place using their delegated financial limits. These are set out in the ICB's Standing Financial Instructions ('SFIs'). All financial approvals outside of these limits shall be made in accordance with the ICB's SFIs.

5. Membership

5.1 The Board shall comprise of the following voting members:

a) ICB Executive Director of Place;
b) Chief Finance Officer;
c) ICB Director of Estates;
d) ICB Clinical Director, being the Clinical Estates Lead;
e) ICB Deputy Director of Estates;
f) One representative on behalf of the Community Providers:
g) One representative from NCL Councils;
h) One representative on behalf of Directors of Place;
i) ICB Director of Digital.

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

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

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

6. Participants and Observers

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

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

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

7. Chair

7.1 The Board Chair shall be the Deputy Chief Clinical Officer**.** The Chair may nominate a deputy to represent them in their absence.

8. Voting

8.1 The ICB has agreed to use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm. This includes working though difficult issues where appropriate. If it is not possible to achieve unanimity a vote will be required. Voting shall be as per clause 8.2 below.

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

9. Quorum

9.1 The Board will be considered quorate when at least six voting members are present, which must include:

a) The Chair;
b) One Finance representative;
c) One Estates representative;
d) One Provider representative; and,
e) One Commissioning representative.

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

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

10. Secretariat

10.1 The Secretariat to the Board shall be provided by NCL Estates Team.

11. Frequency of Board Meetings

11.1 Board meetings will be held every two months but may hold additional meetings as and when necessary. The Board Chair may call additional meetings or cancel meetings as necessary.

12. Notice of Meetings

12.1 Notice of a Board meeting shall be sent to all Board members no fewer than 7 days in advance of the meeting.

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

13. Agendas and Circulation of Papers

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

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

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

14. Minutes of Meetings

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

15. Authority

15.1 The Board is accountable to the Strategy and Development Committee. The Board must act within the remit of these terms of reference and has no executive powers other than those specifically set out in these terms of reference.

16. Reporting Responsibilities

16.1 The Board will report to the Strategy and Development Committee and Primary Care Contracting Committee, as appropriate, on all matters within its duties and responsibilities.

16.2 The Board may make recommendations to the Strategy and Development Committee and Primary Care Contracting Committee, as appropriate, it considers appropriate on any area within its remit.

17. Delegated Authority

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

18. Virtual Meetings and Decision Making

18.1 Board meetings may be held in person or virtually.

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

19. Sub-Boards

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

20. Conflicts of Interest

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

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

21. Gifts and Hospitality

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

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

22. Standards of Business Conduct

22.1 Board members and any attendees or observers must maintain the highest standards of personal conduct and in this regard must comply with:
22.1.1 The law of England and Wales;
22.1.2 The NHS Constitution;

22.1.3 The Nolan Principles;
22.1.4 The standards of behaviour set out in the ICB's Constitution;
22.1.5 The Standards of Business Conduct Policy;
22.1.6 The Conflicts of Interest Policy
22.1.7 The Counter Fraud, Bribery and Corruption Policy,
22.1.8 Any additional regulations or codes of practice relevant to the Board.

23. Review of Terms of Reference

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

23.2 These Terms of Reference will be formally reviewed annually. These Terms of Reference may be varied or amended by the Strategy and Development Committee.

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

Schedule 1
List of Members

The voting members of the Board are:

Position	Name
ICB C Clinical Director	James Avery
ICB Executive Director of Place	Sarah McDonnell-Davies
ICB Chief Finance Officer	Bimal Patel
ICB Director of Estates	Nicola Theron
ICB Director of Primary Care	Sarah McIlwaine
ICB Director of Communities	Sarah D'Souza
ICB Director of Digital	James Tyler
ICB Deputy Director of Estates	Diane Macdonald
ICB Directors of Place	
Community Providers representatives	
NCL Councils representative	Nick Cummings, Assistant Director of Corporate Asset Management

Board Chair:

Position	Name
Deputy Chief Clinical Officer	Michelle Johnson

Participants

Position	Name
ICB Borough Estates Leads	
NHSE Estates Delivery Lead	Karla Damba
ICB Director of Primary Care Finance	Sarah Rothenberg

NHS North Central London
Integrated Care Board
Individual Funding Request Panel
Terms of Reference

1. Introduction

1.1 The Individual Funding Requests Panel ('Panel') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a sub-committee of the Strategy and Development Committee.

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

2. Purpose

2.1 The purpose of the Panel is to consider and make decisions on Individual Funding Requests ('IFR') applications.

3. Role

3.1 The Panel will:

a) Make decisions on individual funding requests applications;
b) Properly consider and follow the ICB's IFR Policy when determining the outcome of individual funding requests applications;
c) Remit decisions for individual funding requests over the panel's financial authority limits to the appropriate decision makers;
d) Act within its delegated authorities from the Board of Members;
e) Have due regard to any relevant quality and safety issues which may arise as agreed by panel members.

4. Financial Authority Limits

4.1 The Panel has the authority to approve IFR requests up to a maximum value of £50,000 (fifty thousand pounds) per year per case. The Panel may not approve IFR applications that exceed this limit.

4.2 The Panel may consider IFR applications which have a greater financial value than the delegated financial authority limits set out in section 4.1 above but does not have the power to approve them. The Panel's decision making powers are set out in section 6 below.

5. Duty as to Affordability and to Meet Financial Control Total

5.1 The Panel has a duty to ensure the IFRs it approves are affordable and will not cause the ICB to breach its financial control total.

6. Decisions

6.1 The Panel may make the following decisions on IFRs that are within their delegated financial authority limits:

a) To reject the application;

b) To reject the application due to insufficient information;
c) To defer decision on the application pending further information;
d) To approve the application without conditions;
e) To approve the application with conditions.

6.2 The Panel may make the following decisions on IFRs that are in excess of their delegated financial authority limits:
a) To reject the application;
b) To reject the application due to insufficient information;
c) To defer decision on the application pending further information;
d) To recommend the application for approval without conditions;
e) To recommend the application for approval with conditions.

6.3 If IFR is outside of the Panel's delegated financial authority limits the decision on whether to approve or reject an application shall be made by the Strategy and Development Committee.

7. Membership

7.1 The Panel shall comprise of the following voting members:
a) An Independent Member;
b) Three clinicians;
c) Commissioning representative;
d) Medicines Management Representative.

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

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

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

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

8. Participants and Observers

8.1 The following people shall attend Panel meetings as standing participants:
a) An IFR Specialist.

8.2 Participants at Panel meetings are non-voting.

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

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

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

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

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

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

9. Chair

9.1 The Panel Chair shall be the Independent Member or a clinician**.** The Chair may nominate a deputy to represent them in their absence.

10. Voting

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

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

11. Quorum

11.1 The Panel will be considered quorate when at least three voting members are present which must include:

a) Chair;
b) A clinician or where the Chair is a clinician an Independent Member;
c) An officer.

11.2 Notwithstanding section 8.1 above, for drugs cases the Medicines Management Representative must be present

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

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

12. Secretariat

12.1 The Secretariat to the Panel shall be provided by the IFR Coordinator.

13. Frequency of Panel Meetings

13.1 Panel meetings will be scheduled as needed to ensure timely decision making. The Panel Chair may call additional meetings or cancel meetings as necessary.

14. Notice of Meetings

14.1 Notice of a Panel meeting shall be sent to all Panel members no less than 5 working days in advance of the meeting.

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

15. Agendas and Circulation of Papers

15.1 Before each Panel meeting an agenda setting out the business of the meeting will be sent to every Panel member no less than 5 working days in advance of the meeting.

15.2 Before each Panel meeting the papers of the meeting will be sent to every Panel member no less than 5 working days in advance of the meeting.

15.3 If a Panel member wishes to include an item on the agenda they must notify the Panel Chair via the Secretariat no later than 5 working days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Panel Chair.

16. Minutes of Meetings

16.1 The minutes of the proceedings of a meeting shall be prepared by the Secretariat and submitted for agreement within 5 working days of the meeting.

17. Authority

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

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

18. Reporting Responsibilities

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

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

19. Delegated Authority

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

20. Virtual Meetings and Decision Making

20.1 Panel meetings may be held in person or virtually.

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

21. Sub-Committees

21.1 The Panel may not appoint sub-committees. The Panel may not delegate any of its functions, powers or decision making authority to a sub-committee.

22. Conflicts of Interest

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

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

23. Gifts and Hospitality

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

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

24. Standards of Business Conduct

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

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

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

25. Review of Terms of Reference

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

25.2 These Terms of Reference will be formally reviewed every two years. These Terms of Reference may be varied or amended by the Board of Members.

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

Schedule 1
List of Members

The voting members of the Panel are:

Position	Name
Independent Member	Ian Bretman
Clinician	Dr Peter Christian
Clinician	Dr Chitra Sankaran
Clinician	Claire Johnston
Commissioning Representative	Penny Mitchell
Medicines Management Representative	

Panel Chair:

Position	Name
Clinician	Dr Peter Christian

The standing participants are:

Position	Name
IFR Specialist	Head of IFR
IFR secretariat	Sarah Williams, IFR Coordinator

NHS North Central London
Integrated Care Board
Individual Funding Request Appeals Panel
Terms of Reference

1. Introduction

1.1 The Individual Funding Requests Appeals Panel ('Appeals Panel') is established in accordance with the Constitution of NHS North Central London Integrated Care Board ('ICB'). It is a sub-committee of the Strategy and Development Committee.

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

2. Purpose

2.1 The purpose of the Appeals Panel is to consider Applicants' appeals against decisions made by the Individual Funding Requests Panel ('Panel').

3. Role

3.1 The Appeals Panel will:

a) Consider and decide on appeals against decisions taken by the Panel;
b) Give proper consideration to appeals when determining the outcome;
c) Act within the delegated authority from the Board of Members;
d) Follow the Individual Funding Requests ('IFR') Policy.

3.2 The role of the appeals process is not to consider the clinical merits of the case but whether due process has been followed in the IFR decision-making process.

4. Financial Authority Limits

4.1 The Appeals Panel has no authority to approve IFR requests.

5. Duty as to Affordability and to Meet Financial Control Total

5.1 The Appeals Panel has no authority to approve IFR requests.

6. Decisions

6.1 The Appeals Panel may make the following decisions:

a) To reject the appeal;
b) To defer decision on the appeal pending further information;
c) To approve the appeal and remit the decision on the individual funding request to the Panel without conditions.

6.2 The Appeals Panel may approve appeals where the Panel:

a) Has acted beyond its lawful powers;
b) Reached a decision that no other reasonable ICB could have reached;
c) Acted unfairly;
d) Failed to follow proper procedures;

e) Placed undue weight on irrelevant matters and this made a material difference to the IFR decision;
f) Breached the patient's human rights;
g) Breached the Equality Act 2010.

7. Membership

7.1 The Appeals Panel shall comprise of the following voting members:
a) An Independent Member;
b) Two clinicians;
c) Governance, Risk and Legal Services Team representative.

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

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

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

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

5. Participants and Observers

5.1 The following people shall attend Appeals Panel meetings as standing participants:
a) An IFR Specialist.

5.2 Participants at Appeals Panel meetings are non-voting.

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

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

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

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

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

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

6. Chair

6.1 The Appeals Panel Chair shall be the Independent Member or a clinician**.** The Chair may nominate a deputy to represent them in their absence.

7. Voting

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

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

8. Quorum

8.1 The Appeals Panel will be considered quorate when at least three voting members are present which must include:

a) Chair;
b) A clinician or where the Chair is a clinician an Independent Member;
c) A representative from the Governance, Risk and Legal Services Team.

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

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

9. Secretariat

9.1 The Secretariat to the Appeals Panel shall be provided by the IFR Coordinator.

10. Frequency of Appeals Panel Meetings

10.1 Appeals Panel meetings will be held as and when necessary.

11. Notice of Meetings

11.1 Notice of an Appeals Panel meeting shall be sent to all Appeals Panel members no less than 5 working days in advance of the meeting.

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e) The Standards of Business Conduct Policy;
f) The Conflicts of Interest Policy;
g) The Counter Fraud, Bribery and Corruption Policy;
h) Any additional regulations or codes of practice relevant to the Appeals Panel.

21.2 The Appeals Panel will have access to sufficient resources to carry out its duties and Appeals Panel members will be provided with appropriate and timely training at least every two years.

22. Review of Terms of Reference

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

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

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

Schedule 1
List of Members

The voting members of the Appeals Panel are:

Position	Name
Independent Member	Chuba Ofili
Clinician	Pradeep Agrawal
Clinician	
Governance, Risk and Legal Services Team Representative	

Appeals Panel Chair:

Position	Name
Independent member	Chuba Ofiii

The standing participants are:

Position	Name
IFR Specialist	Head of IFR
IFR secretariat	Sarah Williams, IFR Coordinator