North Central London
Integrated Care Board

North West London

Board Meeting in Common
Greenwood Centre
37 Greenwood Place
London NW5 1LB

4 December 2025, 14.30-15.30

Agenda

Chair

Mike Bell

Apologies

NCL and NWL ICBs
Anita Charlesworth (NCL and NWL ICBs)

NCL ICB
Jinjer Kandola (NCL ICB)
Julia Neuberger (NCL ICB)
Liz Sayce (NCL ICB)

NWL ICB
Cllr Neil Nerva (NWL ICB)
Cllr Jane Palmer (NWL ICB)

Item		Lead	Purpose	Paper	Time
1	**Opening items**				
1.1	Welcome and apologies	Mike Bell	Note	Oral	14.30
1.2	Declarations of interest *(not otherwise stated)* (NCL ICB and NWL ICB)	Mike Bell	Note	Oral	
1.3	Minutes of the previous NCL ICB Board meetings on 22 July and 30 September 2025	Mike Bell	Approve	3 16	
1.4	Minutes of the NWL ICB Board Meeting on 29 October 2025	Mike Bell	Approve	23	
1.5	Minutes of the NCL ICB Annual General Meeting on 30 September 2025	Mike Bell	Approve	33	
1.6	Actions and matters arising	Mike Bell	Note	39	
2	**Overview Reports**				
2.1	Transition Update	Ian Porter	Note	40	14.35
2.2	Performance Report	Richard Dale Stephen Bloomer	Note	52	14.45
2.3	Quality Report	Jennifer Roye	Note	85	15.00
2.4	Board Assurance Framework	Sarah Morgan	Note	113	15.10

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2.5	Chief Executive's Report	Frances O'Callaghan	Note	120	15.15
3	**For information**				
3.1	Minutes of the NCL ICB Audit Committee Meetings on 10 June and 16 September 2025	Simon Perry	Note		15.25
3.2	Minutes of the NCL ICB Finance Committee Meetings on 1 April and 29 July 2025	Mike Bell	Note		
3.3	Minutes of the NCL ICB Integrated Medicines Optimisation Committee Meeting on 6 May 2025	Jonathan Levy	Note		
3.4	Minutes of the NCL ICB People Board Meeting on 28 April 2025	Liz Sayce	Note		
3.5	Minutes of the NCL ICB Procurement Oversight Group Meeting on 7 May 2025	Stephen Bloomer	Note		
3.6	Minutes of the NCL ICB Quality and Safety Committee Meeting on 1 July 2025	Liz Sayce	Note		
3.7	Minutes of the NCL ICB Strategy and Development Committee Meeting on 18 June 2025	Mike Bell	Note		
4	**Closing items**				
4.1	Any other business				15.30
5	**Future meetings**				
5.1	28 January 2026 24 March 2026				

North Central London
Integrated Care Board

Draft Minutes
Meeting of NHS North Central London ICB Board of Members
22 July 2025 between 1.30pm and 4.15pm
Clerkenwell Room, Laycock Professional Development Centre, Laycock Street, N1 1TH

Present:	
Paul Najsarek	Chair, NCL Integrated Care Board
Frances O'Callaghan	Chief Executive Officer
Stephen Bloomer	Chief Finance Officer
Ibrahim Abubakar	Non-Executive Member
Cllr Peray Ahmet	Leader, Haringey Council
Dr Simon Caplan	GP - Provider of Primary Medical Services
Richard Dale*	Executive Director of Performance and Transformation
Jenny Goodridge	Interim Acting Chief Nurse Officer
Jinjer Kandola	Chief Executive Officer, North London NHS Foundation Trust
Mark Lam*	Chair, Royal Free London NHS Foundation Trust
Victoria Lawson*	Chief Executive, Islington Council
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Sarah Mansuralli*	Chief Strategy and Population Health Officer
Sarah McDonnell-Davies*	Executive Director of Place
Sarah Morgan*	Chief People Officer
Julia Neuberger	Chair, UCLH and Whittington Health
Ian Porter*	Executive Director of Corporate Affairs
Dr Jo Sauvage	Chief Medical Officer
Liz Sayce	Non-Executive Member
William Zermansky	Co-Chair, GP Provider Alliance
In Attendance:	
Anita Charlesworth	Acting Chair, NWL ICB
Dr Clare Dollery	Chief Medical Officer, Whittington Health
Selina Douglas	CEO, Whittington Health
Rob Hurd	Chief Executive, NWL ICB
Apologies:	
Dr Alpesh Patel*	Co-Chair, GP Provider Alliance
Minutes:	
Steve Beeho	Senior Board Secretary

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1	Paul Najsarek welcomed attendees to the meeting, including members of the public and staff who were observing the livestream. Apologies had been received from Alpesh Patel. Will Zermansky was representing the GP Provider Alliance in Alpesh's absence. Paul welcomed Rob Hurd and Anita Charlesworth from NWL ICB.

* Standing Participant

	Three questions had been submitted in advance by a member of the public relating to item 2.2. These would be addressed at that point in the meeting. A written response would also be provided to the questioner after the meeting.
1.2	**Declarations of Interest relating to the items on the Agenda**
1.2.1 1.2.2	Paul Najsarek 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	**Draft Minutes of the NCL ICB Board of Members Meeting on 20 May 2025**
1.3.1	The Board of Members **APPROVED** the minutes as an accurate record.
1.4	**Matters Arising**
1.4.1	Paul Najsarek observed that the actions on the Action Log had either been discharged or were on today's agenda.
1.4.2	The Board of Members **NOTED** the Action Log.
1.5	**Report from the Chief Executive Officer**
1.5.1	Frances O'Callaghan provided an overview of the paper, highlighting the following points: • The NHS 10 Year Plan has now been published. It sets out three decisive shifts: moving care from hospitals into neighbourhoods, replacing analogue processes with digital solutions, and pivoting from treating sickness to prevention. • Neighbourhood delivery is already integral to the work of the ICB, as this is how the ICB works closely with residents, local authorities and primary care, and hospital providers are now being brought much more into the neighbourhood space. • Embedding this into the Boroughs as it moves forward will build on the strong foundations already in place. The ICB is committed to working to build an NHS which works for everybody and local residents feel is providing the support that they need. • A positive Neighbourhood Systems Event was held in June. System leaders from health, social care and the voluntary sector discussed the NCL approach to neighbourhoods, their organisations' role in shaping this, the role of the Integrator and the benefits for residents. • The NCL Community Core Offer was endorsed in NHS England's *2025 Neighbourhood Health Guidelines*. This recognition was a testament to the hard work of everybody involved. • A Health Equity event is being held on 15 September 2025 to showcase the work on the Inequalities Fund scheme. • The Mental Health Core Offer work is a cornerstone of the ICB's neighbourhood delivery. Joint activity plans have been agreed with the North London Foundation Trust to enable more people to be seen by community teams and accelerate crisis responses. • The ICB is increasing awareness and use of the NHS App as part of the *Your Local Health Team* campaign. In other digital work, the Systems and Facilitation team has launched an interactive dashboard for the Long-Term Conditions (LTC) Locally Commissioned Service and work is taking place with UCL Partners to deploy shared EMIS hubs for Complex Care LTC. • The Department for Education has awarded NCL ICB up to £205,746 to run the T Level Industry Placement Coordinator (IPCO) Support Programme from 2025-28. This collaborative initiative places the ICB at the forefront of the national T Level agenda

	and is indicative of the work the ICB is undertaking to understand the wider determinants of health and the impact of education and work on wellbeing.
1.5.2	The Board of Members **NOTED** the Report.
2.	**STRATEGY AND BUSINESS**
2.1	**Organisational Change**
2.1.1	The Chair highlighted the importance of this paper, which set out the case for a merger between NCL and NWL ICBs. It was therefore imperative that the issues it raised receive due time and attention to do them justice. Before the discussion began, he expressed his gratitude to the executive team for their work on this in partnership with NWL colleagues, as well as the contributions of Board members and the stakeholders they represent. He then summarised how he proposed to manage the proceedings.
2.1.2	Frances O'Callaghan introduced the paper, summarising the huge amount of thinking which had gone into it and her own view of the proposed merger. She echoed the Chair's thanks to everybody who had contributed to the paper, and to wider NCL staff who have continued to demonstrate their professionalism amid a high level of uncertainty, She made the following points: • The paper was split into five sections: summary and strategic context; the case for change; the rationale for a strong strategic fit with NWL ICB; the evaluation of the options and the recommendation to the Board. • ICBs were instructed in March that they would need to reduce their overall costs by 50% and the ICB has been working through the implications of this unexpected instruction. The Model ICB Blueprint was subsequently published, setting out the future role of the ICB as a strategic commissioner and market shaper, with a stronger focus on population health, procuring services for residents to meet their wider health and wellbeing needs through neighbourhoods, working in partnership with local authority colleagues. ICBs will no longer be 'holding the ring' on the system but will instead be responsible for commissioning services that deliver the three shifts described earlier. • ICBs were given a future Running Cost Allowance (RCA) of £18.76 per head of population within their geography, which was subsequently increased to £19. • ICBs were asked to complete a template to respond to the Model ICB and set out how they would design and create an organisation based on their new RCA. • The five current London ICBs have different populations. NCL is one of the smaller ICBs, with a resident population of approximately 1.7 million. On either side of NCL, the NWL population is approximately 2.8 million and the NEL population is approximately 2.6 million. South East London ICB has a population of approximately 2.2 million and the South West London ICB population is approximately 1.4 million. If the five ICBs followed the same population per head of capita the result would be five very different sized organisations all being asked to do the same thing in terms of strategic commissioning. • NCL and NWL ICBs consequently came together as both indicated that their initial submissions would not be compliant as they did not believe that they could fulfil all of the requirements within their envelopes, so other solutions would need to be sought. • Colleagues are committed to creating the best organisation that they can, one which people really want to work in, because that will mean that they are committed to delivering what the ICB wants to achieve. The scale of the organisation will be particularly important in this context. • The report sets out the case for change, including the reduction in the RCA and building the transformational capability, including developing new expertise in areas such as market management and specialist analytics which will be needed if the ICB is going to maximise its understanding of the population. • The neighbourhood and place-based models already in place are going to be reduced due to lack of capability to manage that number of people going forward. This would

	have been the case regardless of any merger. However, if NCL and NWL create a single corporate structure it will provide greater flexibility in terms of being able to work with their Borough partners. • NCL recognised that it needed a partner and NWL made it very clear that they wanted to work with NCL. The fact that the two ICBs share a CFO and the two CEOs have a long-standing professional relationship provided the initial confidence to sit around a table and discuss the concept of the two ICBs coming together. It is clear from the work that has taken place in areas such as Work in Health and neighbourhoods that there is a clear strategic alignment, with a shared passion for population health. • Furthermore, both ICBs have delivered a financial balance over a three-year period, working together with their partners, with a strong commitment to their role as stewards of taxpayers' money and recognising the importance of financial stability to both organisations. • She thanked Victoria Lawson for her help in strengthening her understanding of the NWL local authority landscape and for discussing the potential benefits with NWL local authority colleagues. • When NCL and NWL were looking at working together, five evaluation criteria were used: improving patient outcomes through strategic commissioning; strengthening place and neighbourhood arrangements; retaining and attracting the best people; building resilient and cost-effective functions; and the time and cost of change. • After applying these criteria, NCL's preferred choice is option 3b in the paper – a full merger. Although NCL and NWL have not scored the options identically, NWL's preferred choice is also option 3b. In the event of the merger being agreed, both organisations recognise that the transition will be absolutely critical, as the two ICBs have different cultures and different ways of doing things. • Although implementing a merger will be challenging, it will be less difficult than trying to run two organisations in a cluster with two Boards, or a partially-merged organisation. Merging by April 2026 is also the right option because the organisation and its staff need certainty. A full merger represents the strongest solution for NCL and NWL and provides the necessary scale to really grasp the Model ICB and take it forward. People need access to high quality hospitals, but they also need excellent prevention, neighbourhood care and support, so this will also drive the ICB's Out of Hospital strategy. • The merger offers opportunities for greater consistency across the 13 Boroughs while also recognising that this is not a case of 'one size fits all'. There are also significant learning opportunities as the landscape and challenges are constantly changing, while financial pressures will remain tight. • The ICBs have identified a set of risks, including transitional and financial ones. Both ICBs have a proven track record of managing these. • The Board is being specifically asked to approve the recommendation of a full merger with NWL ICB with integrated teams, to approve progression into the national approvals process with delegated final sign-off here and to establish a joint executive-led programme board to govern the merger process. • If this is agreed by the Board, NCL ICB will notify NHS England and ICB staff and begin the due diligence and transition planning, subject to the decision taken by the NWL ICB Board the following day.
2.1.3	Ian Porter then read out the questions which had been submitted in advance by a member of the public: • How will all 13 local authorities scrutinise health decisions from one merged ICB? Will there still be JHOSCs or other overview committees carrying on this function? • As there are two reorganisations taking place with the two ICBs (i.e. Neighbourhood Health and the ICB Merger), will there be a Neighbourhood Health Committee like the Primary Care Committee that will be co-ordinating the process toward Neighbourhood Health Organisations? • What consultation with local authority councillors/JHOSCs/Health and Wellbeing Boards (HWBs) of all the Boroughs involved with the two ICBs has been carried so far or will be there be more consultation once the decision has been made on the merger? How will the public in all 13 boroughs be engaged and informed?

	He noted in response that it is too early for the ICB to talk about partnership and corporate governance arrangements but these will clearly be important areas to think through with NWL colleagues. The ICB recognises the importance of democratic oversight and accountability and the 10 Year Plan makes explicit the role of Health and Wellbeing Boards (HWBs) going forward and the ICB remains fully committed to delivering the Neighbourhood Care model. The ICB has undertaken a wide range of engagement activity, including with local authority leaders, lead councillors for health and care, local authority chief executives and other senior staff. The ICB has also attended a range of partnership forums, including the JHOSC, as well as providing a wide range of updates to stakeholders and staff. This will continue throughout and beyond the merger process, as well as updating the public through the ICB's external communications.
2.1.4	Stephen Bloomer then provided a financial perspective. He noted that he had now been working across NCL and NWL ICBs as CFO for the past four months and this had enabled him to consider different perspectives and learning from both organisations. Both ICBs are hugely ambitious, with strong commitments to financial balance and hitting performance targets. Both are also committed to neighbourhoods, making local care a reality and reducing health inequalities. Each ICB is data-driven, albeit at early stages, and can demonstrate good outcomes from commissioned services. This provides a strong platform for merger. Improving the understanding of data provides a big opportunity for the larger merged ICB to use its size to manage markets better, while also making the most of local relationships. The new ICB can use this ambition and sense of delivery to attract the best staff. Sound finances are crucial, as this creates the ability to address the organisation's priorities and do the things that it really wants to do. There are also interesting differences between the two ICBs. In NWL there is a well-established evidence-based approach to using data to drive performance. NCL has excellent data-driven neighbourhood work and the ambition to do something really different and there is a lot of mutual learning that can be shared. Once a decision is taken to create a single organisation it will be important to show a sense of leadership and be brave as it goes forward.
2.1.5	The Chair then invited Anita Charlesworth and Rob Hurd to reflect on the journey that the two ICBs had been on and the proposal to merge the two organisations. Anita observed that NWL ICB started from the point of view that the 10 Year Plan is asking ICBs to be transformative agents of change. Although NWL could probably have just about made the future ICB allocation work, this would have constrained the ability to be a genuinely high-performing agent of change. Over the past three years NWL have developed a deep understanding of what needs to happen with its population and have done this in a very different way to the approach set out in the 10 Year Plan, using strategic commissioning tools and transforming both the ICB and the system around the use of data and AI. There was a concern that remaining as NWL ICB would leave it vulnerable, whereas joining together with NCL ICB, whose goals and values are closely aligned with NWL's and shares similar population challenges, provides the opportunity to build a new organisation with the skills and capabilities to deliver as a new strategic commissioner. This is therefore not a merger to continue with business as usual – this merger will result in a new and improved form. A number of issues have been raised by colleagues across the system in relation to this proposal, including the risks that accompany a merger such as losing focus and the distraction caused by needing to execute it well, which is essentially an argument for proceeding at pace; the challenge of working across such a large population with 13 very different local authorities while having a genuine grounding in place and needing to make this work at both neighbourhood and Borough level – this will need to be an integral part of the implementation plan; and ensuring that the new ICB receives a fair share of the national pie

	for its population. The importance of addressing these issues does not detract from the point that a merger is the right thing to do.
2.1.6	Rob Hurd prefaced his remarks by confirming that the NWL Board was also being recommended to approve option 3b at its meeting the following day. NWL ICB had undertaken similar engagement work with stakeholders and a number of mitigations have been put in place to address the identified risks. A form of words has been formulated to assure the NWL Board that a merger will not be to the financial detriment of NWL residents, Boroughs or providers. He noted that the complex process to get to this point had involved multiple partners over a short period of time and he thanked Frances O'Callaghan and her NCL colleagues for their contributions in reaching a joint outcome following the development of a robust options appraisal. This was a remarkable achievement. The key challenge will be retaining a clear line of sight to neighbourhoods within 13 Boroughs, bearing in mind commissioners need to understand their population and their needs. By bringing together the learning from the two ICBs, especially around the work of Borough-based and place-based Partnerships and Neighbourhood Health to deliver on inequalities and outcomes, this is a call to arms to make that model effective across the 13 Boroughs. NWL has undertaken excellent work on the involvement strategy on insight with communities which is published monthly and joins up qualitative and quantitative data so that experience is at the heart of decision-making to address the inequalities residents face. This merger represents the opportunity by building at scale to have the skills, data and insights into our communities to be a better strategic commissioner than would be the case if the two ICBs proceeded as sub-scale organisations. Although there will still be challenges ahead, if the two Boards do not give a clear steer to merge, the ICBs will be in a worse position. Once the merger has been approved the implementation work can begin and the quality of this will be key to its success.
2.1.7	The Chair echoed the recognition of the spirit of partnership working displayed between the two ICBs.
2.1.8	The Board of Members discussed the paper. Members were supportive of the direction of travel and made the following comments: • Assuming that the ICBs proceed to merger and implementation, Population Health, neighbourhoods, reducing health inequalities and the use of strategic commissioning must remain central to the new organisation. The new ICB will be covering a much larger area with multiple areas of advantage and severe disadvantage, so it is imperative to maintain focus by having clarity around its vision. • There is a risk of losing key talent during the uncertainty caused by the reorganisation, so moving at pace is vital to maintain momentum and provide assurance to staff at both organisations around the ICB's vision for the future. • As highlighted by the questions from the public, there is a tension between economies of scale versus the increased distance from local authorities. It will be important to put in place mechanisms to mitigate this, as working with 13 Boroughs will clearly be challenging. • Local authorities understandably have concerns about the increased distance and what this means for local residents, as well as around granular detail and what this means for understanding their populations. More clarity will be needed in due course around local leadership and how this connects to overview and scrutiny. • It will be important to build on the engagement to date with local authorities and continue to develop partnership working. Safeguarding and complex care are key issues for local authorities, so assurances would be welcomed about how local authorities and the ICBs can continue to work closely together on this during the transition and going forward. • There is a need to articulate how doing things at scale will benefit neighbourhoods and communities. The Board also needs to feel confident that transition risks are being tracked carefully.

	• It will be important to keep the corporate infrastructure lean to be able to release more money for health services in the neighbourhoods. • Although the reorganisation is in response to the need to reduce operating costs, this should be viewed as an opportunity to reimagine what it means to be an ICB and start to address localism and neighbourhood care. At the same time, the ICB cannot afford to get too distracted by the merger and will need to continue to focus on its key business, such as Start Well. • Once the decision to merge has been agreed, it will be important to quickly develop a clear vision for the new organisation. When the target operating model is confirmed, the ICB can then articulate how this connects with local place/neighbourhoods. This will enable the organisation to develop its strategic commissioning, while also ensuring the vulnerable are not left behind. • Concern was expressed about the potential loss of corporate memory when an organisation expands. • Paul Najsarek, Frances O'Callaghan and the executive team were commended for their work in getting to this stage at pace under such trying circumstances. • There is a strong commitment across the Board to make this work and find creative solutions. It was suggested that it might be fruitful to form small groups to think about how things can be done differently. • It will be important to maintain focus on inequalities and equity and ensure that residents are not disadvantaged by living in under-resourced parts of the system. • It was noted that it is cynical to suggest that this transition is a step towards another transition on the basis that this configuration of ICBs will not be able to deliver the change required. The merger will be a positive step, as the combined ICB will have greater strength as a strategic commissioner and be able to use its money wisely, marshal clinical leadership across the system more effectively and influence markets differently. • There is phenomenal clinical leadership and institutions in NCL and NWL, and these will provide a great platform to build on. • The ongoing commitment of both ICBs to maintaining a focus on quality during the transition was welcomed. Listening sessions have taken place with NCL partners regarding safeguarding and complex care and these will continue.
2.1.9	Frances O'Callaghan reflected on the discussion: • She commended the work of Sarah Morgan, Dan Glasgow and Juliet Brown on the paper. Traditionally 'form follows function' in a reorganisation but at this point the focus is necessarily on form, so it was helpful that there was a strong emphasis on functions in the discussion as it is important not to lose sight of the ultimate purpose of the ICB. • She welcomed the comments and acknowledged that there is more to be done to provide appropriate assurances. • The ICB will continue its commitment to transparency with staff. As part of this there will be a staff briefing following the NWL ICB decision. Assuming that both Boards approve the merger, the ICB will follow the Organisational Change Programme process, beginning with the appointment of a Chair and CEO, as well as a new executive team. Staff are understandably keen to have some clarity about their own positions and the ICB is committed to sharing documentation with staff as soon as possible. • The discussion is a testament to the journey that the two ICBs have been on. Although it has been difficult at times, the right foundations for change have been built by both Boards.
2.1.10	The Chair observed that a meaningful options appraisal needs to contain both belief and doubt and he had personally weighed up the options in that spirit but it was increasingly clear to him, as the ICBs worked through it, that option 3b was the right way for both organisations to proceed. Rather than being defensive, this is an approach to change which provides the strongest chance of achieving excellence in the future for NCL and NWL communities, as well as ICB staff.

	The discussion has been extremely supportive of option 3b and everybody has spoken in favour of it. At the same time, there was no hint of complacency because while getting the decision right is crucial, it is only the start of excellence in execution and delivery. Any decision taken by the Board today about merger remained subject to the NWL Board's approval the following day.
2.1.11	The Board of Members: • **APPROVED** the recommendation of Option 3b for formal merger of the 2 ICBs as the preferred option. • **APPROVED** the progression into the national process for approvals with final sign-off of the transaction delegated to the Chair(s) and CEO(s) at the appropriate time. • **APPROVED** the establishment of a joint executive-led Programme Board to lead and manage the merger process.
2.1.12	Ian Porter then confirmed the next steps. If the NWL Board approved the same recommendation at its meeting the next day, the ICBs will jointly update NHS England, staff and stakeholders on the outcome of the discussions. A detailed wellbeing plan to support staff through the transition process has been developed. Both ICBs will work with NHS England on the required assurance checks and support them with meeting the deadlines to make the orders to dissolve the two ICBs and create a new ICB in time for 1 April 2026. NCL and NWL colleagues will work together to deliver the programme plan and consider transitional governance arrangements to identify areas where it makes sense to do things together.
2.2	**Start Well Maternity and Neonates Progress Update**
2.2.1	The Chair welcomed Selina Douglas and Dr Clare Dollery to the meeting.
2.2.2	Sarah Mansuralli introduced the paper, highlighting the following points: • It was agreed at the previous Board meeting that an update on implementation progress would be brought to this meeting, following the significant decision the Board took in March 2025 regarding maternity and neonates configuration, and also on how this will be delivered in the context of the future ICB changes. • The paper focuses on maternity and neonates, recognising that a decision on the paediatric surgical component of Start Well will be made in due course. • The governance arrangements for the implementation phase have been strengthened, including the establishment of a Senior Implementation Leadership Group which essentially consists of the executive leads from the providers impacted by the reconfiguration. • Following collaboration and discussions between organisations, it has been agreed that Whittington Health will take on the CEO SRO (Senior Responsible Owner) role for the implementation, in recognition of the maternity and neonates component of the Start Well programme requiring cross-site collaboration in order to deliver. • As part of the implementation work, a recent workshop attended by a cross-system multi-disciplinary group from the three providers achieved three key objectives: o Agreeing the effective sequencing and planning of the capital developments to ensure adequate capacity is maintained through maternity and neonatal services during the implementation period and capital developments are delivered in line with the capital plan phasing as set out in the DMBC; o understanding in greater detail the interdependencies, including workforce, clinical and organisational development activity to support the implementation and align these with the capital developments; o agreeing the development and implementation of the clinical pathways and protocols which need to be in place to support the reconfiguration. • As the accountability and leadership of this phase will be handed over to the Whittington Health CEO SRO, work is underway to develop the Memorandum of Understanding (MoU) which will set out clearly the accountabilities and timescales

	within which things need to be delivered. Any further delays will be a risk to both serviceability and the delivery of the reconfiguration that will improve equity, access and experience for NCL residents. There is a huge interdependency between sites to ensure that capacity is maintained during the implementation.
2.2.3	Selina Douglas provided more detail about the current stage of the handover process. Whittington Health view themselves as hosting this arrangement on behalf of the system and conversations have already taken place with CEO colleagues about how they will work together on the programme to deliver the outcomes set out in the DMBC. Alongside that, a detailed piece of work is underway to flesh out the key milestones and to be clear about having the necessary resources in place to deliver this. Clare Dollery, CMO at Whittington Health has been asked to provide support as Executive SRO to provide oversight in terms of the clinical workforce. It was noted that the need to build on compassion for residents around the delivery of their babies and listen to their voices was a key theme of a recent session on maternity care attended by the Secretary of State. This principle will be integral to the hosting arrangement, ensuring that it is clinically-led and absolutely informed by the voices of women and families across NCL.
2.2.4	Clare Dollery reflected that at a time of great change in the NHS, programmes which have been decades in the making are extremely rare. She welcomed the opportunity to work again on Start Well, having previously been the CMO when this phase began five years earlier. She also welcomed the clear enthusiasm in evidence when the various capital programmes were discussed at the recent workshop and people could begin to see in more detail how they will be delivered. Whittington Health are mindful of the expansion of their remit from what goes on at the Trust to what takes place in the wider system and they are keen to embrace the task.
2.2.5	The Board of Members discussed the report, making the following comments: • Frances O'Callaghan welcomed the commitment to the timetable. She noted that under the change in the national capital regime the ICB will no longer hold a system capital 'pot'. Notwithstanding this, there is clearly commitment from the partners but it is important to note that the ICB will need to 'hold the ring' in a slightly different way. • The Royal Free had previously made its position clear that it was disappointed in the outcome of the consultation but it respects the decision and supports both the programme and Whittington Health taking on the CEO SRO responsibility. The decision is already having an impact on the Trust, as some patients are under the impression that services are closed and mothers are starting to vote with their feet. Staff are also feeling anxious, so it is important to be clear about the timetable and give staff and members of the public assurance that the closure of the maternity and neonatal services is some years away, otherwise there is a risk of creating a self-fulfilling prophecy, resulting in the unit being starved of resources and becoming unviable. • As this will be a multi-year programme costing tens of millions of pounds, it is important to be clear who owns that risk for NCL, so that decisions can be made openly and transparently.
2.2.6	Sarah Mansuralli confirmed that active risk monitoring already forms a key part of the programme and a weekly 'live' dashboard has been developed which is underpinning the approach to risk management. This does not take anything away from the pace and timeline issues, and there will be other risks which need to be mitigated as the programme unfolds.
2.2.7	The Board of Members: • **NOTED** the steps taken to set up the implementation architecture for the Start Well maternity and neonatal changes and the planning that is in place • **NOTED** the proposal that the CEO of Whittington will take on the role of implementation SRO and who will lead and coordinate on behalf of the system the implementation activities

	• **NOTED** the proposal that funding be delegated alongside the requirement to deliver the commissioner responsibility for the implementation of Start Well to the provider CEO SRO, underpinned by an MoU with the ICB.
2.3	**NCL ICB People, Culture and Equalities Annual Report 2024/25**
2.3.1	Sarah Morgan introduced the paper, highlighting the following points: • This was the second year this report had been brought to the Board. It brings together the ICB's workforce compliance reporting – Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and the Staff Survey - while also providing an over-arching report of the organisation's approach to People and Culture. The WRES and WDES reports will be published in due course as part of the ICB's statutory requirements. • Although it can feel as if the ICB has been undergoing constant change since the OD Plan was launched, the report highlights the good progress that has been made in this area. • The majority of the priorities for 2024/25 focused on standing up the new structure, delivering the Change Programme and continuing to deliver the OD Plan. The report also highlights key activities undertaken as part of the commitment to make NCL ICB a great place to work. • A number of successes were reflected in the Staff Survey, including standing up the organisation on the basis of high-performing teams (with every team undergoing this training programme), and standing up a new learning and development approach which gives staff access to development funds and opportunities, professional registration and new policies and procedures. The impact of this investment was underlined by NCL ICB scoring highest in two 'people promise' areas in the survey compared to the other London ICBs.
2.3.2	Frances O'Callaghan paid tribute to Sarah Morgan for leading on this work during such difficult times and the fact that this has resulted in the improvement of the ICB's WRES score.
2.3.3	The Board of Members discussed the report, making the following comments: • It was noted that improvements had been made in a number of important areas of the staff survey, including the reduction in the relative likelihood of white staff being appointed from shortlisting compared to BME staff. It is to be hoped that will have a positive impact on staff perceptions of fairness in the promotion process. • The increase in the number of people reporting that reasonable adjustments have been made for them and the increase in the number of people expressing openness about having a disability suggests a welcome organisational and cultural shift. • Although there are still challenges around bullying and harassment which need to be addressed, the demonstrable commitment within the organisation to listen and not shy away from difficult issues was commended. • It was noted that Staff Survey results in London being consistently lower than other parts of the country is a long-standing issue, particularly with regards to the perceptions of staff from a BME background. The London Race Strategy was launched in 2020 to address this and the London WRES scores have begun to improve in certain areas, but this has taken a concerted effort among London NHS organisations. • It was acknowledged that it is difficult to change the dial in this area as it involves a cultural shift and takes time. Given the fact that the Board has approved a significant change, pending the decision made by the NWL ICB Board the following day, it was queried what steps will be taken to ensure that BME staff in particular are treated equitably during the transition process. It would be helpful if this could be tracked as part of the implementation work. • During the previous reorganisation the ICB reviewed the equalities implications at three different points of the change programme and ensured that mitigations were applied at each stage. However, on this occasion the scale of change is so vast that it poses a high risk for the organisation.

	• It was likely that the increase in the number of staff declaring a disability in the last change programme was due in part to staff seeing that the ICB was making changes as a result. It is important that this commitment continues and staff feel confident that shared personal information will be used in a positive way. As a further example, the Carers, Disability and Long-Term Conditions Network, which is sponsored by Ian Porter, has had a significant impact around wellbeing adjustments.
2.3.4	The Board of Members: • **NOTED** the key achievements and activities of the People and Culture function between July 2024 to June 2025. • **NOTED** the progress against the 3-year OD plan (2023-26) • **NOTED** the ICB's equality, diversity and inclusion (EDI) performance against the national EDI standards (WRES, WDES, Gender Pay Gap and EDS22) • **NOTED** the workforce priorities that have been identified for 2025/26.
3.	**OVERVIEW REPORTS**
3.1	**Performance Report**
3.1.1	Richard Dale introduced the Performance Report, highlighting the following points: • NCL GP appointments have consistently averaged over 700,000 during the past year. Same-day appointment availability remains strong, with NCL continuing to outperform the national average. • A&E 4-hour performance improved in June 2025, achieving the in-month target for the second time this year. • Average daily ED attendances and have remained relatively stable. There continues to be improvements in 12-hour delays and ambulance handovers at sites. • Winter planning began in earnest this summer, with an agreement that there should be less focus on seasonality and more focus on the ongoing ability to respond to pressures throughout the year. This will be discussed further at a system event in September. • The report contains a small error in the data around virtual wards: NCL actually hit 80% in June. • NCL is broadly on target for cancer and Referral to Treatment (RTT). • Specific detailed pieces of work will be taking place to understand what is driving the growth in referrals in NCL and looking at the unintended consequences of the capped elective payment performance. • A new oversight framework was published in June. Providers have received their ratings and these will be published in due course. ICBs are not receiving ratings this year, partly due to the organisational changes, but they will still be held to account against other measures. • The ICB is actively working with providers and the London Region to manage this period of transition.
3.1.2	The Board of Members discussed the report. It was highlighted that the diagnostic indicators stood out, in common with other parts of London. In response it was noted that part of the reason for performance in this area looking so stark is that NCL had previously been performing particularly well. The growth in non-obstetric ultrasounds has been highlighted as a factor and the Diagnostic Network is undertaking some work to get to the bottom of this. It looks as if another cause is changes in the way providers have been coding their backlog but more details will be shared when this work has been completed.
3.1.3	The Board of Members **NOTED** the Report.
3.2	**Quality Report**
3.2.1	Jenny Goodridge introduced the Quality Report, which was taken as read. She highlighted that the Care Quality Commission (CQC) conducted an unannounced inspection of Maternity

	services at the North Middlesex Hospital Unit (NMHU), in January 2025, focusing on the 'Safe' and 'Well-led' domains. The service has made significant improvements and is receiving support from the regional Maternity Intensive Support Team, along with support from the Royal Free London group. Following the inspection, the CQC have upgraded the rating from 'Inadequate' to 'Requires Improvement'. The unit will provide regular updates on progress on their CQC action plan to the NCL Local Maternity and Neonatal System (LMNS) Board.
3.2.2	The Board of Members discussed the report, making the following comments: • Gratitude was expressed about the amount of support and collaboration at system level that the unit had received. The ambition is for these services to be outstanding, so there is still a long way to go, but this is nevertheless encouraging progress and the upgrading by the CQC is validation that the unit is on the right trajectory. • It was noted that it has since been confirmed that the potential industrial action referenced in the report will be going ahead. • It was confirmed that the Child Death Overview Process Report themes and recommendations will be shared with numerous partners and it will be Safeguarding Boards who jointly agree the actions across health and social care. • This issue underlines the value of knowing your population. Underlying themes can be potentially traced back to very early childhood and even prenatal, and once there is an understanding of where this is happening at neighbourhood or even hyper-local levels, more proactive work can be done in this space.
3.2.3	The Board of Members **NOTED** the report.
3.3	**Finance Report**
3.3.1	Stephen Bloomer introduced the paper, highlighting the following points: • This has been a disappointing start to the year. The system is reporting a £57m deficit at Month 2, which is almost £14m off-plan. • Four systems accounted for half of the national deficit position and NCL is one of those systems. NHS England introduced a risk-based way of looking of looking at financial performance (RONDA) and in month 2 NCL is in the lowest quadrant (4). The system is completing a Deficit Recovery Plan in response. • The core drivers for this are staffing costs and issues around prescribing, high-cost drugs and complex care. The most material adverse to plan positions in the first two months were reported at GOSH, Whittington Health, North London Foundation Trust and the ICB. • System colleagues have come together in Months 3 and 4 to understand the causes of the variances. Work has taken place around pay pressures and control and there are now processes in place through the HR and Finance teams. • Work was progressing to understand the variance to date regarding the Cost Improvement Plans (CIPs), particularly expenditure controls; and on risk, to ensure that appropriate resource is being put into assessing and managing the real areas of risk. • The Month 3 position is improved – although there is still a deficit position, it is now £7m off-plan and all organisations are reporting either to plan or better, with the exception of GOSH, Whittington Health and North London Foundation Trust. • However, the report illustrated the large amount of risk identified towards the end of this financial year, influenced by winter pressures and staffing costs. The ICB was in discussion with the relevant providers to see how it could support the system and help to address and reduce this pressure. • A report will be brought to the Finance Committee meeting in September, at which the Month 4 financial position would be known.

3.3.2	The Board of Members discussed the report. Assurance was given that the North London Foundation Trust is turning over every stone to address the pay costs challenge. Acuity is also a significant issue in driving up expenditure and the Trust will need to get to the root of this.
3.3.3	The Board of Members: • **NOTED** the Report and • **APPROVED** changes to the Standing Financial Instructions following the creation of the Population Health Strategic Commissioning Committee.
3.4	**Board Assurance Framework (BAF)**
3.4.1	Ian Porter introduced the BAF, highlighting the following points: • There are currently seven risks on the BAF. The scores of two risks (*FIN36- St Pancras Hospital Transformation Programme Funding* and *PC7- ICB Transition*) have decreased since the previous meeting. • In terms of horizon scanning, it is possible that the risk around industrial action might resurface on the BAF. The Start Well risks mentioned earlier will be tracked through the Population Health Strategic Commissioning Committee. By the time of the next Board meeting in November it is possible that a BAF-level risk concerning financial deficit positions may have been added. • A piece of work is being concluded with all of the Trusts to look at the respective BAFs and this will form the basis of a report to the Audit Committee on commonalities. • A review of the level of cyber risk has been commissioned and a report on this will be taken to the Audit Committee in September.
3.4.2	In response to a question from the Chair about the potential impact of the transition on ICB risks, assurance was given that a more detailed Transition risk register sits underneath the BAF which will be monitored by the Programme Board and the Transition Committee.
3.4.3	The Board of Members **NOTED** the Board Assurance Framework.
4.	**ITEMS FOR INFORMATION AND ASSURANCE**
4.1	**Minutes of the Audit Committee Meeting on 25 March 2025**
4.1.1	The Board of Members **NOTED** the minutes of the Audit Committee.
4.2	**Minutes of the Quality and Safety Committee Meeting on 18 March 2025**
4.2.1	The Board of Members **NOTED** the minutes of the Quality and Safety Committee.
4.3	**Minutes of the Strategy and Development Committee Meetings on 2 April 2025**
4.3.1	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	30 September 2025.

North Central London
Integrated Care Board

Draft Minutes
Meeting of NHS North Central London ICB Board of Members
30 September 2025 between 3.30pm and 4.20pm
Clerkenwell Room, Laycock Professional Development Centre, Laycock Street, N1 1TH

Present:	
Mike Bell	Chair, NCL Integrated Care Board
Frances O'Callaghan	Chief Executive Officer
Stephen Bloomer	Chief Finance Officer
Ibrahim Abubakar	Non-Executive Member
Dr Simon Caplan	GP - Provider of Primary Medical Services
Richard Dale*	Executive Director of Performance and Transformation
Jenny Goodridge	Interim Acting Chief Nurse Officer
Mark Lam*	Chair, Royal Free London NHS Foundation Trust
Victoria Lawson*	Chief Executive, Islington Council
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Sarah Mansuralli*	Chief Strategy and Population Health Officer
Sarah McDonnell-Davies*	Executive Director of Place
Sarah Morgan*	Chief People Officer
Ian Porter*	Executive Director of Corporate Affairs
Dr Jo Sauvage	Chief Medical Officer
Liz Sayce	Non-Executive Member
William Zermansky	Co-Chair, GP Provider Alliance
In Attendance:	
Nic Alexander	Clinical Director, North Thames Paediatric Network
Karen Bonner	Chief Nurse, NHS England (London)
Marco Inzani	Associate Director of Transformation
Toby Lambert	Executive Director, Strategy and Population Health, North West London ICB
Sophie Scott	Network Director, North Thames Paediatric Network
Anna Stewart	Director of Service Development: CYP, CAMHS, Maternity and Neonates
Apologies:	
Cllr Peray Ahmet	Leader, Haringey Council
Jinjer Kandola	Chief Executive Officer, North London NHS Foundation Trust
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 Bell welcomed attendees to the meeting, including members of the public and staff who were observing the livestream. He introduced himself as the Chair of NCL London ICB and North West London ICB and this was his first meeting.

* Standing Participant

	Apologies had been received from Cllr Peray Ahmet, Jinjer Kandola, Julia Neuberger and Alpesh Patel. Will Zermansky was representing the GP Provider Alliance in Alpesh's absence. No questions had been submitted in advance by members of the public.
1.2	**Declarations of Interest relating to the items on the Agenda**
1.2.1 1.2.2	Mike Bell 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.
2.	**STRATEGY AND BUSINESS**
2.1	**Winter 2025/26 Planning**
2.1.1	Richard Dale introduced the paper, which described the NCL approach to winter planning, including the key assurance checklist that the ICB is required to measure itself against. He highlighted the following points: • The NCL approach is underpinned by a system commitment to working collectively. Teams and partners have shared their winter plans and a recent event was held to focus on resilience and the alignment of these plans, followed by a regional meeting where the plan was tested against different scenarios. • Alongside this the ICB will continue with the well-rehearsed system processes already in place, including a daily sector call to manage the pressures across sites, and bi-weekly calls with Chief Operating Officers (COOs) and local authority representatives to manage the themes around pressures, plus a CEO-level Flow Board chaired by Pete Landstrom, CEO, Royal Free Group. • Plans are strongly focused on supporting the most vulnerable, enhancing primary care services and access to community care, as well as focusing on avoidable admissions and discharge, making the most effective use of capacity across the system, community beds and care home facilities, underpinned by the use of technology. • In terms of looking forward to how things will be different this winter, there is a focused work programme around increasing vaccine uptake and improving accessibility for staff and vulnerable groups. The implementation of the integrated care coordination hub in partnership with London Ambulance Service (LAS), is starting to maximise alternative care pathways to conveyances to A&E. The Mental Health Crisis Assessment Service (CAS) is being expanded in the north of NCL, which will help to alleviate some of the pressure during winter. Work is also underway around the redevelopment of the North Middlesex urgent treatment centre which will build on the lessons from the progress seen at Barnet Hospital. The ICB will also be looking at how virtual wards can be used more proactively to enrol vulnerable populations ahead of winter. • Modelling has identified 2 - 18 January 2026 as likely to be the most pressured period. An additional set of 'in extreme' actions have been drawn up to use as necessary. • In terms of current performance, overall demand for LAS remains above the previous year's levels and the number of conveyances to hospital are slightly lower. A&E attendances are broadly in line with the same period last year. • There has been good progress against the four hour standard – overall system performance has been above 78% for four consecutive months, thanks to the teams' hard work. • Going forward, the Board will need to seek assurance that optimum use is being made of current capacity before new capacity is opened up and whether the system is making the most of discharge before lunch and discharge at weekends to free up capacity.
2.1.2	The Board of Members discussed the report, making the following comments: • The collective work across the system in this area was commended.

	• It was queried whether enough has been done to prepare for mental health pressures in the north over winter. It was confirmed in response that assurance had been given at a recent Flow Board meeting that the expanded CAS will be opening after Christmas. It was agreed that Richard Dale would look into the possibility of bringing this forward. • It was highlighted that NCL is likely to be particularly under the spotlight with respect to any winter pressures, so it was suggested that further thought might need to be given to potentially doing things differently. • The Winter Wellness campaign has provided practices with excellent toolkits to engage with the public. • It was queried what processes are in place to monitor hospital capacity and potentially expand it when winter pressures begin to bite. • Further to this, it was queried whether there is a particular pathway that could be changed rapidly into virtual wards, using the urgent care response teams. One possibility cited was older people with Urinary Tract Infections (UTIs), as it is known that taking this cohort to hospital can have a negative impact because they decondition in the hospital bed and are more prone to falls. Similarly, if they have dementia, that can be exacerbated by their time in hospital, whereas intravenous antibiotics can be delivered safely and effectively in the home. This is an area which ought to be a real priority. • In light of the decline in vaccination rates, it was queried how this year's approach would be substantially different to the previous year. More detail was also requested on what help will be available for primary care to manage winter pressures. • It was noted that the flu season in Australia during the UK's summer period was the worst in eight years, and it is likely that this will be reflected in the UK this winter. The decoupling of the flu vaccination programme from the COVID one presents an opportunity to increase take-up. • It was queried whether the EQIA referenced in the checklist will be shared with the Board. More information was also requested about who the vaccination programmes will be targeting and which populations are most at risk. • It was queried whether the ICB has any data on people's experience of discharge as there is anecdotal evidence of this being an issue when practical support is not in place. • It was queried how the NCL winter planning is linked with regional planning and what support might be available in the event of NCL's capacity being exceeded. More detail was also sought about the arrangements to keep people in the community when they need to and what this means in practice.
2.1.3	Richard Dale responded to the comments: • Assurance was given that there is more that the system can do to mitigate winter pressures and the COOs will be discussing where more can be done. Making more effective use of critical wards will be critical in this respect. The team is undertaking a piece of analysis to understand capacity at particular times in the day and over the winter period. Joining up that capacity analysis with the daily capacity alerts will enable the ICB to access capacity quite differently. • The ICB will also review whether there are particular pathways that can do more to support vulnerable groups. There is already a strong focus on care homes, so this will feed into that work. • In terms of doing things differently to improve vaccine take-up, the ICB has been working with community providers to put in place some vaccination 'sprints' in care homes for residents and workers to get this done in the quickest possible time. • Assurance was given that the Winter Plan contains funding for primary care, primarily around extra capacity for the Bridging Service, which will be overseen by the Primary Care Operations Group. • It was highlighted that innovative work is taking place at the Whittington around the Bridging Service to enable people to be discharged home earlier and at the right time. • It was confirmed that the EQIA would be circulated to Board members in due course.

	• Suggestions from partners about any additional things that can be done in this space would be welcomed.
2.1.4	Jo Sauvage reflected further on the changed approach to improving vaccine uptake among communities which have previously been less forthcoming: • This year's uptake has benefited from a more data-driven approach. The team has targeted specific areas of poor uptake and taken advantage of opportunities to deliver vaccines in different places and target populations in innovative and visible ways by working with community groups. • There are 154 vaccination sites assured to administer covid-19 vaccination across NCL this winter, with capacity for approximately 90,000 vaccinations per week. Aside from these, there are many other general practices, community pharmacies, hospitals and community providers who are administering flu vaccinations. • A clear communication campaign has also been developed in partnership with the Public Health team to ensure that there is a focus on those communities that are least likely to come forward to be vaccinated. All schools will be visited twice by the school-aged provider and the ICB is also piloting delivery of flu vaccines in nurseries, as part of thinking about how children's places are targeted better. • The reduction in the number of cases of measles over the summer has been reassuring, given the year-on-year decline in uptake of children's vaccines, but there is no room for complacency. The ICB is working closely with the UK Health Security Agency to monitor the number of cases, and there is also clear communication on the offer for vaccination within general practice. General practices are prioritising vaccinating children: 84% of children aged 1 to 12 in NCL have received at least one dose of MMR vaccine.
2.1.5	The Board discussed the paper further: • It was highlighted that despite general vaccination rates improving, they remain disappointing. It was queried what would need to be true to significantly improve them. • It was noted in response that the Covid vaccination programme had shown that rather than organisations simply inviting people to get vaccinated, the level of engagement and cultural competence is what really makes a difference. However, the process of embedding ourselves in communities and engaging with them is challenging and requires persistent effort and significant investment, bearing in mind that the ICB is battling public perception around vaccinations. • Trust is a key factor in immunisation levels. There is a commitment to moving immunisation across the neighbourhood and across general practice because this approach is evidence-based. However, it is important that practices have early awareness of any vaccination strategy so that vaccines can be ordered in good time. • It was noted that the ICB's approach to vaccinations has evolved over the years, with the recognition of the importance of cultural competency and improvements in data and insight, partly as a result of the partnership that has been built up with Public Health. The Borough Partnerships provide feedback from colleagues who have a close understanding of what is happening in the community. • Data is now being used to target capacity more specifically and tailor the access model. This includes changing the point of care and the time of care, as well as taking a behavioural approach. For instance, the Winter Wellness campaign wraps up a range of messages about prevention and how to stay well, rather than focusing on what services to use. People generally do not to wish to talk about jabs but they are happy to have a conversation about keeping themselves well and making good choices, so taking this into account could help to achieve a step change. • Partnership working with local authority colleagues around daily discharge and understanding the impact of delayed discharge will be key. Good arrangements have been established, involving daily conversations about people who need to leave hospital.

2.1.6	The Chair thanked Richard Dale and colleagues across the system for the work on winter planning and proposed a further discussion on immunisation at a Board Seminar.
2.1.7	The Board of Members **APPROVED** the ICB Winter 2025/26 Board Assurance Template prior to the document submission to the region.
2.1.8	Action: Richard Dale to circulate the completed EQIA to Board Members.
2.2	**Medium Term Financial Planning Update**
2.2.1	Steve Bloomer introduced the paper, highlighting the following points: • Planning is taking place for a new organisation, which means looking at things in a slightly different way. The paper therefore sets out both the planned approach and how people will be brought together to deliver this. • The ICB has received an indicative allocation but the actual allocations will not be confirmed until November/December. • There is a large number of technical issues that will need to be resolved as part of this work, so it is helpful to be carrying out this exercise as one organisation. Closing down organisations and starting a new one involves a range of technical issues, so this work will be useful in terms of budget settings and other areas, including looking at balance sheets. • Work has been taking place across NCL and NWL on aligning the two organisations, such as the zero-based exercise undertaken in NCL to gather more details across all contracts, including understanding what activity the ICB is buying, what activity it is receiving, and whether there is therefore any unearned income, and how it then starts to bring this together. • The two ICBs are also looking at where money is currently spent against some of the population need. This is highlighting that the ICBs currently spend too much money in the acute sector and on reactive care, and this will need to be addressed. The plan also requires a lot of detail about the neighbourhood strategies and how they will be brought to life, which is likely to be of wider interest. • The paper sets out some of the roles and responsibilities in the timetable but there is likely to be some slippage. The Board will be kept abreast of progress and it is important to note that any delays will not affect what the system wants to do.
2.2.2	Toby Lambert reflected further on the planning challenges: • Bringing together two approaches to planning will inevitably require some technical alignment. The process is further complicated by the need to develop a five-year plan in the absence of an agreed strategy across the two organisations. • Historically the strategic part of the planning has preceded the financial and operational planning, so that one informs the other, but as it looks as if the deadlines might slip, this may need to be done in parallel rather than in series. • The two ICBs have a similar architecture up and running on the more strategic side which will help to bring the NCL and NWL teams together to think about what they are going to achieve over the first couple of years of the merger organisation. However, although the technical requirement is to produce a five-year plan, as the strategy is yet to be agreed there is probably limited merit in spending much time on the 'out' years at this point, so it would make more sense to produce something which is sufficiently robust for this planning round, before returning to the longer-term strategy after April.
2.2.3	The Chair noted that initial Board discussions about the strategy will get underway at the joint away day on 10 November. Although this will not produce a definitive strategy, it will hopefully give a sense of direction.
2.2.4	Richard Dale highlighted that one of the key signals in the guidance is to move away from a static set of annual plans to a more active process, which will entail planning, strategising and making trade-offs as the ICB delivers its aims for the benefit of its residents. An initial 'compare and contrast' conducted in advance of the away day shows that in terms of the two ICBs' core strategies there are more similarities than differences, notwithstanding the

	variations in how residents experience life chances.
2.2.5	The Board of Members discussed the report, making the following comments: • The fact that the conversation is centring heavily on how things are brought together was welcomed. It is important to remember that despite the challenges, NCL and NWL ICBs are two highly functional organisations, so the new ICB will be inheriting an effective system, which will make it easier to deliver something effective for the population. • Despite the willingness within the system to shift resources from acute to the community, doing this in practice remains extremely difficult. Trusts are only prepared to relinquish a proportion of their budgets if they can be assured that the necessary shift will be delivered that reduces their activity. Going forward, a large amount of energy should be spent on solving that issue. This will require working with local authorities, community partners and GPs to establish what are the essential things that need to be different in order to free up those resources. • It was highlighted in response that the morning of the away day will be focused on looking at international examples of where there has been a successful shift from hospital to community care, from treatment-focused services to ones which actually have a more preventative and anticipatory element. It is helpful that the planning process is not annual, because it will not be possible to achieve this in a single year. Being able to look at the three shifts over a five-year period is a credible way of actually delivering that change. • The new ICB will need to challenge itself as a commissioning organisation. In order to persuade acute Trusts to reduce their budgets the ICB will need to provide solid evidence, data and business cases to allow this to happen. The combination of a forensic eye for detail and a clear vision will be crucial in achieving this. • From a local authority perspective, being able to have early conversations about budget setting, particularly at place, will be incredibly helpful, as demonstrated by the approach to Section 75 the previous year. • It was noted in response that the BCF should not be the limit of the ICB's ambition in terms of transferring resources to local authorities where that is a more cost-effective solution. For example, there might be an opportunity in this space to further incentivise the speed of discharge from acutes into the community.
2.2.6	Frances O'Callaghan agreed on the need for the ICB to be an active agent of change. She also gave assurance that the ICB would be targeting the long-term conditions cohort as a key part of shifting activity out of acute Trusts. Getting the ICB where it wants to be will involve some brave commissioning decisions which will disrupt the status quo and this has not been the ICB's historic role.
2.2.7	The Board of Members **NOTED** the requirements in producing a Medium Term Financial Plan for the merged ICB covering 2026/27-2020/31.
2.3	**Governance Update**
2.31	Ian Porter introduced the paper, highlighting the following points: • The Board was being asked to approve some minor but important changes to the Terms of Reference for the Population Health Strategic Commissioning Committee to ensure alignment with the 10-Year Plan and the model ICB blueprint, recognising the ICB's role as a strategic commissioner in the delivery of new models of care and in market management. • The Board was also being asked to note a mandated amendment to the ICB Constitution which allows the Chief Executive to be the Chief Executive of more than one ICB, which was not previously the case. NWL ICB have made a similar change to their constitution.
2.3.2	The Board of Members: • **APPROVED** the revised Population Health Strategic Commissioning Committee's Terms of Reference; • **NOTED** the revision to the Constitution;

	• **APPROVED** the related amendments, as above, to the Functions and Decisions Map and other governance documentation.
3.	**ANY OTHER BUSINESS**
3.1	There was no other business.
4.	**DATE OF NEXT MEETING**
4.1	11 November 2025. (This was subsequently rescheduled to 4 December 2025.)

Board meeting in public

Wednesday 29 October 2025, 13.00-15.30

Victoria Hall, Sheepcote Road, HA1 2JE

NHS North West London

Minutes

Note regarding agenda

Agenda items were taken in the following order: 1-7. b; 8; 10; 9; 8.a; 11

Item	
	Opening items
1	Welcome from the Chair including introductions and apologies Mike Bell, Chair, welcomed members and attendees to the meeting. It was noted that the Chair and the Executive team were working across NW London and NC London. The Chair thanked Anita Charlesworth for her leadership before his appointment. Members of the public were reminded that this was a meeting in public, and that there would be opportunity for questions to the Board once the meeting had closed.
2	Declarations of interest It was noted that the register of interests was available on the ICB's website, and that item 08.a: business cases for Enhancing Mental Health Crisis Pathways presented an interest for a member of the Board.
3	Notification of any other business The Chair confirmed that no requests for other business had been received.
4	Minutes from the previous meeting, 23 July 2025 The minutes were agreed to be an accurate record of the meeting.
5	Matters arising and action log Frances O'Callaghan, Chief Executive Officer, presented the update: • Action 2025-06: significant work had been done to develop the interface with boroughs for the new operating model. NHS England was expected to publish its model for neighborhoods shortly, and this would inform the next phase in NW and NC London • Action 2025-07: equality and health inequalities impact assessment was being submitted to NHS England in November, and would be shared with the Board The Board: • Noted progress for actions, including actions closed

Item	
	• Noted that actions delegated from the Board to Committees have been subsumed into Committee action logs. **Action/s** To circulate equality and health inequalities impact assessment to the Board **(Sarah Morgan)**
	Performance in NW London
6	Performance reports Stephen Bloomer, Chief Finance Officer and Deputy Chief Executive Officer presented the August 2025 ICS Operational Performance Report (month 4/5 data) and the Q1 Integrated Performance Report: • NW London's overall rating was amber • Cancer 62-day performance in urology, lung, and breast pathways remain challenging, and work was underway to address the challenges • At month 5, NW London ICS's position was breakeven (provider £5.3m deficit offset by ICB £5.3m surplus) The following points were discussed: • The importance of supporting the system through winter, and the work undertaken further to develop system resilience, with preparations in NW London being better than in previous years • Mental health services, and how investment had been used to support services for winter • High number of adults with a learning disability or autism in a mental health or specialist inpatient setting, which was part of a national trend. NW London was focusing on support for ADHD and autism, with the aim of reducing late diagnosis • Variation in completing initial health assessments for Children who are Looked After, with good performance in Brent and Ealing. Cross-agency working would help improve completion rates; the Children & Young People's Mental Health strategy would support this objective • RM Partners was working with partners on improving Cancer 62-day performance, which was often in areas with relatively small numbers of patients, meaning that percentage rates looked high • It was acknowledged that a significant number of people were brought into A&E/ Urgent & Emergency Care that did not require NHS care, and that further work was needed to address this

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	• What could be delivered in the short, medium, and long-term, and how the neighbourhood model of care, which would shortly be published by NHS England would help steer the direction of travel • Developing month by month metrics to support and measure delivery in the short-term The Board reviewed and approved the system performance outlined in the August 2025 ICS Operational Performance Report (M4/5) data) and Q1 Integrated Performance Report.
	Developing the NW London system and strategy
7	<u>Strategic Commissioning Committee Assurance Report</u> Akta Raja, Non-Executive Member and chair of the Strategic Commissioning Committee, presented the report. The Board was advised that the Committee had met once since the last Board meeting in public, and its focus included: • NWL ICS Community and Mental Health Provider Collaborative update • NWL ICS Maternity and Neonatal update • Neighbourhood Health • NWL ICS Children & Young People Mental Health Strategy The Board noted the report.
7.a	<u>Adult Mental Health Stocktake Review</u> Toby Lambert, Director of Strategy & Population Health, and Claire Murdoch, Chief Executive Officer, Central and North West London Mental Health Trust presented the review: • NW London's performance on annual serious mental illness health checks (70%) and early intervention in psychosis (>95%) were the best in England • Increased equity and equality of access though embedding the common core offer has reduced waiting times – over 10% of target seen within four weeks • Inappropriate out of area placements remain at zero, and 35 patients had been brought back into NW London from outside the sector • Work was underway to embed approaches to integrated care with neighbourhoods and Primary Care

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	• There would be further work to improve productivity, outcomes, and value for money The Board discussed the following: • How to take learning from implementing the strategy through to other services, including for children & young people • Long-term plans, including building on work to date in order to move towards integrated health organisations • How to demonstrate how feedback and insight from residents is being used, eg 'You said, we did' • The importance of addressing common mental health problems, as well as people in need of crisis services • The importance of an integrated approach, such as Work Well and the role of Local Authorities The Board: • Thanked the team for its work • Noted and reviewed review progress on the NHS NW London's delivery of the Adult Mental Health Strategy which was in year 2 of delivery • Provided comments and feedback on the work that has been developed and implemented and the impact it is having on patients, the public and the wider system
7.b	<u>Neighbourhood health – next steps</u> Toby Lambert, Director of Strategy & Population Health, and David Williams, Director of Integrated Care, presented the summary of progress to date and priorities for NW London: • Community and Mental Health trusts had been involved in developing the direction of travel for NW London • Borough teams had also been involved in developing the model of care, eg Child Health Hubs in Ealing • In Hounslow, two Care Together Teams had been launched, each linked to three GP practices and supported by community, social care, and specialist staff • Each NW London Place has a host organisation leading the integrator work, building on existing local models with the NW London programme team supporting system wide alignment

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	The following points were discussed: • NHS England guidance on how the Better Care Fund would be used would influence service models in 2026/27 • Provider collaboratives would be putting additional resource into this work, and Place Managing Directors were also taking this work forward • The importance of a consistent approach across Boroughs, eg for frailty and end of life care • How to increase Primary Care involvement • The ICB's role as a strategic commissioner, and how to shift focus and resource to support working at pace The Board: • Congratulated the Neighbourhood Health team for its national recognition • Reviewed the progress to date of neighbourhood health across NW London.
8	<u>Performance & ICB Finance Committee Assurance Report</u> Kunal Patel, Non-Executive Member, presented the report, which summarised the Committee's focus since the last Board meeting, which included: • Diagnostics Update • NW London ICS Finance Report Month 5 • Quality Escalations • Updates on Tackling inequalities in outcomes, experience and access, and helping the NHS to support broader social and economic development: update • Updates on ICB Financial Performance, and Contracts, Integrated Single Financial Environment (ISFE 2) Implementation, and Medium Term Financial Planning Update • Business Cases: Community Diagnostics; Integrated Admission Avoidance and Early Supported Discharge Community Offer; Enhancing mental health crisis pathways It was noted that the Committee had sought assurance regarding Cancer 62-day performance, which had been discussed earlier in the Board meeting. The Board noted and reviewed the report.
8.a	<u>Business case: Enhancing Mental Health Crisis Pathways</u>

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	Claire Murdoch, Chief Executive Officer, Central and North West London Mental Health Trust and Partner Member, Mental Health, was recused. Toby Lambert, Director of Strategy & Population Health, and Jacqui Sarakbi, Associate Director, Mental Health & Learning Disabilities programme, presented the business cases, which proposed targeted investments in mental health services to improve crisis care and patient flow in NW London: • These initiatives were key enablers for improving access, flow and performance across mental health urgent & emergency care pathways, and reduce unwarranted variation • Performance improvement trajectories had been identified for this winter and beyond • The Adult business case aimed to reduce A&E attendances, by increasing admission avoidance, increasing psychiatric liaison team clinical capability, expanding beds in some Boroughs, two new wards for homeless patients, and a women's ward for Complex Emotional Needs • The Children & Young People's (CYP) business case aimed to support the implementation safe space hub, and also the CYP hospital discharge service for children and young people not requiring CAMHS provision but needing supported discharge as a result of emotional and behavioural needs and/or placement or family breakdown It was confirmed that the proposals had been discussed with all Local Authorities. The Board discussed the following: • Expected reductions in length of stay, and how this would be measured (including patient experience, and staffing information) • Providers' role in deciding how business case resources were used to reduce patient flow, including beds being based on clinical need • Working with Local Authorities and third sector to help people use community-based services, thereby reducing hospital admissions • How this investment may impact growth in Mental Health activity and related spending The Board approved the two business cases: • Enhancing mental health crisis pathways for Adults (£11.7m – full year effect) • Children and Young People (£1m – full year effect).
	Assurance and oversight

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9	People & Remuneration Committee Assurance Report Anita Charlesworth, Non-Executive Member, presented the report, which had met once since the last Board meeting in public, and its focus included: • Consistency of approach to workforce reporting at both North West and North Central London ICBs • The significant improvement in appraisal rates and training engagement • Change programme that focussed on readiness, policy alignment and staff support • How the new Executive structure, which was now in place, would mitigate workforce-related risks The Board discussed: • Uncertainty relating to Treasury timelines for funding restructures • Supporting the workforce to focus on the merger, and it was noted that the ICBs were in conversations with trade unions The Board: • Thanked staff for their hard work and continued dedication during a time of change • Noted the report.
10	Audit & Risk Committee Assurance Report Simon Perry, Non-Executive Member, presented the report, which summarised key outcomes from the Audit and Risk Committee meeting held on 10 September 2025. The Board: • Note the Chair's Assurance report • Note the Board Assurance Framework • Note that the NHS NW London Constitution was revised under a mandated change from NHS England to allow for a Joint Chief Executive.
11	Chief Executive Officer's report Frances O'Callaghan, Chief Executive Officer, presented the report, which described the work of the ICB and its partners over the past few months. The Board received assurance that the ICB would remain committed to strategic commissioning. It was noted that the new Executive structure would help steer the

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	organisation to be a strategic commissioner, while retaining nursing and medical leadership, and contributing to reducing running costs. The Chief Executive Officer also thanked staff for their hard work over the past few months. The following points were highlighted: • The 2025/26 Access Programme continued, with Primary Care Network (PCN) Access Improvement Plans and dashboard oversight. Feedback and insights helped identify five themes (accessibility, continuity, digital tools, engagement and equity) to steer 2026/27 commissioning intentions • Significant support was being provided to practices, offering intensive learning and onsite support. 16 practices had participated to date, with a further cohort planned for November • Work continued to strengthen data and digital infrastructure in NW London. 87% of NW London GP practices had signed up to the London Data Service, and 85% across London overall • Reducing health inequalities: work was underway to increase funding distribution in deprived areas, and develop an allocation model. This was being done in collaboration with the health equity team, and builds on 2025/26 priorities, including the Cardio-Renal-Metabolic programme The following points were discussed: • How NHS England would take on performance oversight, and the process for supporting the transition from ICBs to NHS England • NW London and NC London were already working together on a shared planning approach for Winter and 2026/27, which would be consistent for providers. Population health needs would remain as now, with focus on mental health and services provided outside acute trusts • Continued focus on screening and prevention, with a self-sampling HPV pilot launched in October across 25 practices • What value for money would mean for the new organisation as a strategic commissioner, and how the Board would help influence the move to strategic commissioning. The Board noted the report.
	Closing items
12	<u>Any other business</u> There was no other business. The Chair, Mike Bell, closed the meeting.

Item	
	Next meeting
	December 2025 – to be confirmed

Present – Members

Name	Role/ organisation
Mike Bell	Chair
Frances O'Callaghan	Chief Executive Officer
Stephen Bloomer	Chief Finance Officer and Deputy Chief Executive Officer
Anita Charlesworth	Non-Executive Member
Claire Murdoch	Partner Member, Mental Health Services
Cllr Neil Nerva	Partner Member, Local Authorities
Cllr Jane Palmer	Partner Member, Local Authorities
Kunal Patel	Non-Executive Member
Simon Perry	Non-Executive Member (items 1-7. b; 8; 10; 9; 8.a)
Akta Raja	Non-Executive Member
Jennifer Roye	Chief Nurse
Cllr Alexandra Sanderson	Partner Member, Local Authorities
Dr Jo Sauvage	Chief Medical Officer
Dr Geneviève Small	Partner Member, Primary Care
Lesley Watts	Partner Member, NHS Trusts

Present – Named Participants

Name	Role/ organisation
Dr Charlotte Benjamin	NW London Medical Officer
James Benson	Community Provider Collaborative
Richard Dale	Executive Director of Strategy
Robyn Doran	Brent Borough Partnership
Caroline Farrar	Hammersmith & Fulham Borough Partnership
Clive Grimshaw	Harrow Borough Partnership
Toby Lambert	Director of Strategy & Population Health
Sarah Morgan	Chief People Officer

Neha Unadkat	Ealing Borough Partnership

In attendance

Name	**Role/ organisation**
Kerry Doyle	Head of Corporate Governance (minutes)
Emma Perllman	Chief of Staff to Chair
Martyn Schofield	Company Secretary

NHS
North Central London
Integrated Care Board

Draft Minutes
Annual General Meeting of NHS North Central London ICB

30 September 2025 between 1.30pm and 2.20pm
MS Teams

Present:	
Mike Bell	Chair, NCL Integrated Care Board
Frances O'Callaghan	Chief Executive Officer
Stephen Bloomer	Chief Finance Officer
Ibrahim Abubakar	Non-Executive Member
Kay Boycott	Non-Executive Member
Dr Simon Caplan	GP - Provider of Primary Medical Services
Richard Dale*	Executive Director of Performance and Transformation
Jenny Goodridge	Interim Acting Chief Nurse Officer
Mark Lam*	Chair, Royal Free London NHS Foundation Trust
Victoria Lawson*	Chief Executive, Islington Council
Dr Jonathan Levy	GP - Provider of Primary Medical Services
Sarah Mansuralli*	Chief Strategy and Population Health Officer
Sarah McDonnell-Davies*	Executive Director of Place
Sarah Morgan*	Chief People Officer
Simon Perry	Non-Executive Member
Ian Porter*	Executive Director of Corporate Affairs
Dr Jo Sauvage	Chief Medical Officer
Liz Sayce	Non-Executive Member
William Zermansky	Co-Chair, GP Provider Alliance
Apologies:	
Cllr Peray Ahmet	Leader, Haringey Council
Jinjer Kandola	Chief Executive Officer, North London NHS Foundation Trust
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 Bell welcomed everybody to the 2024/25 Annual General Meeting. He highlighted that as he had become chair of North Central London (NCL) ICB and North West London (NWL) ICB relatively recently, he had not had any involvement in the previous financial year. He thanked his two predecessors as NCL ICB Chair, Mike Cooke and Paul Najsarek, for their contributions as ICB Chair during 2024/25. He also thanked the former Non-Executive Members, Dr Usman Khan (who was Chair of the Finance Committee and the Primary Care Committee), Kay Boycott (who was Chair of the Audit Committee) and David Probert (UCLH), who is now Deputy CEO, NHS England.

* Standing Participant

	He briefly described the running order for the meeting and informed members of the public that they could submit questions at any time through the Q&A box on their screens.
1.2	**Summary of the Year and Key Achievements**
1.2.1	Frances O'Callaghan began her presentation by declaring her pride in NCL. While she was also delighted that NCL ICB is going ahead with its merger with NWL ICB, she paid tribute to everybody who had contributed to the success of NCL over the past 12 months. She noted that it was clear that the new government has an ambitious agenda to improve the NHS. The national 'Change NHS' conversation invited people to help shape these changes and as part of this, the ICB brought residents together, listened carefully, and their voices are influencing how health care is being designed. The NHS 10-Year Health Plan sets out three big shifts: from hospital to community, treatment to prevention and from analogue to digital. These shifts mean significant change which will need to be embraced. The Government is committed to putting as much money as it can in the front line, but for ICBs this means that management costs must be cut by 50 per cent. This will be extremely challenging, and she thanked colleagues for continuing to work in such a professional way in the face of this. NCL ICB is well prepared to further accelerate its approach to strategic commissioning as it has three clear priorities: *Knowing our population; Developing our approach to strategic commissioning*; and *Delivering the neighbourhood model*, all of which are vital to tackling health inequalities. The NCL Population Health and Integrated Care Strategy continues to be the north star. The ICB has expertise in strategic commissioning and Borough Partnerships in place, as well as new Integrated Neighbourhood Teams. The decision to align and in future merge with NWL ICB presents a huge opportunity for both NCL and NWL and provides a chance for mutual learning, to the benefit of both populations. **Knowing our population** Knowing its population is crucial to the ICB's ability to commission effectively. The ICB collates, monitors and analyses data through its Outcomes Framework and listens to lived experience in a range of ways, including Community Conversations; the Community Voices Panel consisting of over 1,000 adults reflecting the demographic diversity of NCL; and partnership working with the NCL Voluntary, Community and Social Enterprise Alliance. **Tackling health inequalities** Health inequalities remain stark in NCL. Residents in the most deprived areas on average live 12 years less and have between 17 and 22 fewer healthy years than those in the least deprived areas. As part of the work to tackle inequalities, partners across NCL came together at a recent Health Equity event to plan how to provide more equitable, locally tailored services. **Transforming dental care** The ICB has been working with Whittington Community Dental Service and other partners to create programmes to reach children early who are most at risk of losing their teeth and reducing waiting times. These programmes include supervised toothbrushing for 3 to 4-year-olds in early years settings and encouraging children to cut down on sugar in their diet and do more exercise. **Targeting smoking** As part of its work to target smoking, the ICB has invested in tobacco dependence teams, particularly in maternity services and mental health services. **Improving maternity services** The ICB is committed to improving maternity services and the Board has given considerable

attention to the strategic commissioning capability. Births in NCL are down in common with other parts of London but at the same time increased complexity in pregnancy and during labour continues to be seen.

The ICB ran a public consultation and developed a business case setting out the future of maternity and neonatal services which was approved and it is now working with NHS partners on implementing these changes. (Proposals which had been developed to improve emergency surgery for children were subsequently approved at the ICB Board meeting which followed the AGM).

Primary Care
Access to primary care is a key driver for how patients and residents feel about the NHS. Overall patient satisfaction with general practices in NCL has risen to 73%,and more patients say their practice has got better over the past year, which is higher than the national average. All NCL GP practices now use cloud-based telephony and the ICB is working with them to make best use of this, such as automatic call-back.

96% of NCL pharmacies are delivering Pharmacy First which means they can treat and supply medicines for a range of common health conditions. Pharmacy First is being used over 12,000 times a month in NCL.

NCL is proud to be one of the seven ICBs selected to participate in a national programme testing out new ways of working to close the capacity gap in general practice.

Better healthcare through improving our buildings
This year's highlights have included the official opening of the Welbourne Health Centre in Tottenham, and the refurbishment of Holloway Community Health Centre in Islington and Torrington Park Group Practice in Barnet, alongside further developments in community diagnostic centres.

Data shows a clear link between better local healthcare facilities and better patient outcomes and lower use of A&E. The ICB is working to ensure that buildings are fit for purpose to deliver healthcare in the right place.

Moving to digital
Digital is a significant theme in NCL and across the NHS as a whole. The NCL ICB Digital Team is helping GP practices safely and effectively adopt AI in a range of areas to work more efficiently. Digital development is vital to the success of the Integrated Neighbourhood Teams.

The London Care Record is a secure digital record that brings together an individual's health and care information across the NHS and social care. The ICB is supporting more care homes to adopt this and staff already using it report that it helps to deliver more effective and personalised care to residents and reduces unnecessary ambulance callouts and hospital admissions.

NCL has gone live with digital pathology, with digital scanning of slides transforming diagnostics, helping to improve the speed, accuracy, and accessibility of pathology services. Residents are being encouraged to use the NHS App as capability improves, such as booking appointments.

Emergency care
More people attended NCL A&Es in 2024/25 than the previous year. A&E four-hour performance remained challenged throughout the year, although the 76% target was achieved by the end of 2024/25, which was an improvement on the previous year.

A recent NCL initiative – the Integrated Care Coordination Hub hosted by London Ambulance Service – aims to support patients whose care could be managed closer to home. This multidisciplinary effort is reducing the number of unnecessary ambulance conveyances.

Planning for this winter is well underway, using learning and data from last year, including a focus on wellbeing to help reduce avoidable A&E attendances.

Preventing poor health
One of the big shifts across the NHS is from treating ill health to preventing it in the first place. The NCL Your Local Health Team campaign is designed to empower residents to stay well and access the right care for their needs.

Getting protected by vaccination is a key theme and there have been some significant achievements this year through the vaccination programme, but there is still further to go. This year, over 50 residents have been trained as Community Connectors to run interactive sessions on heart health providing blood pressure checks, health information and referrals.

Reducing waiting times
The Community Diagnostic Centres at Wood Green shopping mall and Finchley Memorial Hospital are speeding up diagnoses so that patients get results and treatment quicker. The Wood Green centre is also helping to tackle health inequalities by serving some of NCL's most deprived communities in a convenient location.

Waiting times have been reduced in a number of elective care specialties, and the ICB is continuing to reduce the numbers of patients on very long waiting lists month-on-month. There has also been investment in additional capacity, such as bringing down waiting times for autism and ADHD diagnoses, but demand remains very high.

Cancer care
NCL has had the best one-year cancer survival rate in England for the last six years at 77.8%, and the joint highest five-year survival rate for patients diagnosed in 2016 at 57.6%. This is a tribute to everybody involved in delivering that care pathway.

However, performance on survival rates needs to improve in some areas, particularly in oesophageal and breast cancer. The ICB is committed to addressing these gaps. NCL is part of an NHS England pilot to offer testing via community pharmacies for Barrett's Oesophagus, which is often a precursor to oesophageal cancer.

More work needs to be done on providing ongoing practical and psychological support for people living with cancer, as well as improving the speed of diagnoses. The NCL Cancer Alliance has launched a comprehensive Cancer Inequalities Strategy to help address the significant difference in cancer mortality rates in different communities.

High-quality mental health support
The ICB is committed to improving mental health services for its populations. The new Highgate East Mental Health Hospital, which was codesigned with service users, opened this year. Significant improvements are also being delivered by patients being able to stay locally for adult acute mental health inpatient care, which is a huge benefit to patients and their friends and families.

There were periods during 2024/25 when inappropriate acute mental health admissions outside NCL were reduced to zero. It is difficult to maintain throughout the whole year due to seasonal demand, but it is known that recovery is aided by proximity to families and friends. NCL also exceeded the national target for people with severe mental illness who have physical health checks.

Breaking down the barriers to work
The ICB aims to support broader social and economic development as there is a strong link between poverty and poor health outcomes. NCL is part of the WorkWell pilot to support people who have a health condition which affects their work life. The ICB works with the Shaw Trust charity which provides coaching and support and NCL is on track to achieve its target of

	supporting 3,000 people over the 18-month pilot into work. People say their coach has given them back confidence, purpose and hope. **Looking ahead – Neighbourhood health delivery** Neighbourhoods will be a significant part of the NHS landscape going forward. The goal is to bring services closer to people, with a greater focus on prevention, and joined-up community support. The ICB is working closely with its local authority partners to ensure that it builds on NCL's social assets in terms of the factors that drive wellbeing. 18 Integrated Neighbourhood Teams in NCL to focus on people most at risk of ill health with targeted support. Health professionals, social workers, housing officers, mental health specialists and more will work as one local team. **Conclusion** Frances ended her presentation by thanking all NCL ICB staff and its partners. Every achievement and innovation she had described was only made possible thanks to their commitment to residents and to delivering the best health outcomes that they can. She noted that although there is uncertainty ahead, there is a shared strength, resilience, and purpose to carry the organisation forward as it joins with North West London ICB. She thanked everybody who has supported the ICB to get this far and looked forward to the next chapter of its development.
1.2.2	Mike Bell thanked Frances for her presentation. He observed that is clear that NCL has created an impressive legacy to be taken forward into the future.
1.3	**Annual Accounts 2024/25**
1.3.1	Steve Bloomer provided an overview of the 2024/25 annual accounts. The ICB met all of its statutory and local financial targets for 2024/25. The ICB lived within its budget, achieved the local surplus target, met its running cost allowance and invested the appropriate amount in the Mental Health Investment Standard. In addition, the ICB delivered £77.7m in efficiency savings. In terms of the ICB's overall budget, 52% was spent on Acute and Integrated Care, 36% on out of hospital providers (community, mental health and primary care), with the remaining 12% spent on Continuing Healthcare, ICB running costs and other costs. Going forward, the ICB will expect to spend more on preventative care and reduce the amount spent on Acute and Integrated Care. The NCL Integrated Care System (ICS) has committed to achieving an overall breakeven target for 2025/26. As part of this, NCL ICB has agreed a surplus target of £27.2m. This ambitious system plan will require a lot of change. The ICB is on target to achieve its target. The main challenges, in common with other ICBs across the country, are Continuing Healthcare, increased prescribing costs and the fact that there are variable contracts in a large number of secondary care areas. A considerable amount of work is taking place to ensure that the ICB can live within its means and more importantly, start to develop a recurrent basis which will provide a strong financial position as the new organisation is stood up in April 2026. This is particularly important because for any strategic commissioner to truly achieve its aims, a strong financial basis is essential. The coming together of NCL and NWL ICBs as part of the new configuration of ICBs will provide a fresh opportunity to work with providers on how services might be delivered differently. As part of this, the ICB will concentrate on ensuring that it is obtaining better control and value in certain areas, such as Continuing Healthcare and prescribing, and take the opportunity provided by the new configuration of the ICB to really test the new models of care. From an ICB perspective, NCL is in as good a shape as it could be as it moves towards

	a new organisation.
1.4	**Questions from the Public**
1.4.1	There were no questions from members of the public who were observing the meeting online.
1.4.2	Liz Sayce reflected that Mike Bell had now been Chair of NCL ICB for a few weeks and asked if anything had struck him as particularly notable compared to his previous ICB, especially in terms of strengths and weaknesses and areas that NCL might want to build on or address as part of the merger.
1.4.3	Mike Bell observed in response that he was impressed by the overall quality of primary care, which will be the bedrock going forward as the ICB progresses the neighbourhood agenda. He had also been impressed by the way fact that NCL has the only system-wide GP Federation. This is a powerful strength as it makes it much easier to talk to GPs. The merger of the two mental health Trusts into the North London NHS Foundation Trust is a tremendous example of creating a platform to build excellence. Having a single mental health provider means that NCL can be far more responsive to the communities it serves and create single pathways. NCL also has an extremely rich acute sector with strong leadership. UCLH and the Royal Free are internationally renowned hospitals and alongside them NCL also boasts specialist hospitals, including Moorfields, the Royal National Orthopaedic Hospital and Great Ormond Street Hospital, which are real centres of excellence that bode well for NCL's population. He welcomed the fact that NCL is layered, with strong foundations across the piece in primary care, the acute sector and mental health. NCL also has constructive relationships with its local authorities and these will continue to be crucial as the ICB moves into the neighbourhood space. The final important part of the NCL jigsaw is its plethora of voluntary and community organisations. The historic investment in this area is another great platform to build on and develop and he looked forward to the year ahead.
1.4.4	Mike Bell thanked everybody for attending and closed the meeting.

North Central London
Integrated Care Board

North Central London ICB
Board of Members Meeting
4 December 2025 - Action Log

On Agenda	
Needs Urgent Update	
In Progress	
Completed	

Meeting Date	Action Number	Action	Lead	Deadline	Update
30 September 2025	32	**Winter 2025/26 Planning Paragraph 2.1.8** To circulate the completed EQIA to Board Members.	Richard Dale	November 2025	The EQIA was circulated on 27 November 2025.

North Central London Integrated Care Board

North West London

North Central London ICB and North West London ICB Board of Members Meeting in Common 4 December 2025

Report Title	Transition Update	**Date of report**	17 November 2025	**Agenda Item**	2.1
Lead Director / Manager	Ian Porter, Executive Director of Transition	**Email / Tel**		lan.porter3@nhs.net	
Board Member Sponsor	Frances O'Callaghan, Chief Executive				
Report Author	Ian Porter	**Email / Tel**		lan.porter3@nhs.net	
Name of Authorising Finance Lead	Stephen Bloomer, Chief Finance Officer	**Summary of Financial Implications** The West and North London ICB will need to meet the £19 per head cost requirement from 1 April 2026. The timely and successful delivery of the transition programme is a critical enabler of this requirement and will result in significant reductions to the future capacity of the newly merged organisation.			
Report Summary	This paper provides an update on the merger of North Central London and North West London ICBs into a single entity by 1 April 2026. It outlines progress to date, including appointment of a joint Executive team, technical preparations, and plans for organisational change to meet statutory cost requirements. The paper also sets out next steps, including staff consultation in December as part of the organisational design work, merger due diligence checkpoints, and programme milestones.				
Recommendation	The NCL and NWL ICB Boards are asked to **NOTE** the progress made and next steps for the transition programme.				
Identified Risks and Risk Management Actions	The significant reductions to ICBs, and the associated timescales, present a number of key risks – including: • Financial risk in achieving cost reduction requirements – with merger and the new organisational design being key to mitigation. • Staff and partner organisation uncertainties – part mitigated through robust communications and engagement plans. • Dependencies on NHS England guidance and timelines – mitigated through regular and structured check-ins with NHSE London. • Future organisational capacity – with clear prioritisation of key activity, including in the context of the nationally set Model ICB, being an important factor in mitigation.				

Conflicts of Interest	Not applicable.
Resource Implications	Significant financial, HR, Communications & Engagement, senior leadership and wider staffing resources are being utilised to deliver all aspects of the transition programme. Property resources are also impacted with a planned rationalisation of corporate office estates across the two ICBs.
Engagement	Extensive engagement with staff, trade unions, and stakeholders through briefings, FAQs, and joint intranet content.
Equality Impact Analysis	An equality impact assessment will be undertaken as part of the organisational change process.
Report History and Key Decisions	• July 2025: Boards agreed to merge. • September / October 2025: update to Boards • November 2025: National approval for voluntary redundancy scheme.
Next Steps	A significant amount of work lies ahead – with key milestones including: • Launch staff consultation in early December (48 days). • Due diligence checkpoint on 31 December 2025. • Programme delivery through quarter 4. • Confirmation of Transfer Order in March 2026. • Merger go-live on 1 April 2026.
Appendices	Not applicable.

Transition Update – Creation of West and North London Integrated Care Board (ICB)

1. Introduction and Recap

The 'Model ICB Blueprint' guidance (May 2025) and '10-year Health Plan for England' (July 2025) set out how ICBs should become 'strategic commissioners', playing a crucial role in the future of the NHS. Integrated Care Boards (ICBs) will need to ensure that funding is deployed optimally to improve population health, reduce inequalities, and improve access to high-quality services.

In undertaking this transformation to strategic commissioning, all ICBs are also required to reduce their running costs to a maximum of £19 per head of population. For North Central London (NCL) and North West London (NWL) ICBs, our weighted population of 4.5m means an administrative cost maximum of £83.4m per year, including all pay costs (administrative and programme pay) and non-pay running costs.

The challenges associated with the transition to the new ICB model and the need to deliver a significant reduction to ICB running costs present a number of risks to the NCL and NWL ICBs including in the context of:

- The delivery of 2026/27 ICB financial plan
- The available future capacity and skills mix to deliver all requirements and priorities as ICBs / strategic commissioners
- Staff morale and the impact of a period of further significant organisational change and associated uncertainties
- Maintaining strong relationships with partners and stakeholders through and beyond transition
- Ensuring the voice of residents / patients is heard in shaping our approach to strategic commissioning.

To mitigate the risks posed by the running cost reductions, in July 2025, both Boards agreed to merge. The new ICB will be the largest in England, serving 4.5 million residents – 48% of the London population. Our size, organisational strengths and the strengths of our partners present a unique opportunity for us to be the best ICB in the NHS.

The merger was approved by NHS England and Government Minsters - for completion on 1st April 2026 and the Chair and CEO of the ICBs have been appointed. Significant work continues to deliver the legal transaction and bring the organisations together in a timely and effective manner.

Since the Boards were last updated, we have:

- Completed the Executive consultation process and appointed a single Executive team for the merged ICB
- Implemented a programme of engagement to ensure the new Chair and CEO have been integrated effectively across both organisations
- Made further progress on the technical requirements to merge by 1 April 2026, including responding to time-critical deadlines from NHS England

- Developed an emerging model for how we work at Place and Neighbourhood level which is currently being tested with partners
- Further developed the plans for organisational change to meet the £19 per head per population requirement by 1 April
- Further developed plans for those services that will stop or transfer from the ICB, including a business case for our plans around complex care
- Held a joint away-day for the members of the two existing Boards – providing opportunity to consider the future approach to strategic commissioning.

Despite continued uncertainty around the approval and funding for redundancies to support the required headcount reduction over the past few months, we have continued to progress the merger transition programme.

2. Current Position

The ask of us over the short and medium-term remains significant. We must deliver on the following:

- Create a clear and compelling Board-level strategic vision and set a 5-year commissioning strategy and population health improvement plan
- Design our new organisation, including our target operating model, our organisational structures and our governance arrangements
- Reduce our cost base to no more than £19 per head of population
- Safely stop or transfer certain functions, in line with our new role and the Model ICB guidance
- Integrate our organisations – including culture and people integration, enhance our ways of working, and align / integrate systems and processes
- Communicate, engage and work with our staff and our stakeholders throughout the process
- Keep our focus on business-as-usual, including delivering the 2026-27 financial planning and supporting the system response to winter pressures.

Since the Boards last met, new national guidance has been made available, covering:

- The finalised ‘Model Region’
- The strategic commissioning framework
- Technical guidance on key activities to ensure a smooth and timely merger process.

Most significantly, on 11th November 2025, we received confirmation of Treasury agreement to run a voluntary redundancy scheme. We need to proceed with this at pace, to maximise the opportunity for costs of voluntary redundancy to be met within the financial year 2025/26. Whilst we will inevitably still carry some financial risk in meeting the £19 allocation from 1st April, this course of action presents the best opportunity to support any staff wishing to exit NCL or NWL ICBs through voluntary redundancy by financial year-end. We are therefore planning to launch consultation in early December, which will run for 48 days (accounting for the Christmas and New Year bank holidays).

Recognising the uncertainty and anxiety our staff are facing, we are committed to aligning as many aspects as possible within a single consultation. The December consultation will therefore incorporate:

- The structural 'end state' design of the new organisation (reflecting the necessary financial reductions)
- The mandated requirement to consult staff on the impact of merger
- The impact of planned changes to staff contractual office bases, as we proceed with rationalising our office estates to deliver further significant financial savings.

3. Overview of Programme Plan, Key Workstreams and Operating Rhythm

We have established a clear operating arrangement and programme plan for the merger which reflects the activities and requirements as set out in the NHS England guidance documents. The programme plan is extensive and helpfully we can draw on previous experience through the merger of CCGs and the transition from CCGs to ICBs.

The high-level phases of the plan are set out below. These phases are not necessarily run in sequence, i.e. some activities from each phase may be underway in parallel.

3.1. Design:

- Define the Target Operating Model (TOM) and ways of working
- Define Executive Management Team composition and Directorate functional scopes **(complete)**
- Design the governance structures and decision-making arrangements
- Design and cost the new organisational structure
- Engaging ICB staff and partners on the vision and operating model

3.2. Implementation:

- Implement the People change programme (including staff consultation)
- Undertake national merger requirements and governance procedures
- Align financial accounts and systems for migration to single ledger
- Implement changes to governance, critical IT systems and business processes
- Plan to transfer services to partners in line with ICB statutory duties and Model ICB guidance

3.3. Integration:

- Develop and execute a holistic organisational development plan
- Simplify, align and integrate IT systems and data landscape
- Consolidate office footprint
- Align standards and policies

- Simplify, align and automate business processes

The timelines and key milestones for the Design and Implementation phases have been subject to change over the past few months due to changing national guidance (in particular the position on redundancies, which has affected all ICBs nationally).

3.4. To deliver on the plan, six workstreams have been established:

1. People
2. Corporate & Governance
3. Finance and Contracting
4. IT and Information Governance
5. Communications and Engagement
6. Transfers of Functions.

Each workstream has a dedicated Executive Lead(s) as Senior Responsible Officer (SRO) – with identified delivery leads in place. The workstreams each meet on a regular basis to review progress made in the previous week and highlight planned activity for the following week along with an overview of actions, milestones and risks. Further information is provided below in Section 5.

Chaired by the Executive Director of Transition, all workstream delivery leads come together at the weekly meeting of the **Transition Working Group**. This group acts as the Programme Management Office for the transition programme plan. It feeds recommendations and escalations from programme workstreams up to the **Joint Transition Executive**.

3.5. The Transition Working Group is a key touchpoint for workstream leads to:

- Be updated on and provide updates on progress against the latest NHS England due diligence requirements and timescales
- Review and discuss interdependencies
- Highlight any areas for escalation to the Joint Transition Executive, including decisions needed
- Flag any risks or issues arising
- Track progress against the overarching programme plan.

The **Joint Transition Executive (JTE)** meets on a weekly basis. The meeting is chaired by the Chief Executive and comprises the ICBs' Executive Management Team. Crucially this meeting provides regular opportunity for oversight of critical deliverables and executive-level decision-making, where required.

Whilst risks are considered through each workstream – an overarching transition risk has also been developed on organisational change / merger for inclusion on the ICBs' Board Assurance Frameworks.

4. Our approach to Due Diligence

NHS England has issued an extensive set of due diligence requirements and deadlines to help ensure a smooth and successful landing of the merger. Each of the workstreams, as above, have factored these requirements into their respective workstream activity and associated reporting.

The ICBs' Executive Director of Transition is a member of the London Operating Working Group and also meets regularly with our NHS England governance leads in the Regional team to ensure we are abreast of the latest requirements from NHS England and to request clarification of requests and timelines, as necessary.

There are two key guidance documents that we are following:

4.1. ICB Merger & Boundary Change Timeline

This is a detailed, granular, step-by-step compilation of deadlines and milestones between now and merger go-live, including responsibilities for the ICB and for NHS England National and Regional teams. While this outlines the critical path to merger, the totality of actions included within the timeline are not all applicable to NCL/NWL as overall boundaries are not changing.

Regular review takes place with NHSE England regional colleagues on the upcoming milestones on the timeline. To date, all milestones for NCL/NWL have been recognised as complete or underway and on-track, other than those where we are awaiting input or confirmation from NHS England (e.g. receipt of information template).

4.2. ICB Merger Due Diligence Checklist

NHS England has provided an overarching "core" checklist to help ensure a timely and successful merger - including sections for People, Finance, IT, IG and Quality. Workstream leads are managing the respective requirements, reviewing them to ensure relevance, and cross-referencing their activity plans to ensure all key criteria are being met.

NHS England undertake assurance on the Due Diligence checklist to ensure that there is consistency of approach. There are key check-points set out to help ensure clarity of what should have been achieved at points in time and to help to identify whether ICBs require any additional support. NCL/NWLs next checkpoint is Check Point 2, on 31 December 2025. For this Checkpoint, we will provide a high-level update against all relevant due diligence activities.

As part of the Transfer Order – in early March we are required to submit to NHS England a list of all staff transferring to the newly formed ICB, which will be a key deliverable for the People Workstream.

5. Workstream Updates

5.1. People

The joint People Team of the two ICBs has established a workstream to lead and deliver the significant amount of work required for the change programme, including to support:

- The organisational design process for the West and North London ICB
- The associated merger process
- Any agreed transfers of current ICB functions to alternative providers.

Our approach to the change programme is underpinned by three key principles:

- Supporting staff with a fair and transparent process
- Maximising the funding opportunity negotiated by NHS England
- Meeting the requirement of reducing to a running cost allowance of £19 per head of population from 1 April 2026.

The organisational design work, including its implementation, will move through a number of key phases – each requiring dedicated focus and capacity. Regular and timely engagement with Trade Union representatives and with all staff of both ICBs is and will continue to be a critical deliverable.

Consulting staff is a statutory requirement and, following the recent national announcements on funding for Voluntary Redundancy, the pace of work has accelerated significantly – working to the launch of all staff consultation in early December (as set out in Section 2 above).

The Team's work will include the development of a Change Management Policy – and the undertaking of individual impact assessments, and an overarching equality impact assessment, of the proposed organisational design.

The Team is continuing to work closely with the Communications and Engagement function to support the regular briefings and other updates to all staff, also including the provision of a robust set of Frequently Asked Questions.

The People Team will also play a key role post the implementation of the new organisation's staffing structure – leading and supporting work in relation to organisational and cultural development and new ways of working etc.

5.2. Corporate Governance

A key aim through the period up to 1st April has been to align the corporate governance arrangements where similar approaches are in place across the two ICBs and where it will be helpful for joined-up discussions and decision-making. As such, the following arrangements are in place for meetings to take place in-Common:

- The ICB Boards
- Strategic Commissioning Committees

- Finance Committees
- Remuneration Committees

Whilst the Audit Committees will remain separate through this short-term period, the work of the Committees will be aligned where possible, including in the consideration of future audit and counter-fraud arrangements for the merged ICB and associated audit planning.

A Joint Transition Committee has been established and will meet in quarter four of 2025/26 as the preparations and key deliverables for the merger accelerate.

In addition to the above, a joint approach to Business Case approvals (where approvals can be made below committee levels) has been put in place, ensuring consistency and efficiency across the two ICBs.

Looking forward, attention now turns to the corporate governance arrangements for the new organisation – with key work including:

- Drafting the new Constitution and Standing Orders – scheduled for Board endorsement in January prior to submission for NHS ENGLAND approval.
- Establishing new Committee arrangements for the merged ICB which, crucially, will need to reflect the key priority role for the ICB as a strategic commissioner
- Recruitment to the new Board of Members – including Non-Executive Members and Partner Members
- Establishing the scheme of delegation and reservation and associated decision-making arrangements below committee levels

Work is underway to align the significant number of organisational policies in place across both NCL and NWL ICBs – with an assessment being undertaken of those policies that need to be aligned in the run-up to 1st April 2026.

It will be important for the new organisation to work from a single 'headquarters' – providing good quality office space for staff to work together and thrive in a positive operating culture. It will also be important, as part of the need to meet the '£19 per head' cost requirement to ensure an optimum balance between office space and the delivery of financial efficiencies.

A clear plan is in place to deliver both elements through the establishment of the single headquarters office environment at Ferguson House, Marylebone Road – and exiting other existing leases in place in other large office bases – resulting in the delivery of significant and timely financial savings.

The planned changes to in-scope staff members' contractual base will be included in the overall staff consultation on the change programme – and all staff will be fully supported as part of this transition.

5.3. Finance and Contracting

The Finance Directorates across the two ICBs have formed a joint finance transition working group to ensure technical and operational readiness for the finance function (including key systems and processes) for the ICB merger on 1st April, as well as compliance with NHS England requirements within relevant dates. This group meets weekly, reports up to the Transition Working Group and ultimately to the Joint Transition Executive. The group has

formed a subgroup focussing on finance procurements – and will also work across a number of key areas:

- Governance
- Accounts and Audit
- Ledger Requirements
- Banking
- Contracts
- Assets
- Liabilities

The working group will deliver the NHS England mergers key requirements and timelines, as referenced above.

Whilst key actions are all on track – close monitoring is taking place including in the context of the simultaneous capacity requirements to implement and report in ISFE2 - and support other key finance deliverables through quarter three and quarter four of 2025/26.

5.4. IT & Information Governance

The digital and IT leadership team across the ICBs have established a joint **ICT merger delivery group** who will have responsibility to produce and deliver the transition plan. **ICT merger workstream groups** have been established to oversee each of the priority workstreams to ensure readiness for 1st April 2026.

The objectives for Phase 1 are to enable West and North London ICB to, from 1st April:

- Collaborate – Share files and folders seamlessly, work collaboratively on projects, and to be attached to a single email domain
- Connect – Be able to work seamlessly from any of the West and North London ICB sites, regardless of whether their IT originated in NCL or NWL
- Access support – Have a single point of access for support and aligned processes (for e.g. starters, movers and leavers)
- Run future IT procurement strategically, with a view to standardising contracts as and when the existing contracts expire
- Support the production of a schedule of all current ICT systems in use across the two ICBs and of associated key-decisions prior to 1st April.

The ICT merger delivery group will also scope requirements post 1st April 2026 to generate phase 2 deliverables for longer-term integration of ICT services.

In addition, an early and important milestone has been completed in relation to the work required with the national organisation data service (ODS) to put in place an organisation code for West and North London ICB.

The delivery group is working through all aspects of the due diligence checklist issued by NHS England to complete IT and Digital relevant tasks.

From an Information Governance perspective, work will take place to identify any key data sharing agreements that the ICBs currently have in place and the action required to transfer any relevant agreements into the new organisation.

5.5. Communications & Engagement

The ICBs are grateful for the input from partners and stakeholders that helped to inform the case for change and options appraisal paper that was considered by the Board in July 2025.

Our relationships with local partners are hugely valued and the ICBs' Communications and Engagement Teams have established a joint delivery workstream - and, in navigating through this challenging period of change, are working hard to make sure key stakeholders remain informed about our plans and involved wherever that is possible. We are doing this through regular meetings and other communication opportunities – and are sharing targeted email updates at key milestones, including most recently the announcement of the new Executive team.

The workstream is also progressing work to support the creation of a new corporate identity for the new ICB, including branding materials, the creation of shared internal and external information platforms and ensuring our staff remain fully updated on all aspects of the change programme

This has been an uncertain and worrying time for the ICBs' staff and the Communications Teams are working to ensure staff in both organisations continue to receive consistent, accurate and timely messages. This includes sending a weekly update from the CEO to every staff member, in addition to staff news bulletins and updates bespoke to the two current organisations. The ICBs have also developed and launched a bespoke intranet site publishing the latest news, information and FAQs, which can be accessed by staff in both organisations. Regular briefings are being held with the joint senior leadership team as well as frequent 'all staff briefings' bringing staff from both organisations together to hear updates directly from the CEO and Executive team. These sessions are recorded for anyone unable to make them and are published promptly on the shared intranet. Staff are encouraged to submit questions via an FAQ form – with responses published as soon as they are available.

5.6 Transfer of Functions

A further element of the transition programme, and in keeping with the Model ICB Blueprint, is the work to consider the transfer out of functions from the ICB – including to maximise the opportunity to balance cost and service delivery. The Board will be updated on any proposed Transfers of Functions including, where required, for business care approval.

6. Looking Forward

Whilst significant and complex work lies ahead, and at a time where our staff need to be fully supported, clear programme planning arrangements are in place to deliver the transition. Further updates will be provided to the Board, including through meetings of the Transition Committee between January and March.

Whilst the merger of the two ICBs does not present any immediate changes to the provision of health care services to residents of North Central and North West London – any subsequent proposals, beyond merger, that may impact the provision of health care services

will be subject to robust governance and equality, and quality, impact assessment arrangements.

We will continue to engage with our key partners and stakeholders as we work through to, and beyond, 1st April 2026 – recognising the importance of their crucial roles in the development and delivery of health and care services including the integrated neighbourhood arrangements.

Engaging with our residents and patients remains a key element of future strategic commissioning and work will be undertaken to consider the optimum model, within available resources, to undertake meaningful and added-value engagement across and within the new ICB's footprint.

The merger of the two ICBs presents a great opportunity, in what will be the largest ICB in the country, to maximise the benefits of scale and the ability to achieve greater economies of scale, to bring together a wide range of strategic partners and to harness the best of both from the strong work currently being undertaken in North Central and North West London.

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North Central London ICB and North West London ICB
Board of Members Meeting in Common
4 December 2025

Report Title	Joint Performance Report	**Date of report**	19 November 2025	**Agenda Item**	2.2
Lead Director / Manager	Steve Bloomer, Chief Finance Officer and Deputy CEO, NCL ICB and NWL ICB	**Email / Tel**		Stephen.bloomer@nhs.net	
Board Member Sponsor	Kunal Patel, Performance and Finance Committee Chair, NWL ICB Steve Bloomer, Chief Finance Officer and Deputy CEO, NCL ICB and NWL ICB				
Report Author	Ben Okoye (NCL), George Absi (NWL) and James Mackenzie (NWL)	**Email / Tel**		James.mackenzie3@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Not applicable.			
Report Summary	The joint North Central London and North West London Integrated Care System Performance Report Summary outlines the latest themes and key messages for system key performance indicators across the two systems. The updates are sourced from the existing performance report formats across the respective systems (which are included as appendices to the joint summary report).				
Recommendation	The NCL and NWL ICB Boards are asked to **NOTE** the performance against the key indicators outlined in the report and discuss any areas where additional scrutiny or clarification are required.				
Identified Risks and Risk Management Actions	As winter pressures increase there is a risk that UEC services, particularly in sites which have historically struggled with demand, may be required to deliver non-optimal care (e.g. corridor care) with the associated clinical and dignity risks. This is being mitigated through a structured set of agreed escalation thresholds and accompanying whole system management plans.				
Conflicts of Interest	Not applicable.				
Resource Implications	Not applicable.				
Engagement	Not applicable.				

Equality Impact Analysis	Not applicable.
Report History and Key Decisions	Not applicable.
Next Steps	Not applicable (standing report).
Appendices	• North Central London ICS Performance Report. • North West London ICS Performance Report.

November 2025 - Joint Performance Report Summary

Introduction

The joint North Central London and North West London Integrated Care System Performance Report Summary outlines the latest themes and key messages for system key performance indicators across the two systems.

The updates are sourced from the existing performance report formats across the respective systems (see appendices). Work is planned through the latter part of quarter 3 and quarter 4 to develop a fit for purpose performance report for the merged system.

2026/27 planning processes are underway with the intention to develop and submit joint ICB performance/activity, workforce and financial returns.

Performance Headlines

Managing the primary physical and mental health needs of residents

Operational indicators that are used to understand the care and experience of patients with on-going or non-urgent health and care needs.

NCL:

- NCL continues to provide a high percentage of primary care same day appointments above the national average – 9.2% up for September 2025.
- NCL also performs well against the national expectation that 90.0% of primary care appointments are booked within two weeks. This is the case now for 11 of the last 12 months.
- September 2025 performance for talking therapies reliable recovery and reliable improvement is on plan, but complete courses of treatment (2+contacts and discharge) achievement remain challenged. A barrier to achievement remains insufficient step 2 (low intensity) referrals being received to generate significant activity to meet targets.

NWL:

- NW London offered 1,533,821 appointments in September 2025, which is 101,081 appointments more than planned. Nearly 54% (52.7% plan) of appointments were delivered on the same day or next day. Two thirds of appointments were delivered face-to-face, with the other appointments delivered flexibility including on-line.
- In October, 33.7% of people requiring mental health support experienced waits of over 12 hours in NW London emergency departments against a stretched target of 20%.
- The reliable recovery rate for Improving Access to Psychological Therapies (IAPT) services was 47.8% (48% plan), meaning patients have moved from a clinical level of anxiety or depression to a non-clinical level of anxiety or depression. Just over seventy percent (67% target) of patients showed a reliable improvement, which is a significant but not complete recovery.

System Flow

Operational indicators that are used to understand the care and experience of patients with unplanned healthcare needs and how well the unplanned care system is coping with demand.

The NCL and NWL systems are starting to show signs of pressure on key system flow indicators with the performance direction deteriorating as we head into the winter months.

NCL:

- In October 2025, four-hour ED performance has improved to 77.3%, up 0.4% from last month, but remains 2.9% below the target of 80.2%.
- People with potentially serious conditions (Category 2) waited on average 37 minutes 48 seconds for an ambulance in September 2025. Performance remains above the 18 minutes target but is an improvement from the same period last year.
- After meeting the virtual ward plan up to July 2025, NCL performance has slipped below trajectory in subsequent months. September 2025 performance is reported at 74.8% against the 80.1% plan.

NWL:

- Four hour ED performance has reduced to 75.3% in October from 76.3% in September. All type ED attendances increased by another 4% in October to 108,695 from 103,970 in September. This is nearly 2,800 patients more than seen in October 2024. Type 1 attendances increase from 50,762 patients in September 2025 to 53,344 patients in October 2025. A&E attendances (type 1&2) are in-line with plan therefore volume is not the main driver in variation for targeted performance.
- People with potentially serious conditions (Category 2) waited on average 32 minutes and 30 seconds for an ambulance in September, which is within the planned figure of an average of 33 minutes and 30 seconds. Average handover times for ambulances was 18 minutes and 50 seconds compared with a target of 18 minutes and 20 seconds.
- Bed Occupancy in hospitals is above the optimal threshold (92%) across multiple sites, which demonstrates the pressures hospitals are currently experiencing.

The key mitigation across both systems includes the continued implementation of the NCL and NWL winter plan interventions. Monitoring arrangements against a set of defined escalation triggers for key indicators have been established. Individual partners have their own organisation governance monitoring, with system wide monitoring undertaken via the respective System Coordination Centres (daily system monitoring), weekly gold meetings (from mid-November) and additional scrutiny through A&E Delivery Boards and System Flow oversight arrangements.

Planned Care and Waiting Times

Operational indicators that are used to understand the care and experience of patients with planned healthcare needs and how well the planned care system is delivering agreed expectations on access, demand management and performance.

NCL and NWL patients are still waiting longer than we would like for planned treatments, diagnostic assessments and cancer treatment. However improvements in reducing the number of patients who have been waiting the longest are continuing.

NCL:

- Referral to treatment (RTT) 18-week performance remains below the target at 63.1% across the system.
- The overall patient tracking list size continued to reduce in September 2025 and now stands at 288,124 patients (down 1.5%), from 292,605 patients in August 2025. The latest position represents the lowest NCL value since October 2024.

- NCL diagnostic 6 week waits remain challenged with 7,879 patients in this cohort of the overall waiting list of 53,469, giving September 2025 performance of 14.7%. Non-obstetric ultrasounds (2,824) and neurophysiology (1,539) are the modalities with the highest volumes of waiters over 6 weeks.
- Community 52 week waits remain above plan in Q2. In September 2025 there were 998 patients waiting for CYP services (mainly in autism, and also speech and language therapies), and 45 patients waiting for adult services (mainly in rehabilitation and pain management).

NWL:

- In September, there were 60% of patients (58% target) waiting no longer than 18 weeks for elective treatment. Whilst elective recovery overall remains on-track, pressures are expected during winter with mitigation support plans in-place.
- The overall Patient Tracking List size (patient's waiting to start treatment) increased in September to 289,569 patients (up 1.8%), from 284,345 patients in August. There were increases at Chelsea and Westminster Hospitals Trust (CWHT) (2,958 patients) and The Hillingdon Hospital Trust (THHT) (2,301 patients), whereas Imperial College Healthcare NHS Trust (ICHT) and London North West University Hospitals Trust (LNWUHT) broadly remained the same.
- Diagnostics performance (although improved in October) remains a concern, whilst cancer (2 week wait urgent suspected cancer & 62 day standards) and some CYP waiting times remain areas for improvement.
- The key mitigation is the identification of additional in-year targeted investment to support RTT, CYP ADHD and Autism assessments (£10m to the Acute Provider Collaborative for elective RTT and £10m for CYP Mental Health).
- Community 52 week waits at CNWL have significantly reduced. There are now 28 patients across NW London waiting for treatment from 507 patients in August.

Alongside capacity, productivity and transformation mitigations, the ICBs are leading a joint collaborative system-wide programme of work to assess elective referral demand and demand management across West & North London. This has been undertaken in partnership with Acute Trusts and primary care to understand referral growth, analyse variation, and agree mitigating steps to ensure equitable and sustainable pathways across the system. The longer term ambition is to reduce the proportion of outpatient activity delivered in hospitals, with a gradual shift towards delivery in neighbourhood settings over time.

Additional areas of performance improvements and concerns

We have seen performance improvements in a number of areas:

NCL:

- While we recognise there is still further to go, we have seen significant improvement in our cancer operational performance across North Central London over the past year. Due to an incredible, coordinated effort across our Trusts, primary care, ICB, regional and Cancer Alliance team the North Central London Cancer Alliance (NCLCA) is:
    - Currently the 2nd highest performing alliance on the Faster Diagnosis Standard (compared to 18th in September 2024).

  - Currently the top performing alliance on the 62 day Standard (compared to 17th in September 2024).
- NCL access for CYP mental health services achievement remains healthy throughout 2025/26, with September 2025 recorded as 29,504 against a plan of 24,310.
- Perinatal mental health access continues to improve across NCL, with the latest position for September 2025 reported as 2,026 against a plan of 2,010.

NWL:

- Elective recovery – good progress has been made around reducing long waits
- Community waiting times – NWL has some of the lowest waiting times in the country
- Mental health community crisis – NWL one of the best performing systems in England for the proportion of new urgent referrals to community crisis services with a face-to-face contact within 24 hours.
- Diabetes care – NWL is one of the best performing systems in England for the completion rates of the nine diabetes care processes, ensuring robust monitoring and early detection of diabetes.
- Mortality rates – NWL acute trust's have some of the lowest mortality rates in the country.

The following areas are being kept under review due to concerns over performance:

NCL:

- Adult mental health average length of stay (LoS) remains high in NCL. Continued high demand for inpatient beds, and volumes of patients who are clinically ready and fit for discharge (CRFD) but remain on the wards is a contributing factor. Ward level dashboards simplifying access to vital indictors have now been published with a call to action for all ward leaders to develop improvement plans to reduce LoS, CRFD and improve flow.
- Urgent community response (UCR) referrals remain below plan in NCL during 2025/26. Close work with NCL ICB CMO and Place Directorates is in place to establish the way UCR teams can optimise their work with other partners around admission avoidance within Integrated Neighbourhood Teams, while maintaining the consistent operating model across NCL.

NWL:

- Diagnostics performance (although improved in October) remains a concern, whilst cancer (2 week wait urgent suspected cancer & 62 day standards) and some CYP mental health waiting times remain areas for improvement. Significant investment has been made into the latter with improvements expected during Q3 and Q4.

Financial Delivery

North Central London ICS:

- NCL ICS reported a YTD deficit of £41.8m at M7 which represents an adverse variance of £18.4m against the YTD plan.

- The adverse variance is entirely driven by the provider sector (£18.4m) where it mainly relates to pay pressures with the ICB reporting a YTD surplus of £15.9m which is line with plan.
- The YTD position also includes the impact of Industrial Action (IA) of c.£3.5m in previous months, of which c.£3m relates to net pay costs and c.£0.5m of income loss due to IA. Unlike in previous years, we understand there is no funding to follow to offset the costs of IA.
- Whilst the M7 system bottom line is £3.4m favourable against the recovery plan, five providers namely NLFT, GOSH, RFL, T&P and WHIT are adverse against the recovery plan mainly due to IA pressures. We have plans at local level that deliver balance although there remains risk.
- Mitigating financial recovery action includes MARS at a number of providers, closure of unfunded capacity and vacancy freezes amongst the main interventions.

North West London ICS

- The ICS month 7 position is a £0.05m surplus, made up of providers £5.05m deficit offset by ICB £5.1m surplus (deterioration of £2.3m since M6).
- Key drivers to the providers £5m variance from plan relate to CIP slippage £14.7m, NI pressures £5.5m, Industrial Action £3.8m, Pathology £3.9m, and inflation £0.5m, partially offset with ERF over performance £7.8m, Non recurrent benefits, higher than expected clinical other income, reduced bank and agency costs and increased vacancies £15.6m.
- The YTD ICS efficiency is 94.3% (90.7% at M6), with unidentified efficiencies at 1.9% (2.5% at M6). The forecast reported to NHSE was £312.9m which is £9m favourable to plan.
- Provider Pay is adverse to plan by £26.7m at M7 (1%) with agency spend representing 0.9% of overall pay.

North Central London
Integrated Care Board

NCL ICB Performance Report

November 2025

Author: NCL ICB Performance Team

NCL ICB Performance Report Overview

North Central London
Integrated Care Board

Introduction

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

The report focusses on the following key areas:

- Overview of constitutional standards (slide 3)
- Primary care and urgent and emergency care (slide 4)
- RTT (slides 5 to 7)
- Diagnostics and cancer (slide 8)
- Mental health talking therapies and community virtual wards (slide 9)

This report includes a high-level overview of performance and associated metrics – 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 Oversight Framework, Operational Plans, the Long-Term Plan and NHS Constitutional Standards.

The report incorporates aspects of the 2025/26 NHS Priorities and Operational Plan. NCL ICB is monitoring activity against trajectories considering all known risks. This includes the further collaborative work with providers to work towards elective targets, improving bed capacity to enhance A&E performance trajectories, and the efficient use of mental health beds to improve patient flow and reduce the average length of stay in adult acute beds.

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

The ICB's approach to performance management is designed to complement the NCL 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 NHS ICS Population Health Strategy.

Key Performance Headlines – 2025/26

NHS
North Central London
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Elective

- Although the NCL validated PTL continues to reduce in 2025/26, there has been an increase in referrals both within NCL and from outside. RFL is the largest recipient in the sector.
- Across all providers there is a challenge relating to the need for increased activity levels to improve performance, while managing the availability of workforce and financial constraints – providers are working to balance these priorities, however deviation from plans exists throughout 2025/26.

UEC

- A&E 4-hour performance improved in October 2025 by 0.4% to 77.3%, standing at 2.9% below the target.
- 12 hour waits from arrival remain off target plan for the second month running and was recorded for October 2025 at 9.1%. This is 0.7% above the current plan.
- Average ambulance handover time, is also off target plan for the second month. October 2025 was recorded at just over 27 minutes – above plan by more than 2 minutes.

Cancer

- While we recognise there is still further to go, there has been a significant improvement in cancer operational performance across NCL over the past year.
- In September 2024, the North Central London Cancer Alliance (NCLCA) ranked 18th out of 21 Alliances for its **Faster Diagnosis Standard** (FDS) performance (71.8%). This compares to September 2025 (latest available data) where we now rank second (79.6%) and are one of only three systems to exceed the 2025/26 annual target for the FDS (77.0%).
- Similarly, in September 2024, the NCLCA ranked 17th out of 21 Alliances for its **62-day performance** (62.2%). In September 2025, we now rank first (75.9%) and are the only system to exceed the 2025/26 annual target for the 62-day standard.
- This is all thanks to an incredible, coordinated effort across our Trusts, primary care, ICB, regional and Cancer Alliance teams.

Mental Health

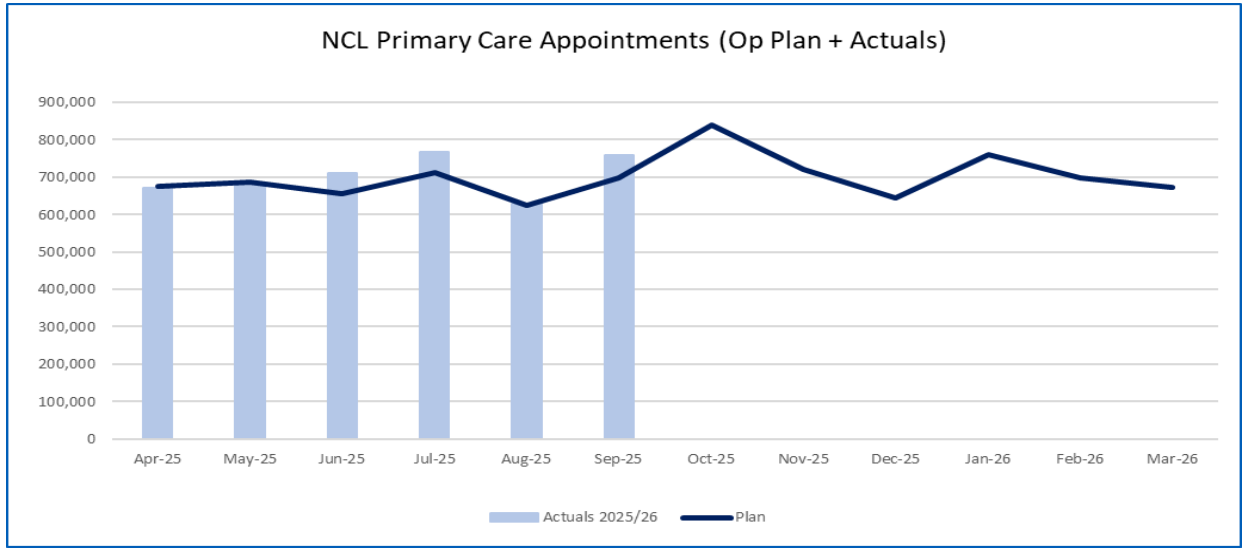
- Performance for Talking Therapies reliable recovery (actuals of 46.4% vs a plan of 46.2%) and reliable improvement (68.5% vs 67.7%) has increased to meet target at the end of Q2. Completed courses of treatment for 2+contacts and discharge (actuals of 7,778 vs a plan of 8,438) remains challenged.
- NCL access for CYP services achievement remains healthy throughout 2025/26, with September 2025 recorded as 29,504 against a plan of 24,310.

Performance Update – 2025/26 (1/6)

North Central London
Integrated Care Board

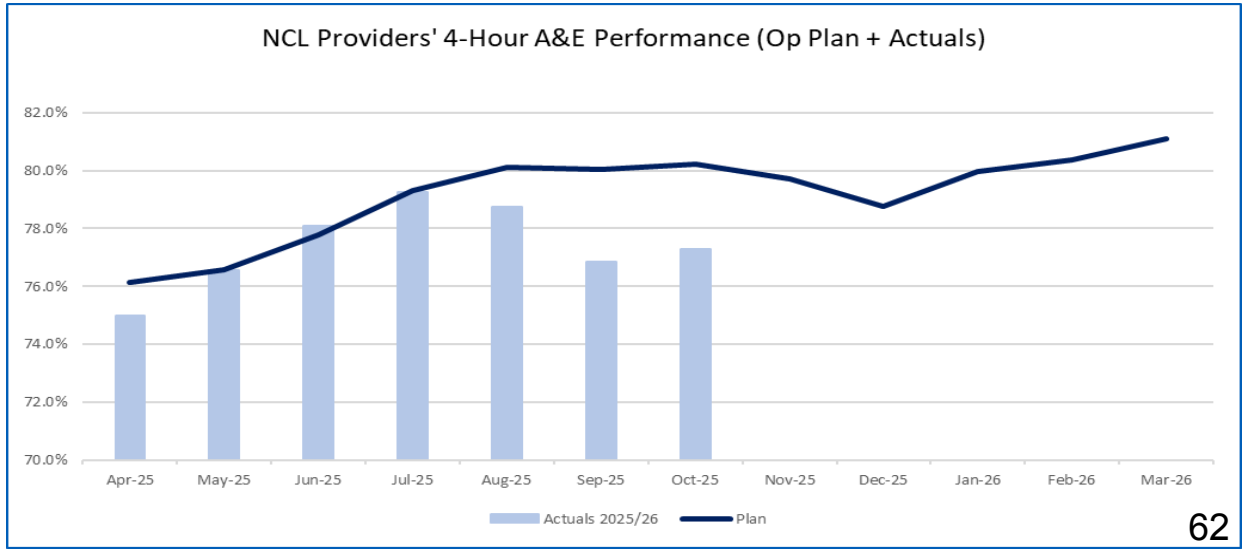
Primary Care

- NCL GP appointments were 757,677 for September 2025 and have averaged over 716,000 a month for the last 12 months.
- 2025/26 NCL primary care appointments to September 2025 are higher than the same period for 2024/25, with a 4.1% increase reported, and also above plan for the month.
- NCL continues to provide a high percentage of same day appointments above the national average – 9.2% over this value for September 2025.
- NCL also performs well against the national expectation that 90.0% of primary care appointments are booked within two weeks. This is the case now for 11 of the last 12 months.



UEC

- A&E 4-hour performance improved in October 2025 but was 2.9% below target at 77.3% - average ED attendances per day increased from last month, as did ambulance handovers. 12 hour waits from arrival have been within plan during 2025/26, apart from the last 2 months. October 2025 actuals reported as 9.1% against a plan of 8.4%.
- Ambulance handovers longer than 30 minutes increased from last month (up 515 to 3,684), while those over 60 minutes also increased (up 130 to 516).
- NRS Healthcare, the equipment supplier across London went into liquidation in July 2025, so impacting the discharge of some patients. A new supplier has now been confirmed, with work underway to mobilise the contract across NCL.



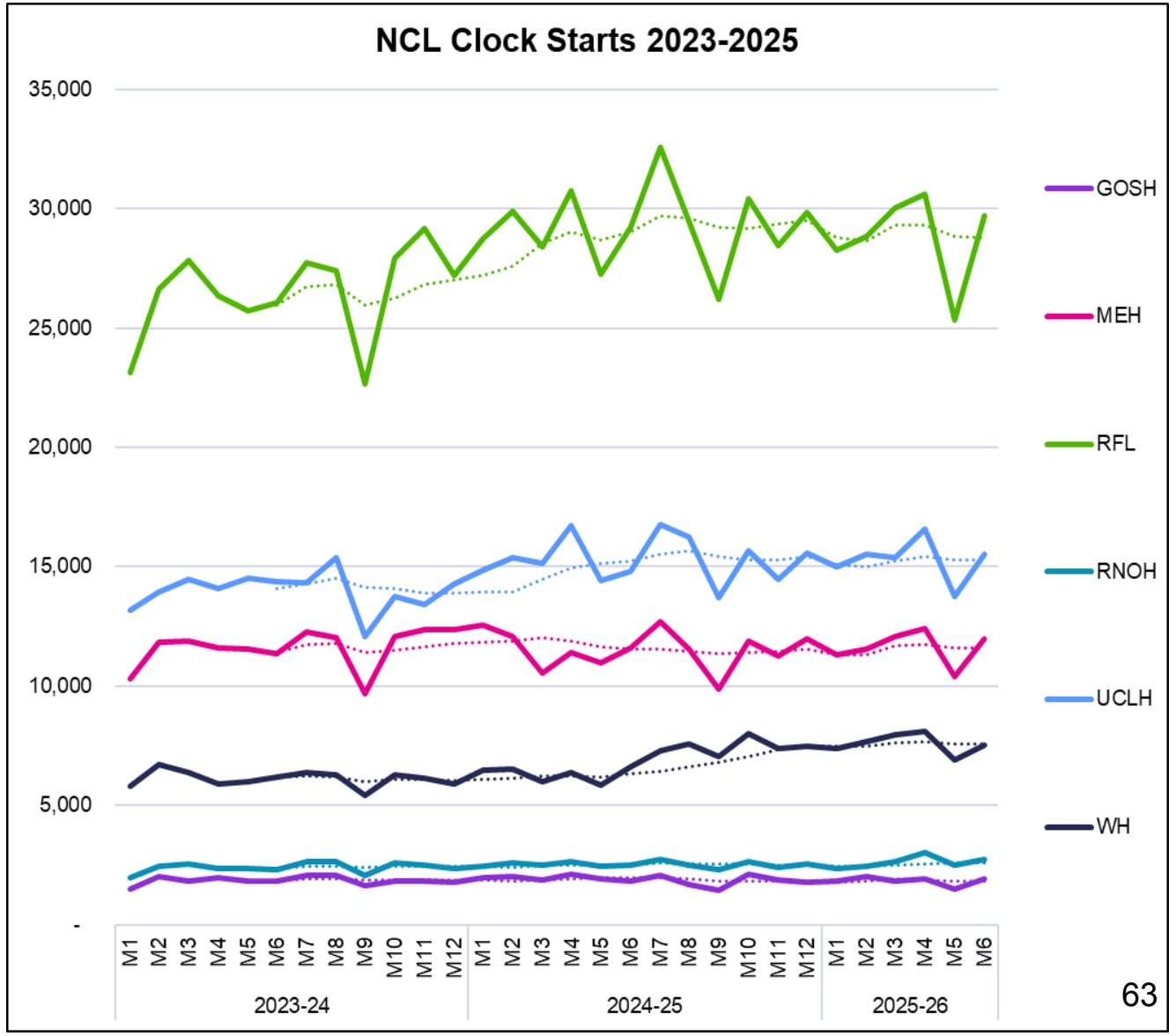
Performance Update – 2025/26 (2/6)

North Central London Integrated Care Board

RTT Clock Starts

- The number of clockstarts increased by 1.7% between M1 and M6 of 2024/25 and 2025/26. This represented an additional c6,800 patient pathways joining the NCL system waiting list.
- RFL and GOSH have seen a decrease in clockstarts in 2025/26, as their counts reduced by 0.8% and 6.8% respectively. WH clockstarts increased by 20.4%, RNOH by 3.3%, MEH by 0.8% and UCLH by 0.4%.
- Work is being undertaken by NCL ICB Performance and Improvement Team to understand the drivers of referrals and growth in the PTL. NCL's distinctive position with specialist hospitals makes us a significant net importer of patients from outside of the system, alongside potential growth in demand for general and specialist services, and the RSS closure. All factors are potential drivers.

NCL Provider	Clock Starts 2023-24	Clock Starts 2024-25	Clock Starts 2025-26	Change M1-M6 24/25 – 25/26
RFL	317,812	351,229	172,797	-1,475
UCLH	167,869	183,782	91,706	+352
WH	73,256	82,579	45,548	+7,726
GOSH	22,115	22,655	10,955	-800
MEH	139,364	138,401	69,697	+538
RNOH	28,752	30,251	15,615	+501
Grand Total	**749,168**	**808,897**	**406,318**	**+6,842**



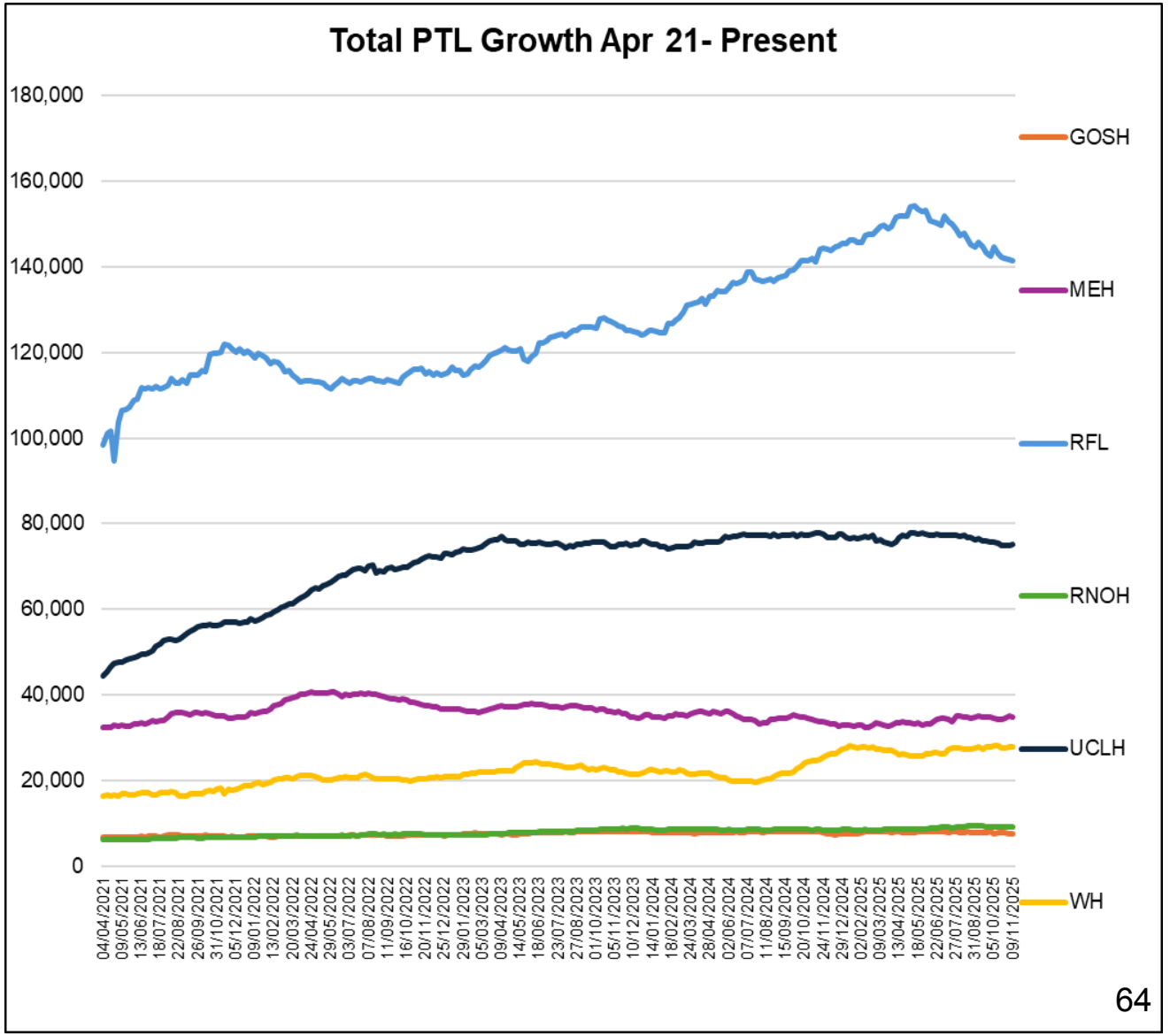
Performance Update – 2025/26 (3/6)

NHS North Central London Integrated Care Board

PTL Over Time

- The total NCL system PTL has decreased by 1.7% over the last year and increased by 44.0% overall since 2021.
- All PTLs are largely influenced by the non-admitted cohorts.
- This year April to November 2025, the PTL has reduced by 1.9% (-5,234) with the greatest increases at MEH (+1,784) & WH (+807). RFL has been making visible reductions to their PTL (-7,833) since April 2025.
- Specialties with the greatest increasing list size include dermatology, ENT, gastroenterology, gynaecology, trauma & orthopaedics, and urology.
- Trusts have been incentivised to validate their patients to clean the PTL and this has led to reductions, but with an increase in demand, and financial and workforce constraints, progress on waiting list reduction is limited.

% Growth	Apr-21 to Mar-22	Apr-22 to Mar-23	Apr-23 to Mar-24	Apr-24 to Mar-25	Apr-25 to Present
GOSH	3.3%	6.3%	2.5%	3.0%	-3.1%
MEH	23.6%	-7.2%	-3.9%	-7.8%	+5.4%
RFL	14.9%	6.3%	9.4%	13.5%	-5.2%
RNOH	15.3%	7.3%	11.6%	2.1%	+4.6%
UCLH	40.5%	22.0%	-0.8%	-0.6%	-0.2%
WH	28.6%	5.1%	-2.8%	25.5%	+3.0%
NCL	**26.8%**	**8.0%**	**3.6%**	**7.3%**	**-1.7%**

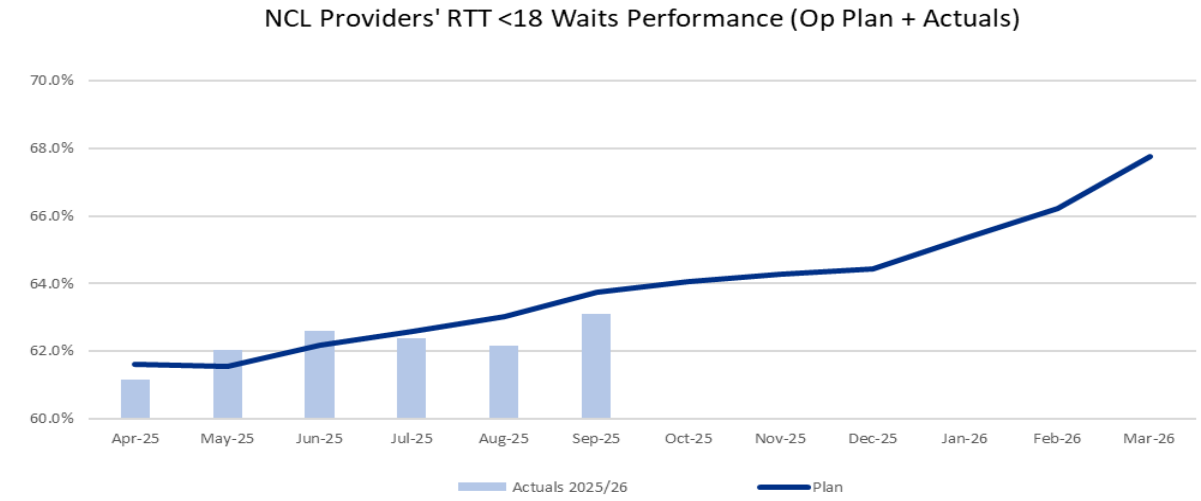


Performance Update – 2025/26 (4/6)

North Central London
Integrated Care Board

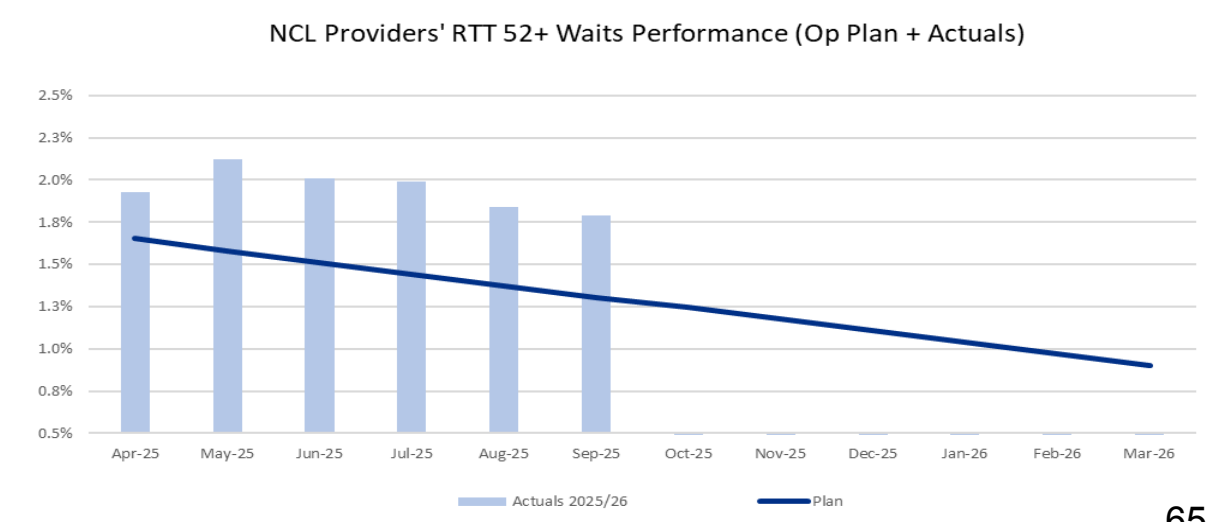
RTT – <18 Waits

- The national ambition is for providers to deliver 60.0% for RTT performance by March 2026 or a 5.0% improvement on the November 2024 position, whichever is the more challenging.
- As of September 2025, based on published data for 18ww performance, NCL providers overall are reported at 63.1%, which is 0.7% behind plan, but with an improved position reported compared to April 2025 – this represents a shortfall of 8,653 patients to the September 2025 target. For 18w performance, RFL and RNOH are currently on plan.
- Overall, NCL challenges are mainly in the surgical pathways such as ENT, gynaecology, urology and orthopaedics.



RTT – 52+ Waits

- The national ambition for providers is that no more than 1.0% of pathways should be waiting 52 weeks or more by March 2026.
- For September 2025, the NCL provider position is 0.5% off target, at 1.8%.
- All NCL providers except RNOH are off plan in September 2025.
- The largest providers by volume are RFL and UCLH, and whilst there were increases in the patient cohorts reported into Q1 of 2025/26, both providers have reported a reduction for September 2025, when compared to September 2024. RFL a 24.8% reduction, and UCLH a 5.7% reduction.
- NCL currently has 5,156 pathways waiting >52w, with the largest cohort (2,850) at RFL.

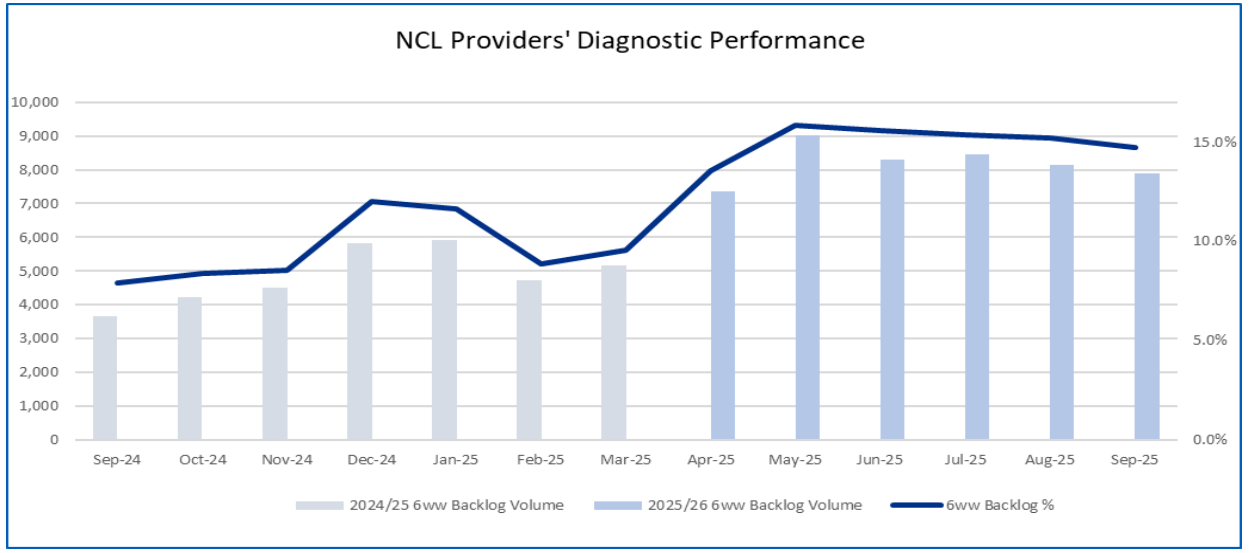


Performance Update – 2025/26 (5/6)

North Central London Integrated Care Board

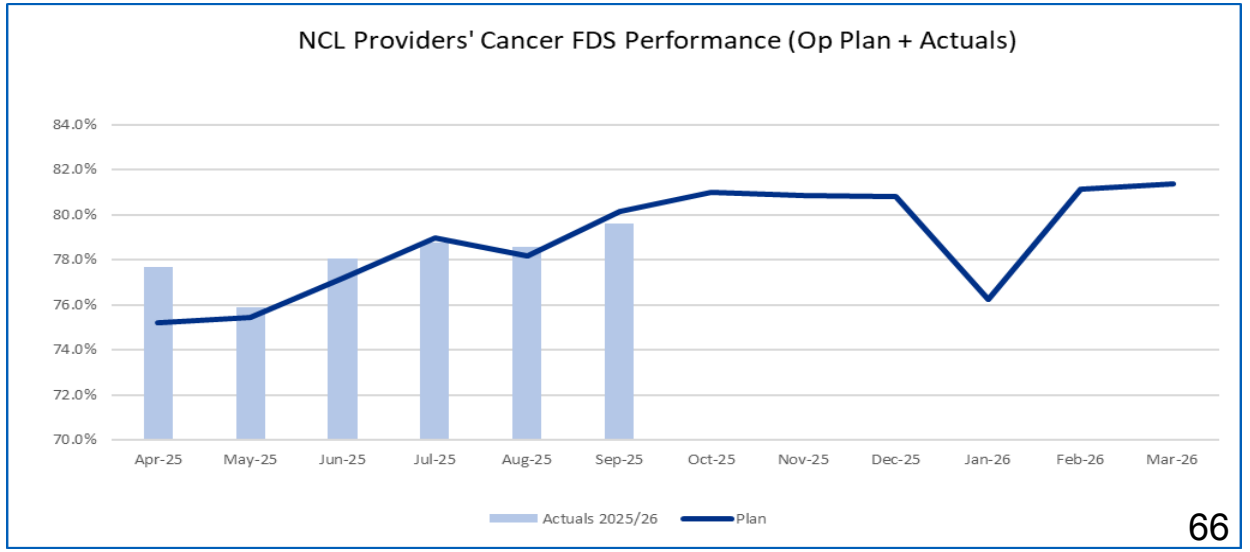
Diagnostics

- NCL providers' aggregated performance for September 2025 was 14.7%, with 7,879 patients waiting over 6 weeks – 2,824 requiring a non obstetric ultrasound (NOUS).
- RFL hold the highest volume of the NOUS cohort (1,964) and reported significant growth in Q1 of 2025/26 from increasing demand, and reduced waiting list initiatives due to financial constraints. An NCL task and finish group is reviewing demand and capacity issues for the RFL service.
- Neurophysiology accounts for 19.5% of the total NCL backlog (1,539 patients), with the largest cohort at RFL (783). Increasing RFL demand had been seen via GP direct access since mid-2023, but this route is now deactivated as of May 2025.



Cancer

- The national Faster Diagnosis Standard (FDS) performance ambition is for providers to achieve 80.0% compliance by March 2026.
- In September 2025, FDS compliance for NCL providers overall was reported as 79.6%, which is 0.6% below plan.
- UCLH, WH, and RNOH, all met their individual targets for September 2025, while RFL were 2.7% off target.
- The national ambition for 62-day performance is 75.0% compliance by March 2026.
- September 2025 performance for NCL providers overall is reported at 75.9%, which is 1.7% above target. All providers apart from RFL (0.8% off) met their individual targets.

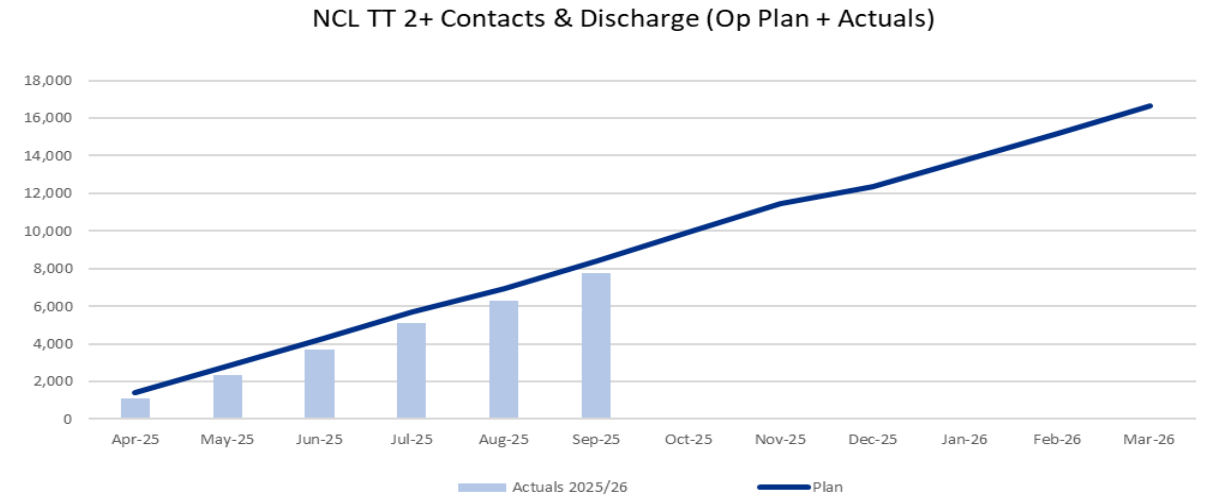


Performance Update – 2025/26 (6/6)

North Central London Integrated Care Board

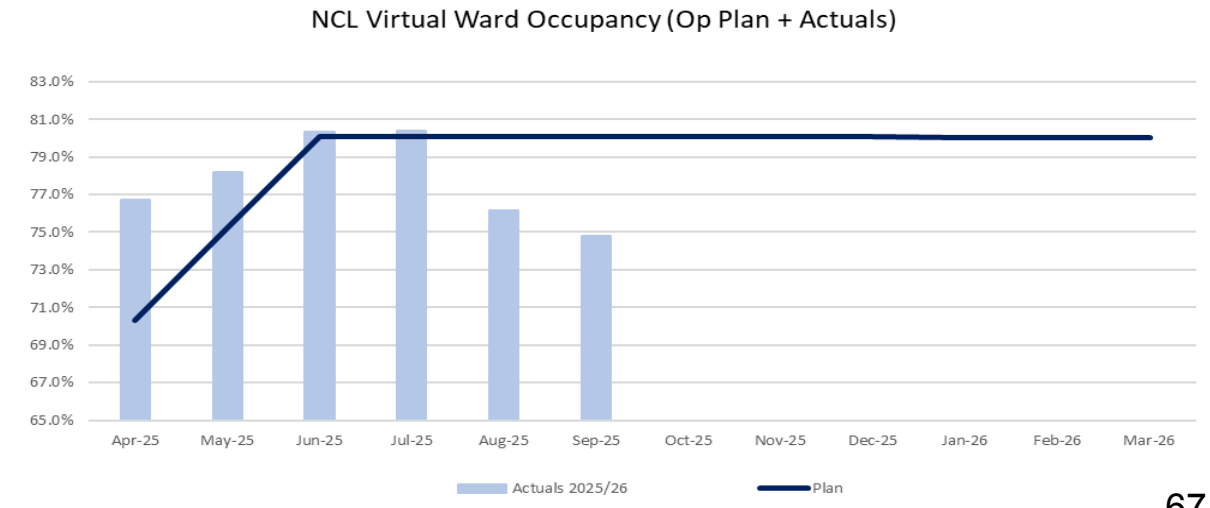
Mental Health – Talking Therapies (TT)

- September 2025 performance for TT reliable recovery and reliable improvement is on plan, but complete courses of treatment (2+contacts and discharge) achievement remains challenged.
- Engagement with digital providers is underway to improve access via digital front door.
- A targeted DNA reduction strategy is in place reviewing reminder systems (e.g., SMS and calls) and ensuring consistent application of DNA discharge policies across teams.
- Pathway optimisation reviews are underway for stepped care and triage models to maximise step 2 utilisation. Work with system colleagues continues to consider the demand for step 2 and 3 services, and the implications for any potential model changes.



Community – Virtual Wards (VW)

- The NCL ambition for 2025/26 is to increase VW capacity to 285 beds by March 2026, with a minimum of 80.0% utilisation in all services.
- After meeting the plan up to July 2025, NCL performance has slipped below trajectory in subsequent months. September 2025 performance is reported at 74.8% against the 80.1% plan.
- VW repatriation pathways are now in place between NCL sites for NMUH, BH, RFH and CNWL, with work underway to extend to WH pending the required governance process.
- VW repatriation across all boroughs will ensure universal access for all residents, and ease pressures on acute services in NCL.



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NCL Supporting Documents

Mental Health
Learning Disability & Autism
Acute
Finance

NCL Mental Health + LD&A Dashboard

North Central London
Integrated Care Board

NCL - Mental Health and LD&A Measures		TARGET 24/25 - Q3	2024/25			TARGET 24/25 - Q4	2024/25			Plan 25/26	TARGET 25/26 - Q1	2025/26			TARGET 25/26 - Q2	2025/26		
			October	November	December		January	February	March			April	May	June		July	August	September
CYP - MH	CYP Access 1 Contact (Incl MHST)	23,418	22,003	22,377	22,653	24,989	23,140	24,111	26,140	24,989	23,187	27,099	27,525	28,026	24,310	28,103	29,064	29,504
Adult - MH	Talking Therapies 2+ Contacts & Discharge	11,630	9,065	10,353	11,407	15,586	12,576	13,717	14,951	16,648	4,253	1,117	2,361	3,704	8,438	5,131	6,309	7,778
	Talking Therapies - Reliable Recovery	48.7%	43.5%	46.3%	43.7%	48.2%	45.2%	47.2%	48.2%	48.7%	47.8%	44.9%	43.3%	45.1%	46.2%	43.5%	45.3%	46.4%
	Talking Therapies - Reliable Improvement	67.7%	67.0%	66.7%	64.0%	68.1%	64.4%	67.1%	68.0%	67.7%	66.9%	65.7%	65.7%	66.9%	67.7%	66.4%	68.6%	68.5%
	Perinatal	1,840	1,587	1,662	1,581	2,010	1,816	1,821	1,905	2,010	1,917	1,939	1,951	1,973	2,010	1,989	1,998	2,026
	Adult Community Access- 2 Contacts	22,772	20,094	20,148	20,307	23,823	20,483	20,769	20,937	23,823	21,350	21,088	21,207	21,300	21,721	21,536	21,606	21,815
	SMI - Physical Health Checks	69.1%	60.1%			71.0%	67.9%			n/a	n/a	59.0%			n/a	TBC		
	Individual and Placement Support Access	785	492	588	681	1,046	760	852	929	1,322	1,104	987	1,007	1,015	1,196	1,059	1,080	1,158
	Number of Inappropriate Active OAPs	4	6	1	5	0	3	5	3	0	1	7	2	2	0	4	4	1
	Average LoS Combined Metric	n/a	n/a	n/a	n/a	n/a	51.0	53.0	62.0	41.0	42.8	60.0	60.0	53.0	42.5	54.0	56.0	59.0
	Dementia Diagnosis Rate 65+	68.9%	67.3%	67.4%	67.2%	69.0%	67.1%	67.2%	67.2%	66.7%	66.7%	67.3%	67.4%	67.5%	66.7%	67.7%	67.9%	TBC
LD&A	Annual Health Checks	53.9%	44.2%	51.0%	57.3%	75.0%	66.7%	75.0%	85.9%	75.0%	16.2%	3.7%	9.4%	15.3%	35.0%	24.4%	30.9%	38.5%
	Adult inpatients (ICS Commissioned)	18	16	16	15	18	19	19	25	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Adult inpatients (NHSE Commissioned)	21	19	19	18	21	18	17	17	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Adult inpatients - Learning Disability	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	17	20	24	21	20	19	21	18	18
	Adult inpatients - Autistic	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	17	18	18	18	18	18	18	13	14
	CYP inpatients	10	9	9	9	9	7	8	6	5	8	6	6	8	7	6	6	5

NCL Acute Dashboard

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NCL - Selected Acute Services		2024/25					2025/26						
		November	December	January	February	March	April	May	June	July	August	September	October
Urgent care	*4-Hour AE performance plan*	*76.1%*	*76.7%*	*77.8%*	*78.4%*	*79.8%*	*76.1%*	*76.6%*	*77.8%*	*79.3%*	*80.1%*	*80.0%*	*80.2%*
	4-Hour AE performance	72.7%	73.4%	74.8%	74.6%	76.0%	75.0%	76.6%	78.1%	79.2%	78.7%	76.8%	77.3%
	12 hour waits performance plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*10.3%*	*9.8%*	*9.5%*	*9.4%*	*9.1%*	*8.5%*	*8.4%*
	12 hour waits performance	9.1%	10.5%	10.4%	9.8%	8.4%	9.1%	8.2%	7.7%	7.4%	8.1%	10.0%	9.1%
	LAS handovers	8,336	8,427	8,784	7,954	8,783	8,798	8,594	8,624	9,339	8,957	8,688	9,423
	Ambulance handovers 30 min+	2,817	3,153	3,398	2,806	2,703	3,079	2,888	2,824	2,964	2,830	3,169	3,684
	Ambulance handovers 60 min+	408	569	720	388	287	424	332	388	290	293	386	516
	Average handover time plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*00:28:08*	*00:27:11*	*00:26:17*	*00:25:05*	*00:24:52*	*00:24:38*	*00:25:19*
	Average handover time	00:25:46	00:27:19	00:29:17	00:25:36	00:23:57	00:25:55	00:25:11	00:25:38	00:24:25	00:24:35	00:26:18	00:27:24
RTT	*New RTT pathways (Clockstarts) plan*	*61,185*	*51,058*	*60,103*	*60,037*	*60,340*	*64,208*	*67,155*	*63,496*	*66,746*	*62,615*	*64,174*	*68,967*
	New RTT pathways (Clockstarts)	68,900	60,514	70,592	65,676	69,107	65,983	67,926	69,721	72,523	60,238	69,262	*TBC*
	RTT incompletes plan	*264,416*	*264,454*	*262,747*	*262,753*	*263,175*	*296,860*	*297,236*	*297,652*	*298,300*	*298,703*	*298,728*	*299,027*
	RTT incompletes	289,204	292,001	292,706	294,419	293,828	297,517	296,655	294,859	294,602	292,605	288,124	*TBC*
	Less than 18 weeks plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*182,914*	*182,923*	*185,065*	*186,708*	*188,233*	*190,460*	*191,516*
	Less than 18 weeks	181,775	181,321	180,324	181,900	181,700	181,937	184,018	184,573	183,802	181,910	181,807	*TBC*
	Less than 18 weeks performance plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*61.6%*	*61.5%*	*62.2%*	*62.6%*	*63.0%*	*63.8%*	*64.0%*
	Less than 18 weeks performance	62.9%	62.1%	61.6%	61.8%	61.8%	61.2%	62.0%	62.6%	62.4%	62.2%	63.1%	*TBC*
	52+ waits plan	*5,609*	*5,365*	*4,998*	*4,656*	*4,337*	*4,912*	*4,696*	*4,488*	*4,299*	*4,102*	*3,888*	*3,718*
	52+ waits	5,941	5,257	5,299	5,417	5,354	5,739	6,302	5,929	5,867	5,382	5,156	*TBC*
	52+ wait performance plan	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*1.7%*	*1.6%*	*1.5%*	*1.4%*	*1.4%*	*1.3%*	*1.2%*
	52+ waits performance	2.1%	1.8%	1.8%	1.8%	1.8%	1.9%	2.1%	2.0%	2.0%	1.8%	1.8%	*TBC*
Diagnostics	*Imaging plan*	*65,063*	*58,933*	*64,434*	*59,438*	*63,866*	*62,842*	*65,432*	*65,754*	*70,756*	*64,687*	*66,436*	*71,424*
	Imaging activity	68,796	65,279	72,352	65,860	70,965	65,217	68,924	69,248	73,529	67,109	71,278	*TBC*
	Endoscopy plan	*4,480*	*4,186*	*4,480*	*4,206*	*4,617*	*4,593*	*4,892*	*4,844*	*5,046*	*4,873*	*4,815*	*4,795*
	Endoscopy activity	5,019	4,298	4,792	4,924	5,145	4,716	4,996	4,714	4,977	4,620	4,682	*TBC*
	Total Diagnostic 6+ weeks	4,503	5,821	5,902	4,716	5,152	7,373	9,027	8,285	8,461	8,135	7,879	*TBC*
	Total Diagnostic 6+ weeks performance	91.5%	88.0%	88.4%	91.1%	90.4%	86.5%	84.1%	84.4%	84.6%	84.8%	85.3%	*TBC*
Cancer	*Cancer 31-day treatments performance*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*90.8%*	*90.5%*	*91.1%*	*92.4%*	*90.6%*	*92.3%*	*93.2%*
	Cancer 31-day treatments performance	89.4%	91.5%	88.9%	93.9%	92.9%	92.5%	93.2%	94.0%	93.7%	93.2%	91.8%	*TBC*
	Cancer 62 days performance plan	*69.8%*	*69.6%*	*68.9%*	*70.5%*	*72.4%*	*68.6%*	*69.0%*	*71.5%*	*74.3%*	*71.8%*	*74.2%*	*75.8%*
	Cancer 62 days performance	67.7%	70.2%	63.5%	63.3%	69.2%	66.6%	65.7%	66.8%	70.1%	74.7%	75.9%	*TBC*
	28-day Faster Diagnosis Standard plan	*75.3%*	*74.8%*	*74.6%*	*75.8%*	*77.1%*	*75.2%*	*75.4%*	*77.2%*	*79.0%*	*78.2%*	*80.2%*	*81.0%*
	28-day Faster Diagnosis Standard	74.2%	74.1%	68.0%	77.2%	78.8%	77.7%	75.9%	78.0%	78.7%	78.6%	79.6%	*TBC*
Beds	*Average G&A beds occupied plan*	*2,724*	*2,644*	*2,708*	*2,717*	*2,678*	*2,602*	*2,599*	*2,554*	*2,557*	*2,519*	*2,551*	*2,573*
	Average G&A beds occupied	2,704	2,606	2,339	2,765	2,722	2,674	2,666	2,656	2,678	2,596	2,652	2,686
	Average G&A beds available plan	*2,937*	*2,899*	*2,934*	*2,925*	*2,914*	*2,835*	*2,843*	*2,820*	*2,808*	*2,771*	*2,790*	*2,808*
	Average G&A beds available	2,927	2,886	2,486	2,970	2,955	2,915	2,909	2,906	2,936	2,879	2,896	2,939
	Average G&A beds occupancy plan	*92.7%*	*91.2%*	*92.3%*	*92.9%*	*91.9%*	*91.8%*	*91.4%*	*90.6%*	*91.1%*	*90.9%*	*91.4%*	*91.6%*
	Average adult G&A beds occupancy	92.4%	90.3%	94.1%	93.1%	92.1%	91.7%	91.6%	91.4%	91.2%	90.2%	91.6%	91.4%

25/26 M7 Financial Position - Overview

North Central London
Integrated Care Board

M7 Financial Position Overview – Overview as of WD9

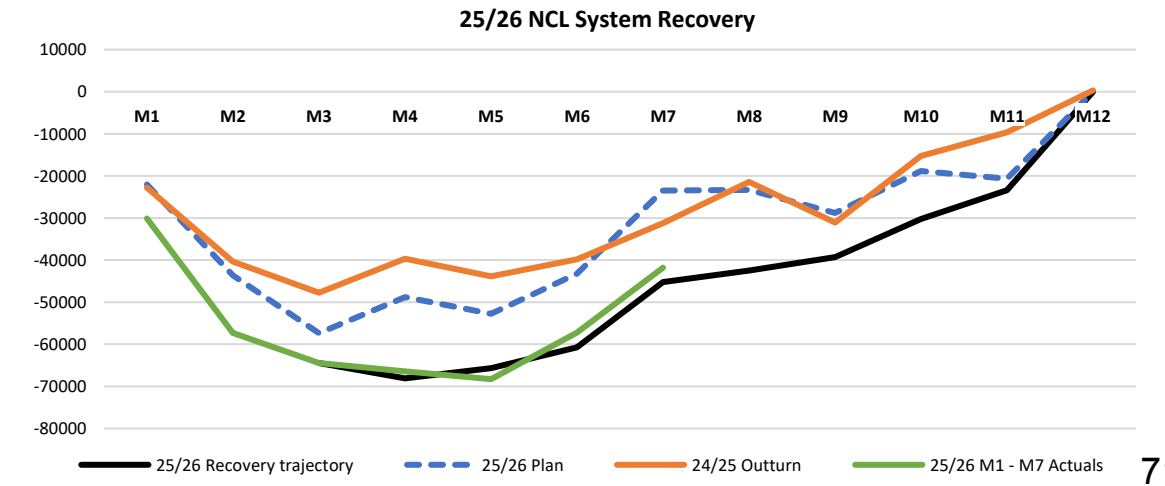
- NCL ICS reported a YTD deficit of £41.8m at M7 which represents an adverse variance of £18.4m against the YTD plan.
- The adverse variance is entirely driven by the provider sector (£18.4m) where it mainly relates to pay pressures with the ICB reporting a YTD surplus of £15.9m which is line with plan.
- The YTD position also includes the impact of Industrial Action (IA) of c.£3.5m in previous months, of which c.£3m relates to net pay costs and c.£0.5m of income loss due to IA. Unlike in previous years, we understand there is no funding to follow to offset the costs of IA.
- Whittington (£6.9m adv) – The trust are reporting additional cost of delivering elective activity, enhanced care, corridor care, industrial action impact and A&E flows as main drivers of that variance. The trust have confirmed they will achieve the 25/26 plan through non-recurrent measures.
- GOSH (£6.8m adv) – Reported pressures on Pay due to efficiency savings under delivery and higher staffing levels than planned. The trust also transacted their Mutually Agreed Resignation Schemes (MARS) scheme in M7 which hasn't been fully absorbed in month.
- NLFT (£6.8m adv) - indicated a continuation of pressures from M12 of 24/25 into 25/26 M7 and slippages in delivery of planned savings as the main contributors of the £5.8m adverse variance.
- RFL (£2.9m adv) – This relates to the impact of industrial action, premium to cover mental health nurses and commercial income underperformance but have plans in place to recovery these pressures.
- T&P (£1.7m adv) - relates to the loss of an NHSE education contract. This has been raised with NHSE and we are currently awaiting discussions on next steps regarding the future of the trust.

M7 Financial performance against the recovery plan and next steps

- Following a difficult start to the financial year the system agreed a recovery plan (right) where **we confirmed the system's intent to deliver a balanced plan in 25/26**.
- Whilst the M7 system bottom line is £3.4m favourable against the recovery plan, five providers namely NLFT, GOSH, RFL, T&P and WHIT are adverse against the recovery plan mainly due to IA pressures. We have plans at local level that deliver balance although there remains risk.
- Mitigating financial recovery action includes MARS at a number of providers, closure of unfunded capacity and vacancy freezes amongst the main interventions.

	M7 Year to date			Forecast Outturn		
Organisation	YTD Plan (29th April submission)	YTD Actual	YTD Variance	Annual Plan (29th April submission)	Forecast Outturn	FOT Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Trust Total	(39,319)	(57,691)	(18,372)	(27,192)	(27,192)	-
NCL ICB	15,862	15,862	-	27,192	27,192	-
System Total	**(23,457)**	**(41,829)**	**(18,372)**	**-**	**-**	**-**

Drivers of the M7 Variance £'000	
Income	59,088
Pay Run rate	(58,319)
Non-Pay run rate	10,271
Efficiency savings	(26,714)
IA impact	(3,525)
Other	826
System Adverse Variance	**(18,372)**



North West London Integrated Care System
Working together for better health and care

NHS
North West London

NW London Integrated Care System

Operational Performance Report
October 2025

NWL ICS Leadership – 21st November 2025

Steve Bloomer, Chief Financial Officer

System Flow	Overall assessment	Delivery against targets	Performance Direction
System Flow	🟡	🟡	🔴
Waiting Times	🔴	🟡	🟡
ICS	🟡	🟡	🟡

Delivery of Operating Plan	Overall assessment	Delivery against targets	Performance Direction
Finance	🟢	🟢	🟢
Activity	🟡	🟡	🟡
Workforce (WTE Plan)	🟢	🟢	🟡
ICS	🟢	🟢	🟡

Red - Action Required	◆
Amber - Action Ongoing	▲
Green - No Action	●
No RAG - No Indication	○

System Flow:

- Winter pressures are impacting system flow indicators including ambulance handover times, urgent & emergency care and discharge from hospital – see slide 4.
- Four hour ED performance has reduced to 75.3%, as well as a noticeable increase in G&A bed occupancy and delays in pathway 1 and 3 discharges. A&E attendances (type 1 & 2) are in-line with plan therefore volume is not the main driver in variation for targeted performance.
- All type ED attendances increased by another 4% in October to 108,695 from 103,970 in September. This is nearly 2,800 patients more than seen in October 2024. Type 1 attendances increase from 50,762 patients in September 2025 to 53,344 patients in October 2025.
- Winter plans are in place. A robust structure and established reporting is in place to monitor the winter plans. Individual partners have their own organisation governance monitoring, with system wide monitoring undertaken via the System Coordination Centre (daily system monitoring), weekly gold meetings (from mid November) and bi-monthly System Flow Board.

Waiting Times:

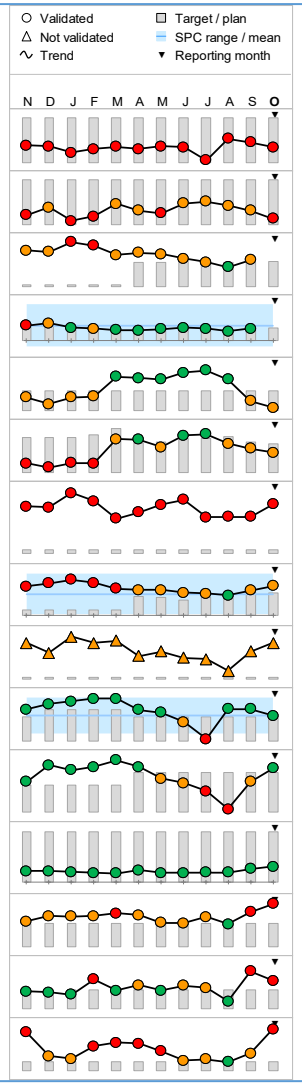
- The overall Patient Tracking List size increased in September to 289,569 patients (up 1.8%), from 284,345 patients in August. There were increases at CWHT (2,958 patients) and THHT (2,301 patients), whereas ICHT and LNWUHT broadly remained the same.
- Diagnostics performance (although improved in October) remains a concern, whilst cancer (2 week wait urgent suspected cancer & 62 day standards) and some CYP waiting times remain areas for improvement.
- Elective recovery overall remains on-track. There was a Residential Doctors strike between Friday 14th November to Wednesday 19th November.
- Community 52 week waits at CNWL have significantly reduced. There are now 28 patients across NW London waiting for treatment from 507 patients in August.

Finance & Operating Plan Delivery:

- The ICS month 7 position is a £0.05m surplus, made up of providers £5.05m deficit offset by ICB £5.1m surplus (deterioration of £2.3m since M6). Elective and non-elective activity remains to plan. Total SDEC activity increased in October with a further improvement expected for November.

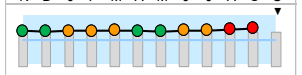
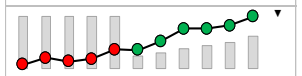
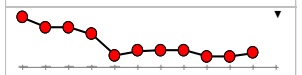
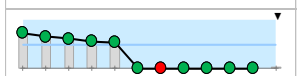
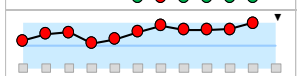
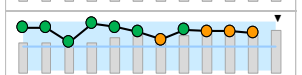
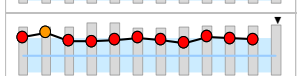
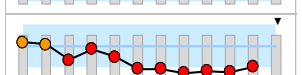
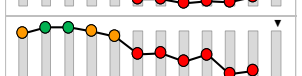
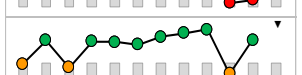
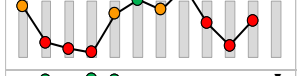
Current Operational Performance – Flow

KPI ID	KPI name Short display name	Latest data reported	Unit e.g. £000s, %, WTE etc.	Latest Value As per unit	Target or plan As per unit	Variance to target As per unit	RAG	Goal	Direction
UE050	% of ambulance hospital handovers within 15 minutes	Oct 25/26	%	44.0	65.0	(21.0)	R	↑	↘
UE122	% of ambulance Handovers within 45 minutes	Oct 25/26	%	93.7	100.0	(6.3)	R	↑	↘
UE096	Ambulance handover times (Mean)	Sep 25/26	Minutes	18.5	18.2	0.3	A	↓	↗
UE031	LAS Category 2 – mean response time	Sep 25/26	Minutes	32.3	33.6	(1.3)	G	↓	↗
UE078	% of ED (all types) attendances seen within 4 hours of arrival to ED	Oct 25/26	%	75.2	78.0	(2.8)	A	↑	↘
UE079	% of ED (type 1) attendances seen within 4 hours of arrival to ED	Oct 25/26	%	58.7	60.9	(2.2)	A	↑	↘
ME074	Patients presenting with a Mental Health crisis waiting in ED for more than 12 hours	Oct 25/26	%	33.7	20.0	13.7	R	↓	↗
UE056	Patients waiting over 12 hours in ED	Oct 25/26	%	10.9	8.5	2.4	A	↓	↗
UE024	Overnight general and acute beds occupied rate	Oct 25/26	%	95.2	92.0	3.2	A	↓	↗
LO023	Occupancy rate in rehab beds	Oct 25/26	%	86.0	85.0	1.0	G	↑	↘
LO065	Virtual Wards occupancy rate	Oct 25/26	%	86.6	85.0	1.6	G	↑	↗
UE115	Discharge: Average Delay Days (P0) in Optica	Oct 25/26	Days	0.3	1.0	(0.7)	G	↓	↗
UE108	Discharge: Average Delay Days (P1) in Optica	Oct 25/26	Days	2.9	2.0	0.9	R	↓	↗
UE109	Discharge: Average Delay Days (P2) in Optica	Oct 25/26	Days	6.0	5.0	1.0	R	↓	↗
UE110	Discharge: Average Delay Days (P3) in Optica	Oct 25/26	Days	11.5	7.0	4.5	R	↓	↗



- **Urgent and Emergency Care**: In October,75.3% (down from 76.3% in September) of people attending emergency departments in NW London spent less than 4 hours in the department compared to 78% plan. Performance for type 1 also declined from 59.7% in September to 58.7% (plan 60.9%). High Intensity Unser (HIU) plans have been implemented across all boroughs and ED sites. The percentage of patients waiting 12 hours or more deteriorated, with performance at 10.9% October from 9.3% in September. UEC delivery boards have agreed winter plans, which are overseen by the System Flow Board.
- **Ambulance Services**: Handover targets now focus on 15 and 45 minutes. In September the 15 minute performance declined slightly. Mitigations in place include the Integrated Care Coordination Hub, optimising referrals into alternative pathways to ED and targeted work with Health Care Professional and care home calls to 999. Hear and Treat (25%) and See and Treat (30%) performance remains strong.
- **G&A Bed Occupancy:** Bed occupancy is above the optimal threshold (92%) across multiple sites.
- **Mental Health**: In October, 33.7% of people requiring mental health support experienced waits of over 12 hours in NW London emergency departments compared to 30% in September (the stretch target is 20%). The System Flow Board oversees actions being taken to reduce waits for patients, this includes reviewing crisis plans to support people access crisis alternatives, particularly for high Intensity Users (40% of cohort).
- **Hospital Discharges**: In October, discharge performance for pathways 1 and 3 declined. Better Care Fund plans for all 8 boroughs have been agreed with targets. Delay day targets have been established across pathway 1-3 to monitor impact of these schemes and are being tracked via System Flow Board.
- **Virtual ward occupancy rates** has improved in September and October, partly due to de-commissioning of underutilized pathways. Evaluation, showed high satisfaction rates with over 11,000 patients managed, delivery of 34 pathways saving approximately 8,500 bed days and 530 admissions avoided. Next steps include, increasing referrals from ICC and ED, standardising pathways and decommissioning pathways not delivering due to low demand.

Current Operational Performance – Waiting Lists

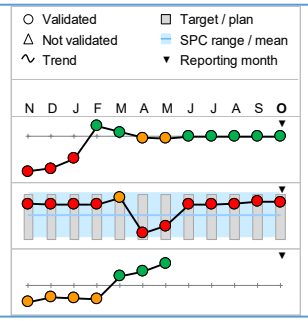
KPI ID	KPI name Short display name	Validated / Not validated / Trend / Target / plan / SPC range / mean / Reporting month N D J F M A M J J A S O	Latest data reported	Unit e.g. £000s, %, WTE etc.	Latest Value As per unit	Target or plan As per unit	Variance to target As per unit	RAG	Goal	Direction
EL069	RTT total incomplete waiting list		Sep 25/26	People	289,569.0	267,340.0	22,229.0	R	↓	↗
EL112	% RTT incomplete pathways less than 18 weeks		Sep 25/26	%	60.0	58.0	2.0	G	↑	↗
EL089	Number of RTT incomplete Pathways > 65 Weeks		Sep 25/26	Number	149.0	0.0	149.0	R	↓	↗
EL024	RTT incomplete Pathways > 52 Weeks		Sep 25/26	%	1.9	2.0	(0.1)	G	↓	↘
DI011	Patients waiting over 6 weeks for a diagnostic test		Sep 25/26	%	23.8	5.0	18.8	R	↓	↗
CA010	Cancer - 28 day faster diagnosis standard (FDS) Attainment		Sep 25/26	%	79.2	80.0	(0.8)	A	↑	↘
CA008	62-day Standard Attainment		Sep 25/26	%	74.8	83.2	(8.4)	R	↑	↘
CA004	Cancer - two weeks waits		Sep 25/26	%	79.1	93.0	(13.9)	R	↑	↗
ME081	% MH CYP Treated within 18 weeks		Sep 25/26	%	73.8	89.0	(15.2)	R	↑	↘
ME082	% MH CYP 1st seen within 4 weeks		Sep 25/26	%	63.9	58.3	5.6	G	↑	↘
ME031	Urgent Referral to Treatment Waiting Times for CYP with an eating disorder		Sep 25/26	%	100.0	95.0	5.0	G	↑	→
ME033	Routine Cases : 95% of CYP with eating disorders accessing treatment within 4 weeks		Sep 25/26	%	88.0	95.0	(7.0)	R	↑	↗
PC022	% of Primary Care Appointments within 14 days		Sep 25/26	%	88.6	85.0	3.6	G	↑	↗

- **Elective performance** continues to be monitored through the Planned Care Board with winter plans in place to add resilience during the winter period.
- **Elective Waiting List**: In September, the total Patient Tracking List (PTL) increased from 284,345 patients in August to 289.569 patients in September. There were increases at CWHT (2,958 patients) and THHT (2,301 patients), whereas LNWUHT broadly remained.
- **Referral to Treatment (RTT) performance:** In September the plan for patients waiting 18 weeks or more for treatment was met.
- **Diagnostic 6 week performance**: The diagnostic performance improved to 23.8% in September from 24.4% in August. However challenges remain across a range of modalities including audiology (35.3%) and echocardiology (36.8%). An update paper was presented to the Performance and Finance Committee. Activity is being monitored against the agreed Operating Plan for 2025/26,
- **Cancer Waiting Times**: The 62 day cancer standard and 2WW performance remains below plan with the drivers for the 62 days and 2WW performance are at LNW and THHT. Challenges in some pathways around capacity and demand, which is being worked through. Improvement projects are underway for specialities such as breast, prostate, urology and gynae. Performance is overseen by the NW London Cancer Board, with support from Royal Marsden Partners (RMP).
- **Eating Disorders**: Urgent treatment referral times for CYP eating disorders improved to 100% in September, with improved in performance also achieved for routine treatment times**.**
- **Mental health Children & Young People (CYP) waiting times**: Performance for CYP treated within 18 weeks generally remains steady. Performance is being tackled at a borough level.
- **Primary care**: the number of GP appointments delivered monthly remains above plan, as well as the percentage of appointments delivered same/next day and within 14 days. Approximately 66% of appointments are delivered face-to-face.

Finance, activity and workforce

Finance

KPI ID	KPI name Short display name	Latest data reported	Unit e.g. £000s, %, WTE etc.	Latest Value As per unit	Target or plan As per unit	Variance to target As per unit	RAG	Goal	Direction
FI001	Total System reported YTD position (variance against plan) £'m	Oct 25/26	£'M	0.0	0.0	0.0	G	↑	→
FI010	System reported efficiency YTD (CIP)	Oct 25/26	%	90.0	100.0	(10.0)	R	↑	↗
FI021	YTD Productivity compared with 19/20	May 25/26	%	2.4	0.0	2.4	G	↑	↗

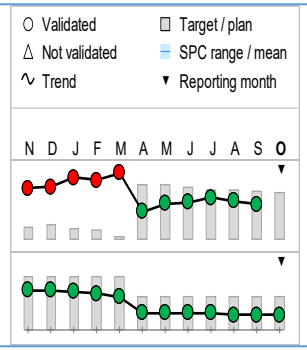


Finance Key messages:

- The ICS month 7 position is a £0.05m surplus, made up of providers £5.05m deficit offset by ICB £5.1m surplus (deterioration of £2.3m since M6).
- Key drivers to the providers £5m variance from plan relate to CIP slippage £14.7m, NI pressures £5.5m, Industrial Action £3.8m, Pathology £3.9m, and inflation £0.5m, partially offset with ERF over performance £7.8m, Non recurrent benefits, higher than expected clinical other income, reduced bank and
- The YTD ICS efficiency is 94.3% (90.7% at M6), with unidentified efficiencies at 1.9% (2.5% at M6). The forecast reported to NHSE was £312.9m which is £9m favourable to plan.

Workforce

KPI ID	KPI name Short display name	Latest data reported	Unit e.g. £000s, %, WTE etc.	Latest Value As per unit	Target or plan As per unit	Variance to target As per unit	RAG	Goal	Direction
WO019	Total Staffing WTE(Staff in post+bank+Agency)	Sep 25/26	Number	66,160.0	67,023.0	(863.0)	G	↓	↘
WO013	Agency spend as % of total Paybill	Oct 25/26	%	0.9	2.0	(1.1)	G	↓	→

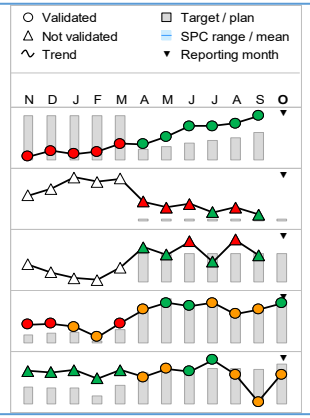


Workforce Key messages:

- **There is now no ICS workforce analyst in post. Workforce performance is being monitored by the Collaboratives.**
- Performance to plan for Month 6 – September 2025 shows a total staffing WTE within plan by 1,013 WTE.
- Agency spend as a % of the total pay bill remains stable and below plan.
- There are currently no escalations.

Activity

KPI ID	KPI name Short display name	Latest data reported	Unit e.g. £000s, %, WTE etc.	Latest Value As per unit	Target or plan As per unit	Variance to target As per unit	RAG	Goal	Direction
EL112	% RTT incomplete pathways less than 18 weeks	Sep 25/26	%	60.0	58.0	2.0	G	↑	↗
EL059	Elective daycase compared to Ops Plan	Sep 25/26	%	102.1	100.0	2.1	G	↓ ↑	↘
EL060	Elective ordinary compared to Ops Plan	Sep 25/26	%	99.5	100.0	(0.5)	G	↓ ↑	↗
UE103	A&E Attendances (All Types)	Oct 25/26	Number	108,659.0	109,796.0	(1,137.0)	G	↓	↗
UE034	Total SDEC activity	Oct 25/26	Number	7,949.0	8,665.0	(716.0)	A	↑	↘



Activity Key messages:

- RTT activity over performed plan in September. In 2025/26 we want activity to be on plan.
- All type A&E attendances has been above plan since September, however was below plan for October. Four-hour performance has remained consistent during this time, although performance dipped in September and October.
- Total SDEC activity increased in October with a further improve expected for November.

NHSE Operating Plan 2025/26 performance

NWL Operating Plan Performance (1/3)

KPI ID	KPI name Short display name	Latest data reported	Unit e.g. £000s, %, WTE etc.	Latest Value As per unit	Target or plan As per unit	Variance to target As per unit	RAG	Goal	Direction
CA008	62-day Standard Attainment	Sep 25/26	%	74.8	83.2	(8.4)	R	↑	↘
CA010	Cancer - 28 day faster diagnosis standard (FDS) Attainment	Sep 25/26	%	79.2	80.0	(0.8)	A	↑	↘
CA023	31 day 1st Treatment standard (From DTT)	Sep 25/26	%	97.2	96.0	1.2	G	↑	↘
DI003	Diagnostic Tests - CT	Sep 25/26	Number	27,293.0	27,489.0	(196.0)	G	↓ ↑	↘
DI004	Diagnostic Tests - MRI	Sep 25/26	Number	14,036.0	16,497.0	(2,461.0)	R	↓ ↑	↘
DI005	Diagnostic Tests - NOUS	Sep 25/26	Number	22,280.0	28,748.0	(6,468.0)	R	↓ ↑	↘
DI012	Diagnostic Tests 6-week performance - MRI	Sep 25/26	%	19.9	13.6	6.3	R	↓	↗
DI013	Diagnostic Tests 6-week performance - CT	Sep 25/26	%	6.0	11.0	(5.0)	G	↓	↘
DI014	Diagnostic Tests 6-week performance - NOUS	Sep 25/26	%	23.5	18.5	5.0	A	↓	↗
DI021	Diagnostic Tests Activity - Colonoscopy	Sep 25/26	Number	1,648.0	1,740.0	(92.0)	R	↓ ↑	↗

KPI ID	KPI name Short display name	Latest data reported	Unit e.g. £000s, %, WTE etc.	Latest Value As per unit	Target or plan As per unit	Variance to target As per unit	RAG	Goal	Direction
DI022	Diagnostic Tests Activity - Flexi sigmoidoscopy	Sep 25/26	Number	420.0	487.0	(67.0)	R	↓ ↑	↘
DI023	Diagnostic Tests Activity - Gastroscopy	Sep 25/26	Number	2,041.0	2,341.0	(300.0)	R	↓ ↑	↘
DI024	Diagnostic Tests Activity - Cardiology – echocardiography	Sep 25/26	Number	5,336.0	6,158.0	(822.0)	R	↓ ↑	↘
DI025	Diagnostic Tests Activity - DEXA	Sep 25/26	Number	1,138.0	1,870.0	(732.0)	R	↓ ↑	↘
DI026	Diagnostic Tests Activity - Audiology	Sep 25/26	Number	2,506.0	4,227.0	(1,721.0)	R	↓ ↑	↘
DI027	Diagnostic Tests, 6-week waiting time - Colonoscopy	Sep 25/26	%	32.6	13.4	19.2	R	↓	↗
DI028	Diagnostic Tests, 6-week waiting time - Flexi sigmoidoscopy	Sep 25/26	%	29.4	12.0	17.4	R	↓	↗
DI029	Diagnostic Tests, 6-week waiting time-Gastroscopy	Sep 25/26	%	40.3	11.1	29.2	R	↓	↗
DI030	Diagnostic Tests, 6-week waiting time - Cardiology – echocardiography	Sep 25/26	%	48.5	34.4	14.1	R	↓	↗
DI031	Diagnostic Tests, 6-week waiting time - DEXA	Sep 25/26	%	1.4	11.7	(10.3)	G	↓	↗
DI032	Diagnostic Tests, 6-week waiting time - Audiology	Sep 25/26	%	47.7	19.5	28.2	R	↓	↗

NWL Operating Plan Performance (2/3)

KPI ID	KPI name Short display name	Validated / Not validated / Trend / Target / plan / SPC range / mean / Reporting month N D J F M A M J J A S O	Latest data reported	Unit e.g. £000s, %, WTE etc.	Latest Value As per unit	Target or plan As per unit	Variance to target As per unit	RAG	Goal	Direction
EL024	RTT incomplete Pathways > 52 Weeks		Sep 25/26	%	1.9	2.0	(0.1)	G	↓	↘
EL108	Outpatient first attendances without a procedure - ERF scope		Sep 25/26	%	100.5	100.0	0.5	G	↓ ↑	↗
EL109	Outpatient follow up attendances without procedure - ERF scope		Sep 25/26	%	102.5	100.0	2.5	G	↓ ↑	↗
EL059	Elective daycase compared to Ops Plan		Sep 25/26	%	102.1	100.0	2.1	G	↓ ↑	↘
EL060	Elective ordinary compared to Ops Plan		Sep 25/26	%	99.5	100.0	(0.5)	G	↓ ↑	↗
EL069	RTT total incomplete waiting list		Sep 25/26	People	289,569.0	267,340.0	22,229.0	R	↓	↗
EL072	Patient Initiatiated Follow Up discharges		Sep 25/26	%	0.9	3.1	(2.2)	A	↑	↗
EL107	Outpatient procedures - ERF scope		Sep 25/26	%	100.8	100.0	0.8	G	↓ ↑	↘
EL116	RTT - The number of completed admitted RTT pathways in the reporting period		Aug 25/26	Number	7,019.0	7,644.0	(625.0)	R	↓ ↑	↘

KPI ID	KPI name Short display name	Validated / Not validated / Trend / Target / plan / SPC range / mean / Reporting month N D J F M A M J J A S O	Latest data reported	Unit e.g. £000s, %, WTE etc.	Latest Value As per unit	Target or plan As per unit	Variance to target As per unit	RAG	Goal	Direction
EL118	RTT incomplete Pathways < 18 Weeks for a first appointment %		Sep 25/26	%	17.0	61.2	(44.2)	R	↑	↗
EL120	RTT- The number of completed non-admitted RTT pathways in the reporting period		Aug 25/26	Number	38,003.0	45,930.0	(7,927.0)	R	↑	↘
LO065	Virtual Wards occupancy rate		Oct 25/26	%	86.6	85.0	1.6	G	↑	↗
LO073	Urgent Community Response (UCR) referrals		Aug 25/26	Number	1,365.0	2,121.0	(756.0)	R	↑	↘
LO074	Community services waiting list over 52 weeks		Sep 25/26	Number	28.0	838.0	(810.0)	G	↓	↘
LO075	Community services waiting list over 52 weeks - CYP		Sep 25/26	Number	15.0	782.0	(767.0)	G	↓	↘
LO076	Community services waiting list over 52 weeks - Adults		Sep 25/26	Number	13.0	56.0	(43.0)	G	↓	↘
ME014	CYP with a learning disability or autism in an inpatient setting		Sep 25/26	Number	14.0	11.0	3.0	R	↓	↗
ME016	CYP accessing NHS funded mental health services		Sep 25/26	Number	17,165.0	23,940.0	(6,775.0)	R	↑	↗
ME024	Women receiving access to perinatal services		Sep 25/26	Number	1,557.0	2,905.0	(1,348.0)	R	↑	↗

NWL Operating Plan Performance (3/3)

KPI ID	KPI name Short display name	Latest data reported	Unit e.g. £000s, %, WTE etc.	Latest Value As per unit	Target or plan As per unit	Variance to target As per unit	RAG	Goal	Direction
ME032	Access to Individual Placement and Support Services	Sep 25/26	Number	685.0	1,494.0	(809.0)	R	↑	↗
ME060	% of People with learning disability (14 years old and above) with an annual health check	Sep 25/26	%	36.0	35.0	1.0	G	↑	↗
ME075	Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)	Sep 25/26	Number	4.0	0.0	4.0	R	↓	↗
ME076	Reliable recovery rate for those completing a course of treatment and meeting caseness - Talking Therapies	Sep 25/26	%	47.8	48.0	(0.2)	A	↑	↗
ME077	Reliable improvement rate for those completing a course of treatment - Talking Therapies	Sep 25/26	%	70.4	67.0	3.4	G	↑	↗
ME083	Reliance on mental health inpatient care for adults with a learning disability	Sep 25/26	%	27.0	28.0	(1.0)	G	↓	↗
ME085	MH Adult Acute Inpatient LoS (average)	Aug 25/26	Days	42.0	42.5	(0.5)	G	↓	
PC036	Appointments in general practice	Sep 25/26	Number	1533,821.5	1432,732.0	101,089.5	G	↑	↘
UE034	Total SDEC activity	Oct 25/26	Number	7,949.0	8,665.0	(716.0)	A	↑	↘
UE053	Non-elective spells with a length of stay of 1 or more days	Aug 25/26	Number	11,946.0	18,480.0	(6,534.0)	G	↓	↘

KPI ID	KPI name Short display name	Latest data reported	Unit e.g. £000s, %, WTE etc.	Latest Value As per unit	Target or plan As per unit	Variance to target As per unit	RAG	Goal	Direction
UE054	Non-elective spells with a length of stay of zero days	Aug 25/26	Number	6,721.0	6,797.0	(76.0)	G	↓	↘
UE056	Patients waiting over 12 hours in ED	Oct 25/26	%	10.9	8.5	2.4	A	↓	↗
UE078	% of ED (all types) attendances seen within 4 hours of arrival to ED	Oct 25/26	%	75.2	78.0	(2.8)	A	↑	↘
UE079	% of ED (type 1) attendances seen within 4 hours of arrival to ED	Oct 25/26	%	58.7	60.9	(2.2)	A	↑	↘
UE096	Ambulance handover times (Mean)	Sep 25/26	Minutes	18.5	18.2	0.3	A	↓	↗
UE102	% of ED (all other types except type 1) attendances seen within 4 hours of arrival to ED	Sep 25/26	%	97.3	97.4	(0.1)	A	↑	↘
UE103	A&E Attendances (All Types)	Oct 25/26	Number	108,659.0	109,796.0	(1,137.0)	G	↓	↗
UE106	Number of specific acute non elective spells in the period	Aug 25/26	Number	18,667.0	18,480.0	187.0	A	↓	↘
UE107	Non elective spells with a length of stay of 7 or more days.	Aug 25/26	Number	3,474.0	3,067.0	407.0	R	↓	↘

Note: Indicator UE103 includes NWL patients attending A&Es outside of NWL.

Operating Plan performance overview

- Of the 60 RAG rated performance metrics, 22 (37%) are green (meeting or exceeding plan), 12 (20%) are amber (just off plan) and 26 (43%) are red (below plan). **This represents an improvement in performance from the last report** with green rated metrics increasing from 24% last month, 27% amber (just off plan) and 51% were red (below plan).
- Improvements were seen in elective care, outpatient, CYP learning disabilities and mental health provision.
- Almost half of the red rated metrics are related to diagnostics performance (activity and 6-week). In particular, for 2025/26 we want diagnostic activity to be on plan so significant over performance is assessed as red, as is significant under-performance.
- Outpatient first appointments, follow up attendances and procedures are now within plan.
- The number of patients waiting 52 weeks or more for treatment in the community (adults and childrens) has significantly reduced from 507 patients in August to 28 patients in September. This is mainly due to a reduction of the waiting list at CNWL.

RAG Rating Methodology – Assessment of ICS Position

- The overall assessment is made up of three components that are ranked and then multiplied by a weighting factor:
  - Delivery against plan: This is viewed as the most important component so weighted x5.
  - Performance Direction*: This is viewed as the next most important component so weighted x 3
  - Degree of Assurance: Subjective assessment by performance and planning team of how assured we are on the plans to address red delivery against plan is weighted x2
- The ranking is achieved by taking the sub-components of each component, turning it into a percentage of the total number of indicators that have that characteristic and using this to rank them. For example:
  - We have selected 16 System Flow Indicators. Of those 4 are green compared to plan (25% so ranked second), 9 are amber compared to plan (56.3% so ranked highest), and 3 are red compared to plan (18.7% so ranked lowest).
  - Therefore Amber against plan contributes 15 to the total score (ranking score of 3 x weighting score of 5 = 15).
- The same approach is applied to all components to develop the overall assessment score.
- The Overall assessment score is made up of the following sub-components:
  - Green Score = (% green to plan score) + (% good perf direction score) + (% of Assured mitigation plans score)
  - Amber score = (% amber to plan score) + (half of % good perf direction score) + (half of % poor perf direction score) + (% of Partially assured mitigation plans score)
  - Red Score = (% red to plan score) + (% poor perf direction score) + (% of not assured mitigation plans score)
- Amber override is used to make the assessment amber under the following conditions: 1. Green and amber have the same score. 2. Red and amber have the same score . 3. If Red and Green scores are close to each other (currently set at gap less than 5)

* The Performance direction is calculated by forecasting (linear forecast function) the next two data points based on the current month actual and the previous two month actuals. Green arrow is moving in a positive direction towards plan and red arrow is a negative direction from plan.

Month 7 Finance – ICS Financial Position

M7 Position

The ICS month 7 position is a £0.05m surplus, made up of providers £5.05m deficit offset by ICB £5.1m surplus (deterioration of £2.3m since M6).

Key drivers to the providers £5m variance from plan relate to CIP slippage £14.7m, NI pressures £5.5m, Industrial Action £3.8m, Pathology £3.9m, and inflation £0.5m, partially offset with ERF over performance £7.8m, Non recurrent benefits, higher than expected clinical other income, reduced bank and agency costs and increased vacancies £15.6m.

The YTD ICS efficiency is 94.3% (90.7% at M6), with unidentified efficiencies at 1.9% (2.5% at M6).

The forecast reported to NHSE was £312.9m which is £9m favourable to plan.

Provider Pay is adverse to plan by £26.7m at M7 (1%) with agency spend representing 0.9% of overall pay.

The ICS is forecasting breakeven in m7 across all providers and ICB.

System Financial Position	In Month			Year to date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Operating Income	580.6	591.2	10.6	4,006.8	4,063.4	56.6	6,861.6	6,947.1	85.6
Pay Expenditure	(378.4)	(380.4)	(2.1)	(2,650.9)	(2,677.7)	(26.7)	(4,545.5)	(4,587.7)	(42.2)
Non-pay Expenditure	(185.8)	(192.9)	(7.1)	(1,303.3)	(1,343.6)	(40.3)	(2,222.5)	(2,272.6)	(50.1)
Non-operating items / Other Spend	(7.8)	(6.8)	1.0	(54.0)	(48.7)	5.4	(93.6)	(86.8)	6.8
Total Provider Position	**8.5**	**11.1**	**2.5**	**(1.5)**	**(6.5)**	**(5.1)**	**0.0**	**(0.0)**	**0.0**
NWL ICB Position	**0.0**	**2.3**	**2.3**	**0.0**	**5.1**	**5.1**	**0.0**	**0.0**	**0.0**
Total System Position	**8.5**	**13.4**	**4.8**	**(1.5)**	**(1.5)**	**0.0**	**0.0**	**(0.0)**	**0.0**

Run rate and risk

Net mitigations for the system are £0.4m which is £14.9m of efficiency risk offset with £15.3m of net mitigations. Mitigations mainly relating to plans to identify efficiency gaps and temporary staffing and vacancy controls.

Organisations	In Month			Year to date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
	£'m	£'m	£'m	£'ms	£'ms	£'ms	£'ms	£'ms	£'ms
Acute	9.4	11.8	2.4	5.3	(0.9)	(6.2)	0.0	0.0	0.0
Community / Mental Health	(0.9)	(1.0)	(0.1)	(8.0)	(7.9)	0.1	0.0	0.0	(0.0)
Ambulance Services	(0.0)	0.2	0.2	1.3	2.3	1.0	0.0	0.0	0.0
Sub Total	**8.5**	**11.1**	**2.5**	**(1.5)**	**(6.5)**	**(5.1)**	**0.0**	**0.0**	**0.0**
NWL ICB	0.0	2.3	2.3	0.0	5.1	5.1	0.0	0.0	0.0
Total	**8.5**	**13.4**	**4.8**	**(1.5)**	**(1.5)**	**0.0**	**0.0**	**0.0**	**0.0**

Capital Variances

The YTD charge against capital including impact of IFRS 16 (system capital) is an underspend of £10.6m (M6: £9.2m). The YTD plan is £130.5m.

The YTD underspend is due to delays in signing IFRS 16 leases , some lag in the building works on the NE London Ambulance station, clinical equipment purchases and IT/Digital expenditure. However, there is variability in the YTD position across Providers with CWFT and ICHT showing YTD overspends due to accelerated spend on the Ambulatory Diagnostic Centre (ADC) and backlog maintenance.

The system is reporting a break-even forecast outturn position comprising an overspend of £15.9m in system capital , offset by £15.9m from the capital freedom and flexibility allocation.

North Central London
Integrated Care Board

North West London

North Central London ICB and North West London ICB
Board of Members Meeting in Common
4 December 2025

Report Title	Quality Report	**Date of report**	16 November 2025	**Agenda Item**	2.3
Lead Director / Manager	Jennifer Roye, Chief Nurse Officer, NCL ICB and NWL ICB	**Email / Tel**		j.roye1@nhs.net	
Board Member Sponsor	Jennifer Roye, Chief Nurse Officer, NCL ICB and NWL ICB				
Report Author	Dee Malone, Acting Director of Quality and Clinical Standards, NCL ICB Darren Jones, Director of Nursing – Quality, Patient Safety and Safeguarding, NWL ICB	**Email / Tel**		Deirdre.malone@nhs.net darrenjones@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** None.			
Report Summary	The report provides a summary of the risks, issues and areas of note in relation to quality of commissioned services in NCL, this was presented to the NCL Quality and Safety Committee on 14 October 2025. The Chief Nurse at NWL ICB presents a Quality report to the Finance and Performance Committee. These have been incorporated into the Quality report. **NCL ICB Quality report** **1. Maternity Incentive Scheme (MIS) Year 7 NCL progress** Maternity providers across North Central London Integrated Care System provided an assessment of their progress against each of the ten Safety Actions within the MIS scheme to the Local Maternity and Neonatal System (LMNS) Board in August 2025. The LMNS rated each of the providers, in relation to risk to compliance, and are assured that most outstanding areas will be compliant by end of the calendar year. There is a risk that Whittington Health may declare non-compliance against Safety Action 4. They have advised the LMNS that checks on training				

compliance for two locum doctors were incorrect. The information provided by the recruiting agency to Bank Partners was incorrect and therefore this means they are non-compliant for this safety action. The Trust's Director of Midwifery is discussing this with Regional Chief Midwife and following up with the Maternity Incentive Scheme Clinical Lead.

1. **Independent investigation into NHS maternity and neonatal care**

Baroness Valerie Amos will lead a national independent investigation into maternity and neonatal care in England.

Fourteen providers have been named, three of which have been subjected to a public inquiry into their services, none of these are within NCL.

Interim findings and recommendations are expected in December 2025, with the final report anticipated in Spring 2026.

2. **Community Equipment Contract update**

Nottingham Rehab Ltd, trading as NRS Healthcare, were contracted through a consortium model overseen by Kensington, Chelsea and Westminster Local Authority to provide Community Equipment to 23 London Boroughs. This included Barnet, Camden, Haringey and Islington in NCL; Enfield have a separate community equipment contract with another provider.

NRS went into liquidation in August 2025. The ICB, along with Local Authority colleagues, have put mitigations in place until the new provider, Essex Cares, takes over the contract in Autumn.

3. **CQC inspection report into services at North London NHS Foundation Trust**

The CQC conducted a comprehensive inspection of all mental health wards for adults of working age and Psychiatric Intensive Care Units (PICU), including twenty wards across four sites (Chase Farm, St Ann's Hospital, Highgate West and Edgware Community Hospital) between 10 February and 4 March 2025.

The services were rated as 'Requires Improvement' overall. The CQC issued thirteen requirement notices where the CQC considered the Trust breached the Health and Social Care Act. The trust submitted the final approved action plan to the CQC on 15 August 2025.

4. **Publication of the Kingdon review into Paediatric Audiology services in England**

This report was published on 10 November 2025, the committee have been appraised on the independent review during the year.

Both NCL and NWL commission the provision of children's hearing services and have been involved in the national improvement work. It is important that the Board are sighted on the review and recommendations.

NWL ICB Quality Report

1. In Quarter 2 of 2025/26, 87 patient safety incident Investigations were reported: four of which were Never Events.

2. In Quarter 2 2025/26 the five highest event types were:
    - Apparent/actual/suspected self-inflicted harm – 18
    - Maternity/obstetric (the three separate types combined) – 12

- Sub-optimal care of the deteriorating patient – 7
  Treatment delay – 7
- Diagnostic incident including delay (incl. failure to act on test results) – 6
  Medication incident – 6
- Surgical/invasive procedure incident – 4

3. There were four Never Events reported during Q2;
   - Surgical error – Retained guidewire from femoral vascath insertion. Object removed and no long term harm to the patient.
   - Surgical error – Wrong site surgery. Patient consented to right total hip replacement, however, the left hip was replaced. Patient was assessed as needing both left and right hip replacements therefore there was no harm to the patient.
   - Pending review – Scalding of patients. Whilst left alone in the shower, the patient, who was under one to one care, turned on the hot water tap in the shower, resulting in burns to their face, chest, shoulder and back. It was identified that the shower did not have a thermostatic valve that would have controlled the maximum temperature.
   - Surgical error – Misplaced naso or oro-gastric tubes. It was identified that a patient had received feed through a tube that was not located within the stomach. The radiological report following insertion identified the tube as being within the stomach.

4. In Quarter 2 there were two maternal deaths reported:
   - A woman died 9 days following a caesarean. She was she presented to A&E with stroke-like symptoms and was diagnosed with suspected Thrombotic Thrombocytopenic Purpura (TTP). Despite urgent plasma exchange, she suffered two cardiac arrests and sadly died.
   - A Trust was notified of the death of a woman who had delivered in July 2023 and had died in March 2024 from gastric cancer. The Trust was notified by MBBRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) following a review of data received from the Office of National Statistics listing cases of maternal deaths that were registered in England and Wales in 2023/2024.

5. In Quarter 2, there were seven prevention of future deaths reports which mentioned North West London providers, all of them were cases where the provider was an interested party and there were no specific actions for the Trusts.

6. Paediatric Audiology Review Update

Ealing Community Partnership
The look back review of cases and recall of children review has now determined that there are 2660 children being recalled and not the 9,000 plus cases that had originally been reported. This has resulted from cases screened and the removal of children who have undergone school screening, alongside the removal of duplicate records.

A subsequent peer review visit was completed, week commencing 15 September, and found that significant improvements within the service had been completed and therefore, the provider has re-opened the service for children aged three and above. The recall of children requiring to be reassessed is currently underway.

7. Infection Prevention and Control

At month five of this financial year, NWL had 5/6 organisms over the in year ambition. This has been presented to the NWL Performance Committee with discussion on challenges of residents in their own homes with no packages of care.

The IPC team have continued to meet with the provider IPC leads, attend IPC committees, Gram Negative Bloodstream Infection (GNBSI) working groups and Acute and Provider collaboratives.

Increase in respiratory cases
There has been an upturn in people displaying respiratory symptoms as expected with the return of schools. Flu season has not yet been declared but have seen an increase in Covid.

8. Joint Targeted Area Inspection (JTAI) Hillingdon

This inspection took place from 16 to 20 June 2025. It was carried out by inspectors from Ofsted, the Care Quality Commission (CQC), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and His Majesty's Inspectorate of Probation (HMIP). The inspection focused on the multi-agency response to unborn children and children aged 0 to 7 years who are victims of domestic abuse. The inspection team identified areas of strengths such as:

- The members of the partnership know themselves well and understand that they need to strengthen the response to victims of domestic abuse in Hillingdon.
- The partnership leaders' response to the inspection findings and their commitment to implement changes to better support victims of domestic abuse

Areas that required improvement included e.g.:

- How effectively the multi-agency public protection arrangements (MAPPA) and multi-agency risk assessment conference (MARAC) processes are being used to protect children and adults from domestic abuse and how well these processes are integrated with, and used to inform, wider work to support and protect children and families.
- Strategic and operational links between probation and the partnership, in particular with regard to strengthening the effectiveness of disruption activity.

Feltham Prison and Young Offenders Institution (B Side)

- CQC completed an inspection of this unit early September. Once published the findings of this inspection will be shared with the NWL Performance Committee.

9. There is varying experience of the new community equipment providers from local providers in North West London.

- Medequip (covering Boroughs of Ealing and Hillingdon, including existing contract for Hounslow) have mobilised well, with good experience reported.
- Twenty Four-Seven (covering Hammersmith and Fulham, Westminster and Royal Borough of Kensington and Chelsea) are experiencing some stock issues, however there is confidence that the provider will deliver on the contract.
- Provide (covering Brent and Harrow) continue to only provide urgent and emergency equipment and no specials orders. There are some concerns being raised regarding the ability of this provider to deliver a

	good standard in the future. This is currently being monitored by the LA contract team.
Recommendation	The NCL and NWL ICB Boards are asked to **NOTE** the content of this report.
Identified Risks and Risk Management Actions	Relevant risks will be added to the appropriate risk register and monitored on an ongoing basis by the quality teams at both NCL and NWL ICB until new governance arrangements have been established in readiness for 1 April 2026.
Conflicts of Interest	Not applicable.
Resource Implications	This will be considered as part of the upcoming staff consultation and establishing priority areas of work within the CNO portfolio.
Engagement	Not applicable.
Equality Impact Analysis	Not applicable.
Report History and Key Decisions	NCL ICB present a Quality report to the NCL Quality and Safety Committee and the NCL ICB Board. NWL ICB present a Quality report to the NWL Finance and Performance Committee.
Next Steps	Establish the governance process for reporting risks and concerns relating to the quality and safety of commissioned services to the ICB Board from 1 April 2026.
Appendices	Quality Report to the NCL and NWL ICB Board meeting in common.

North Central London Health and Care Integrated Care System

North West London Integrated Care System

NHS

Quality Report to the NCL and NWL ICB Board in common.

December 2025.

Contents

North Middlesex Hospital Unit update

The CQC conducted an unannounced focused inspection of maternity services at the NMHU in January 2025, focusing on the safe and well-led domains. The maternity services have been working hard to make improvements since the last inspection in May 2024, where the CQC rated both the safe and well-led domains as ‘Inadequate’. The service was rated as ‘Requires Improvement’ in May 2025.

The maternity unit have developed an Improvement Plan for maternity services incorporating the findings from the CQC inspections, recommendations following the diagnostic review of maternity services, commissioned by the North Middlesex University Hospital in September 2023 and undertaken by the NHSE Maternity Safety Support Programme (MSSP).

The improvement plan is reviewed at the weekly maternity governance meetings and is overseen by the Royal Free Group who are responsible for oversight, implementation and monitoring of these actions.

The NCL Local Maternity and Neonatal System (LMNS) receive regular updates from each of the four maternity and neonatal providers at the LMNS Board and through the monthly Perinatal Quality Review Group.

Background:
The Maternity (Perinatal) Incentive Scheme (MIS) is a Clinical Negligence Scheme for Trusts (CNST) operated by NHS Resolution (NHSR) and is now in it's seventh year.

The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST Members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as in previous years' schemes. Trusts that can demonstrate they have achieved all ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

To be eligible for payment under the scheme, Trusts must continue to update the MIS Y7 Audit Tool and save evidence into the relevant folders on the NCL LMNS FutureNHS space by Monday 26 January 2026 to allow ICB colleagues to review the evidence before meeting with the formal assurance meeting with Trusts on 09 February 2026. All Trust's are required to submit their completed Board Declaration to NHS Resolution by 12 noon on Tuesday 03 March 2026. The declaration must be signed by the Trust's Chief Executive Officer and the Accountable Officer of the Integrated Care System (ICS). This serves as evidence that both are fully assured and in agreement with the compliance submission.

Our NCL providers have submitted evidence and progress against the safety actions since April to the LMNS, with a letter confirming the LMNS's assessment on progress provided in September 2025.
A summary of progress is provided on the next three slides.

Safety Actions and Evidence as reviewed by the LMNS in August 2025 at mid point in the year.

UCLH

Safety Action	Evidence	LMNS RATING	Recommendations by the LMNS
1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Trust has given verbal assurance to the LMNS they are on track against SA 1 for MIS Year 7. UCLH was also compliant with SA1 for MIS Y6.	On track	Commence uploading of evidence in support of SA 1 and update the MIS Y7 audit tool.
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard.	Verbal assurance at MIS catch up meetings and the August LMNS Board meeting that SA2 is on track.		NCL LMNS is rating this SA Amber as a matter of precaution until the July score card data will not be available until October 2025.
3. Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Transitional Care pathway in place as per MIS Y7 requirements.	On track	No concerns noted by the LMNS.
4. Can you demonstrate an effective system of clinical workforce planning to the required standard?	UCLH have advised although they are compliant with their MIS Y6 neonatal nursing workforce action plan, there is a need for the Trust to work up a broader action plan for neonatal nursing workforce. If UCLH decide more staff are required, the Trust will not be compliant against the British Association of Perinatal Medicine (BAPM) standards.	At risk	LMNS advised that if additional neonatal staff are required the Trust will need to upload the following: • Trust board minutes showing BAPM recommendations for neonatal nursing workforce are not being met. • Neonatal workforce action plan is on the Trust's Risk Register and progress against these submitted to the LMNS and Neonatal Operational Delivery Network (ODN).
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Birthrate+ report presented to the Trust Board in January 2025, with Midwifery Workforce oversight report presented to the Trust Board in January and July 2025.	On track	Commence uploading of evidence in support of SA 5 and update the MIS Y7 audit tool.
6. Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three? - ***note: includes all six elements.***	Saving Babies Lives assurance in place.	On track	N/A.
7. Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Trust has advised Maternity and Neonatal Voice Partners (MNVPs) co-chairs are unable to attend every Trust governance, quality, and safety meetings at speciality/divisional/directorate level as per the MIS Y7 guidance.	At risk	This is in line with what other NCL Trusts have advised us, and other LMNSs in London and around England are reporting.
8. Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Challenges with the anaesthetic workforce attending training specifically for maternity emergencies.	At risk	The LMNS will rate this Amber until UCLH confirms maternity emergencies professional training is no longer at risk and evidence is saved in support of the required standard.
9. Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Verbal assurance to the LMNS they are on track with SA 9 for MIS Y7 and were compliant with SA 9 for MIS Y6.	On track	Commence uploading of evidence in support of SA 9 and update the MIS Y7 audit tool.
10. Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Verbal assurance to the LMNS they are on track with SA 10 for MIS Y7 and were compliant with SA 10 for MIS Y6.	On track	Commence uploading of evidence in support of SA 10 and update the MIS Y7 audit tool.

Safety Actions and Evidence as reviewed by the LMNS in August 2025 at mid point in the year.

Royal Free Group

Safety Action	Evidence	LMNS RATING	Recommendations by the LMNS
1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	North Middlesex did not meet this requirement in Y6, assurances provided that they are on track to meet the requirement in Y7.	On track	
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard.	Verbal assurance at MIS catch up meetings, and to the August LMNS Board meeting that SA2 is on track.		NCL LMNS is rating this SA Amber as a matter of precaution until the July score card data will not be available until October 2025.
3. Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Transitional Care pathway in place as per MIS Y7 requirements.	On track	No concerns noted by the LMNS.
4. Can you demonstrate an effective system of clinical workforce planning to the required standard?	BAPM standards are not being met due to Neonatal QIS trained nurses (Qualified in Speciality), plans in place to address this.	At risk	LMNS have rated this as amber until the following evidence has been saved: • Formally recorded in the Trust Board minutes that BAPM recommendations for neonatal nursing are not being met. • Agreed action plan and monitoring of progress against this, submitted to the LMNS and ODN.
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Birthrate+ report and bi-annual staffing report presented to the Trust Board in June 2025.	On track	N/A
6. Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three? - ***note: includes all six elements.***	Saving Babies Lives assurance in place.	On track	N/A.
7. Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Trust has advised Maternity and Neonatal Voice Partners (MNVPs) co-chairs are unable to attend every Trust governance, quality, and safety meetings at speciality/divisional/directorate level as per the MIS Y7 guidance.	At risk	This is in line with what other NCL Trusts have advised us, and other LMNSs in London and around England are reporting.
8. Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	NMUH has flagged multi-professional maternity emergencies training is an area of concern due to anaesthetist compliance, action plan in place.	At risk	LMNS is rating as Amber until compliance against all relevant staff training for SA8 is confirmed given uncertainty around multi-professional maternity emergencies training compliance.
9. Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Non-Executive Director appointed, strengthen senior leadership within maternity to oversee this safety action.	At risk	LMNS is rating this Amber as the NMUH did not pass SA9 last year.
10. Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Verbal assurance to the LMNS they are on track with SA 10 for MIS Y7 and have appointed 0.6 WTE Band 7 PMRT midwife to support.	At risk	LMNS is rating this Amber since NMUH did not pass SA 10 last year.

Safety Actions and Evidence as reviewed by the LMNS in August 2025 at mid point in the year.
Whittington Health

Safety Action	Evidence	LMNS RATING	Recommendations by the LMNS
1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Verbal assurance given with Quality Assurance Committee (QAC) papers and Maternity Clinical Governance and Safety Champions meeting (MCGSCM) uploaded into the MIS Y7 SA 1 folder which include quarterly PMRT updates.	On track	N/A
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard.	Verbal assurance at MIS catch up meetings, and to the August LMNS Board meeting that SA2 is on track.		NCL LMNS is rating this SA Amber as a matter of precaution until the July score card data will not be available until October 2025.
3. Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Transitional Care pathway in place as per MIS Y7 requirements.	On track	No concerns noted by the LMNS.
4. Can you demonstrate an effective system of clinical workforce planning to the required standard?	Trust advised the LMNS that checks on training compliance for two locum doctors were incorrect. The information provided by the recruiting agency to Bank Partners was incorrect and therefore this means they are non-compliant for this safety action. The Trust's Director of Midwifery is discussing this with Regional Chief Midwife and following up with the Maternity Incentive Scheme Clinical Lead.	At risk	LMNS have rated this as amber until the following evidence has been saved: • Records of advice given/email correspondence with the London Regional Chief Midwife and the Maternity Incentive Scheme Clinical Lead as evidence.
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Birthrate+ report and bi-annual staffing report presented to the Trust Board in June 2025.	On track	N/A
6. Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three? - ***note: includes all six elements.***	Saving Babies Lives assurance in place.	On track	N/A.
7. Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Trust has advised Maternity and Neonatal Voice Partners (MNVPs) co-chairs are unable to attend every Trust governance, quality, and safety meetings at speciality/divisional/directorate level as per the MIS Y7 guidance.	At risk	This is in line with what other NCL Trusts have advised us, and other LMNSs in London and around England are reporting.
8. Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Whittington Health advised the LMNS in August about in facilitating staff training for consultants, action plan in place.	At risk	LMNS is rating as Amber until all evidence is uploaded for the reporting period, this needs to be completed by November.
9. Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Verbally assurance to the LMNS on track with SA 9 and were compliant with SA 9 for MIS Y6.	On track	N/A
10. Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Verbally assurance to the LMNS on track with SA 10 and were compliant with SA 10 for MIS Y6.	On track	N/A

National Maternity Inquiry

The Secretary for Health and Social Care has appointed Baroness Valerie Amos to lead a national Independent Investigation into maternity and neonatal care in England, interim recommendations are now expected in early 2026, with the final report anticipated to be published in Spring 2026. The Trusts listed below have been selected to be included in the review. While none of our maternity providers across NCL and NWL are included, the outcome of the review will provide an opportunity to review recommendations and assess maternity services against these.

Trust	CQC rating for maternity services	Public inquiry
Barking, Havering and Redbridge University Hospitals Trust.	Requires improvement 2021	No
Blackpool Teaching Hospitals Foundation Trust.	Requires improvement 2025	No
Bradford Teaching Hospitals Foundation Trust.	Requires improvement 2024	No
East Kent Hospitals University Foundation Trust.	Good 2025	Yes
Gloucestershire Hospitals Foundation Trust.	Good 2015	No
Leeds Teaching Hospitals Trust.	Inadequate 2025	No
Oxford University Hospitals Foundation Trust.	Requires improvement 2024	No
Queen Elizabeth Hospital King's Lynn Foundation Trust.	Good 2024	No
Sandwell and West Birmingham Hospitals Trust.	Requires improvement 2024	No
Shrewsbury and Telford Hospital Trust.	Requires improvement 2024	Yes
University Hospitals of Leicester Trust.	Requires improvement 2024	No
University Hospitals of Morecambe Bay Foundation Trust.	Inadequate 2023	Yes
University Hospitals Sussex Foundation Trust.	Requires improvement 2023	No
Yeovil District Hospital (now part of Somerset Foundation Trust)	Inadequate 204	No

Nottingham Rehab Limited (trading as NRS Healthcare)

On 01 August 2025, Nottingham Rehab Ltd, trading as NRS Healthcare went into liquidation with PricewaterhouseCoopers (PwC) appointed to oversee the process.

NRS were contracted through a consortium model overseen by Kensington, Chelsea and Westminster Local Authority to provide Community Equipment to 23 London Boroughs. This included Barnet, Camden, Haringey and Islington in NCL, Enfield have a separate community equipment contract with another provider.

There have been long standing issues with this contract since it commenced in 2023, including a legal challenge made against NRS by the previous contract holder. All concerns have been escalated to the local authorities by the Complex Care team and community providers such as Whittington Health, this contract is managed by the Strategy and Population Health Directorate on behalf of the ICB.

Position in NCL regarding Community Equipment.

1. The Executive Director, Communities, Adults & Health at Barnet Local Authority is overseeing the commissioning of the Community Equipment service across London and is in regular liaison with ICB colleagues.
2. The ICB have agreed a sub-contract with Camden Local Authority securing community equipment for the boroughs of Barnet, Camden, Haringey and Islington until Essex Carers, a subsidiary of Essex County Council who have been appointed to provide community equipment and have taken over the depots in NCL along with several staff previously employed by NRS, are fully mobilised later this year.

Individuals working within the Strategy and Population Health Directorate are overseeing this process on behalf of the ICB.

CQC inspection North London Foundation Trust

- The CQC conducted a comprehensive inspection of all mental health wards for adults of working age and psychiatric intensive care units (PICU), including 20 wards across 4 sites (Chase Farm, St Ann's Hospital, Highgate West and Edgware Community Hospital) between 10 February and 4 March 2025.
- The inspection was conducted in response to several incidents and deaths that had occurred within the in-patient wards, to understand the themes and learning that has taken place.
- The Trust was rated as 'Good' in the domains of caring and responsiveness, and 'Requires Improvement' in the domains of safety, effectiveness and well-led.
- North London NHS Foundation Trust was formed in November 2024 following the merger of 2 former trusts: Barnet, Enfield and Haringey Mental Health NHS Trust and Camden and Islington NHS Foundation Trust.

Positive practice

- Staff were positive about working at the Trust and reported feeling supported by their managers, felt respected and valued.
- Good career development opportunities and access to further training.
- Patients and carers interviewed said that staff were caring and kind.
- Evidence of Quality Improvement projects across the Trust, staff were positive about these and the benefits of these in improving pathways.
- Staff were trained in and demonstrated a good understanding of the Mental Health Act Code of Practice, citing easy access to administrative support and legal advice on implementation.
- Patients had access to information about independent mental health advocacy, such as posters on notice boards.
- Staff had completed mandatory training on supporting autistic people and provided examples of specific individual adjustments e.g. providing ear plugs and music to reduce the volume of the ward alarms.
- St Ann's Hospital has close links with the local Jewish community. Fresh kosher snacks and bread are brought each day for those requesting a kosher diet.
- An LGBTQ+ group for patients had recently started at Highgate West Mental Health Centre. There was also a women's forum which staff and patients could attend.

Areas for improvement

- Seclusion reviews did not always happen at the scheduled frequencies; intermittent patient observations were not always carried out in line with the Trust policy.
- Compliance rates for key training, such as life support and prevention and management of violence and aggression were low.
- Risk assessments were not always completed on admission and did not always include all identified risk.
- Care plans were not always updated and did not always include patient views, or include plans for managing specific needs, e.g. not care plan to support a blind patient on the ward,
- Staff did not always receive regular supervision and appraisals. Team meetings were not always happening each month.

Next steps

1. The CQC issued 13 requirement notices where the CQC considered the Trust breached the Health and Social Care Act. The final approved action plan was submitted to CQC on 15 August 2025.
2. The action plan was discussed at an Extraordinary Quality and Safety Group (QSG) on 16 September and will be monitored monthly at QSG with oversight at bimonthly Quality and Safety Committee (sub-Board committee) and Executive Management Group (EMC).

Kingdon review of children’s services

Kingdon review of children’s hearing services: final report - GOV.UK published on 10 November 2025, following the NCL Quality and Safety committee. It is an important review as children’s hearing services are provided across both NCL and NWL ICB footprints.

The Kingdon review of NHS children's hearing services found systemic failings, leading to nearly 300 children being harmed by missed or delayed diagnoses, an underestimation of the true figure. The report identifies the profession as "overlooked, undervalued and underfunded" and criticizes the lack of national oversight, variable service quality, and long waiting lists.

Key recommendations include mandatory professional registration for all audiologists, improved governance, and better training and workforce support.

Key findings

Systemic failings: The review found that children's hearing services have been neglected for years due to a lack of investment, oversight, and proper regulation.

Harm to children: At least 300 children have been harmed by failed or delayed diagnoses, and this number is likely higher as patient reviews are ongoing.

Variable quality: The quality of services is inconsistent, with many children facing long waiting lists and significant delays in care, which can affect their development.

Workforce issues: There is a lack of proper training and professional development (CPD) for the audiology workforce, and a lack of a unified professional register.

Incident response: The review found serious problems with how incidents are reported and addressed within NHS services.

Kingdon review of children's services, con't

Recommendations

Mandatory registration: Require all audiologists working in the NHS to be registered on a single professional register, improving training and CPD.

Improved governance: Implement better governance arrangements for audiology services at the NHS trust and Integrated Care Board levels.

Enhanced training: Improve the quality of training and provide better career progression pathways.

Modern commissioning: Develop new, modern commissioning frameworks with key performance indicators to ensure quality.

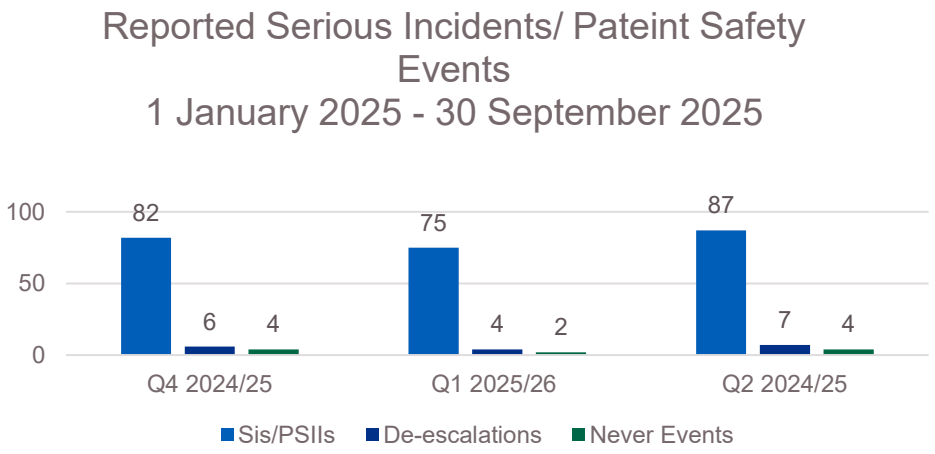
Incident response: Establish clear regional incident response processes for widespread patient safety concerns.

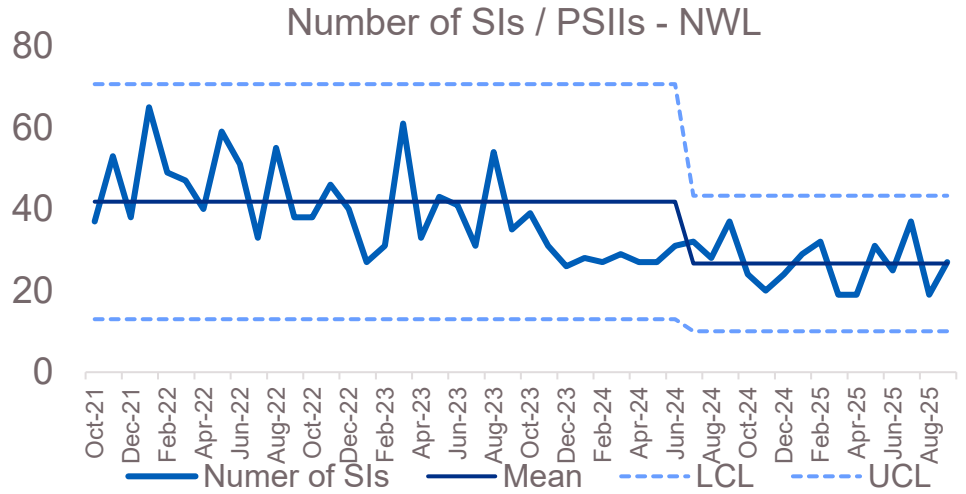
NHS North West London Quality Escalations

	Slides
1. Patient Safety Incidents Reported Q2	16-19
2. Paediatric Audiology Review update	19
3. Infection Prevention Control update	20-21
4. Regulatory Body Updates	21-22
5. Community Equipment Update	23

NWL Q2 Patient Safety Update

Patient Safety Incident Investigations (PSIIs)
In Quarter 2 of 2025/26, 87 PSIIs were reported: four of which are Never Events. Following local review, seven patient safety incident investigations were de-escalated as following review they did not reach the threshold as a patient safety incident investigation/serious incident. Four of the seven PSIIs de-escalated were cases reported within this quarter, therefore, the number of PSIIs progressing is 83. The trends over the past 9 months by quarter are noted below in Chart 1.





In Quarter 2 2025/26 the five highest event types were:

1. Apparent/actual/suspected self-inflicted harm – 18
2. Maternity/obstetric (the three separate types combined) – 12
3. Sub-optimal care of the deteriorating patient – 7

Treatment delay – 7

4. Diagnostic incident including delay (incl. failure to act on test results) – 6

Medication incident – 6

5. Surgical/invasive procedure incident – 4

NWL Q2 Patient Safety Update

Never Events

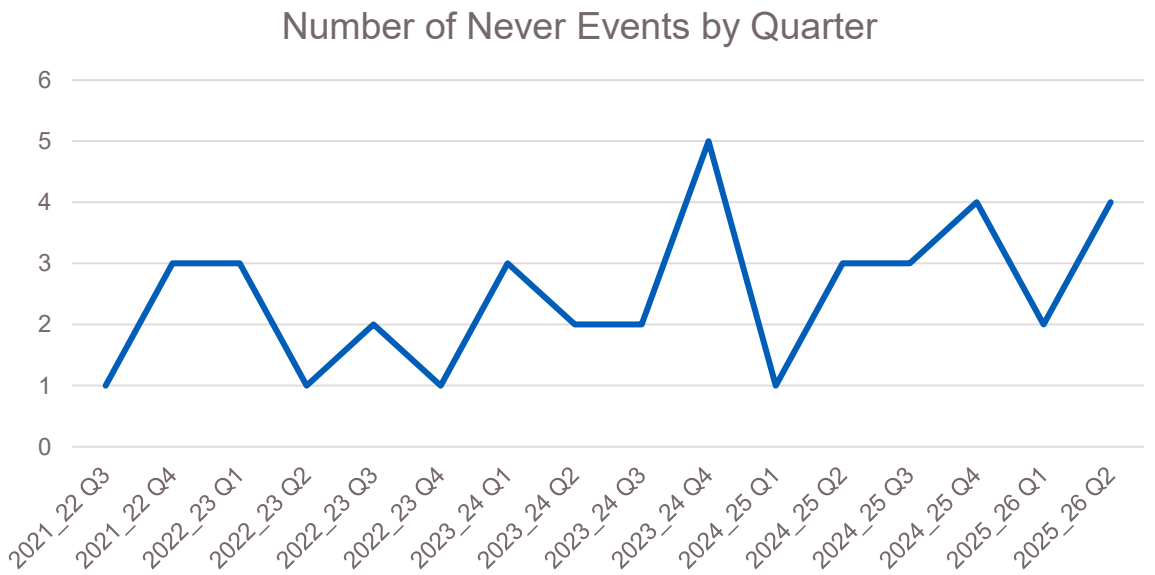
Never Events are not necessarily the most serious type of incident, but are defined as being 'wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a National level'.

A Never Event PSII report will continue to be reviewed by the ICB and mechanisms to monitor (closure meetings) the completion of the action plan and demonstrates lessons have been embedded will continue.

There were four Never Events reported during Q2;

1. Surgical error – Retained guidewire from femoral vascath insertion. Object removed and no long term harm to the patient.
2. Surgical error – Wrong site surgery. Patient consented to right total hip replacement, however, the left hip was replaced. Patient was assessed as needing both left and right hip replacements therefore there was no harm to the patient.
3. Pending review – Scalding of patients. Whilst left alone in the shower, the patient, who was under one to one care, turned on the hot water tap in the shower, resulting in burns to their face, chest, shoulder and back. It was identified that the shower did not have a thermostatic valve that would have controlled the maximum temperature.
4. Surgical error – Misplaced naso or oro-gastric tubes. It was identified that a patient had received feed through a tube that was not located within the stomach. The radiological report following insertion identified the tube as being within the stomach.

Chart 3 below shows the number of Never Events reported since Oct 2021 within NHS North West London providers.



NWL Q2 Patient Safety Update

The table below reflects the top 5 type of incident reported between October 2024 and September 2025. The table below demonstrates Incident Type (number, percentage of total incidents reported that quarter).

Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26
Maternity/obstetric (the three separate types combined) (12, 17%)	Maternity/obstetric (the three separate types combined) (12, 15%)	Apparent/actual/suspected self-inflicted harm (16, 22%)	Apparent/actual/suspected self-inflicted harm (18, 22%)
Apparent/actual/suspected self-inflicted harm (9, 13%)	Sub-optimal care of the deteriorating patient (12, 15%)	Sub-optimal care of the deteriorating patient (10, 14%)	Maternity/obstetric (the three separate types combined) (12, 14%)
Diagnostic incident including delay (9, 13%)	Apparent/actual/suspected self-inflicted harm (10, 13%)	Treatment delay (8, 11%)	Sub-optimal care of the deteriorating patient (7, 8%)
			Treatment delay (7, 8%)
Surgical/invasive procedure incident (5, 7%)	Diagnostic incident including delay (8, 10%)	Maternity/obstetric (the three separate types combined) (8, 11%)	Diagnostic incident including delay (6, 7%)
			Medication Incident (6, 7%)
Treatment delay (4, 6%)	Surgical/invasive procedure incident (7, 9%)	Diagnostic incident including delay (7, 10%)	Surgical/invasive procedure incident (4, 5%)

Maternal deaths

Maternal death or maternal mortality is defined in slightly different ways by several different health organisations. The World Health Organization (WHO) defines maternal death as the death of a pregnant mother due to complications related to pregnancy, underlying conditions worsened by the pregnancy or management of these conditions. This can occur either while she is pregnant or within six weeks of resolution of the pregnancy. Deaths up to 12 months postnatally are logged in NWL and if they occur after six weeks, are defined as late maternal deaths.

In Quarter 2 there were two maternal deaths reported:

1. A woman died 9 days following a caesarean. She was she presented to A&E with stroke-like symptoms and was diagnosed with suspected Thrombotic Thrombocytopenic Purpura (TTP). Despite urgent plasma exchange, she suffered two cardiac arrests and sadly died.
2. The Trust was notified of the death of a woman who had delivered in July 2023 and had died in March 2024 from gastric cancer. The Trust was notified by MBBRACE following a review of data received from the Office of National Statistics listing cases of maternal deaths that were registered in England and Wales in 2023/2024.

NWL Q2 Patient Safety Update/Paediatric Audiology Review Update

Prevention of Future Death Notices (PFD's)
Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 Act, and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, where an investigation gives rise to concern that future deaths will occur, and the investigating coroner is of the opinion that action should be taken to reduce the risk of death, the coroner must make a report to the person the s/he believes may have the power to take such action. The prevention of future deaths reports are known as PFDs which are published on the www.judiciary.uk website.

In Quarter 2, there were seven PfDs which mentioned North West London providers, all of them were cases where the provider was an interested party and there were no specific actions for the Trusts.

Paediatric Audiology & Auditory brainstem response (ABR) testing - Update on current paediatric audiology position

Following completion of the stage 3 reviews, the following services were assessed as:

Name of Provider	Assessment outcome
Imperial College Healthcare NHS Trust	**Partial Assurance**
The Hillingdon Hospital	**Partial Assurance**
Ealing Community Partnership (Carmelita House & Jubilee House)	**Low/No Assurance**
London North West University Healthcare	**Assured**

Ealing Community Partnership
The look back review of cases and recall of children review has now determined that there are 2660 children being recalled and not the 9,000 plus cases that had originally been reported. This has resulted from cases screened and the removal of children who have undergone school screening, alongside the removal of duplicate records.

A subsequent peer review visit was completed, week commencing 15 September, and found that significant improvements within the service had been completed and therefore, the provider has re-opened the service for children aged three and above. The recall of children requiring to be reassessed is currently underway.

Infection Prevention Control (IPC) Update

Infection Prevention Control (IPC) – Update

Health Care Associated Infections (HCAIs)

Following the recent publication of the NHS Standard Contract 2025/26: Minimising Clostridioides difficile and Gram-negative bloodstream infections April 2025 V3, the Business Intelligence Team has incorporated these into the monthly HCAI reports. Trust thresholds for GNBSIs and for C.difficile are the lower of their 2024/25 thresholds or of 10% decrease on 2024 calendar year cases.

At month five of this financial year, the system has 5/6 organisms over the in year ambition this has been presented to the performance committee with discussion on challenges of residents in their own homes with no packages of care.

The IPC team have continued to meet with the provider IPC leads, attend IPC committees, GNBSI working groups and Acute and Provider collaborates to ensure oversight, seek assurance and understand the learning.

All cases (Community and Acute Trusts) per month at NWL ICS

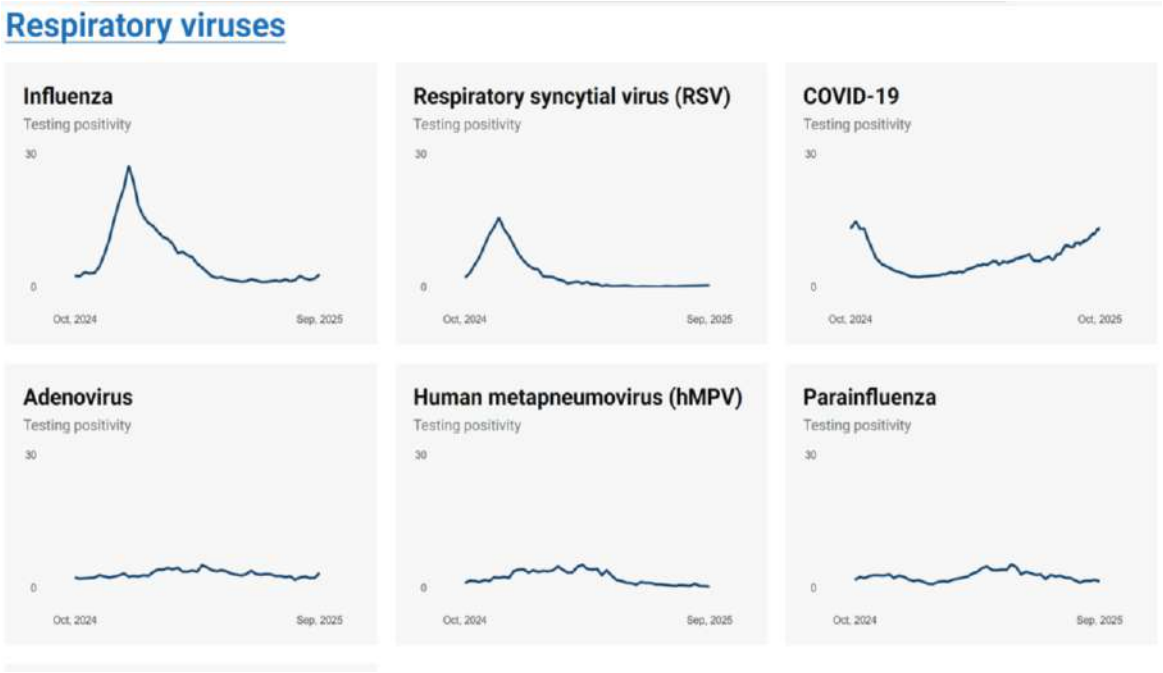
(August 2025 data is provisional)

	2025-04	2025-05	2025-06	2025-07	2025-08	2025-09	2025-10	2025-11	2025-12	2026-01	2026-02	2026-03	YTD Total	YTD Threshold	Monthly Threshold	Yearly Threshold
E. coli	123	153	112	169	129	-	-	-	-	-	-	-	686	563	113	1,351
Klebsiella spp	22	36	38	48	41	-	-	-	-	-	-	-	185	190	38	455
Pseudomonas aeruginosa	15	15	17	21	16	-	-	-	-	-	-	-	84	75	15	180
C. difficile	35	27	24	35	29	-	-	-	-	-	-	-	150	141	28	338
MRSA	4	2	5	7	3	-	-	-	-	-	-	-	21	0	0	0
MSSA	30	26	22	21	32	-	-	-	-	-	-	-	131	116	23	279

IPC Update/Regulatory Body Updates

Increase in respiratory cases

There has been an upturn in people displaying respiratory symptoms as expected with the return of schools. Flu season has not yet been declared but have seen an increase in Covid.



Joint Targeted Area Inspection (JTAI) Hillingdon

This inspection took place from 16 to 20 June 2025. It was carried out by inspectors from Ofsted, the Care Quality Commission (CQC), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and His Majesty's Inspectorate of Probation (HMIP). The inspection focused on the multi-agency response to unborn children and children aged 0 to 7 years who are victims of domestic abuse.

Headline findings
Strengths

- The members of the partnership know themselves well and understand that they need to strengthen the response to victims of domestic abuse in Hillingdon.
- The partnership leaders' response to the inspection findings and their commitment to implement changes to better support victims of domestic abuse.
- The partnership has recently put in place well-considered and robust governance arrangements aimed at providing a framework to support a more effective approach to tackling domestic abuse.
- Once risk is identified, experienced and caring practitioners across early help, social care, in healthcare settings, schools, probation and police work together collaboratively and well, to offer generally effective help and protection.

Regulatory Body Updates

- The Hillingdon Domestic Abuse and Advocacy Service offers high-quality support which strengthens the support and protection of victims of domestic abuse.

What needs to improve?

- How effectively the multi-agency public protection arrangements (MAPPA) and multi-agency risk assessment conference (MARAC) processes are being used to protect children and adults from domestic abuse and how well these processes are integrated with, and used to inform, wider work to support and protect children and families.
- Strategic and operational links between probation and the partnership, in particular with regard to strengthening the effectiveness of disruption activity.
- The effectiveness of multi-agency joint working, in strategic and operational contexts, to tackle domestic abuse. In particular, how well an accurate needs assessment is used to drive the commissioning of services and to assess impact?
- The effectiveness of the scrutiny arrangements of the partnership.
- The timeliness of child protection processes and the consistency, quality and pace of information-sharing across the partnership

Improvement actions are currently being agreed for implementation amongst the safeguarding partnership.

Feltham Prison and Young Offenders Institution (B Side)

CQC completed an inspection of this unit early September. Once published the findings of this inspection will be shared with the committee.

Community Equipment Provider Update

Mobilisation of new providers following the demobilisation of the Nottingham Rehab Services (NRS) contract following insolvency

There is varying experience of the new community equipment providers from local providers in North West London.

- Medequip (covering Boroughs of Ealing and Hillingdon, including existing contract for Hounslow) have mobilised well, with good experience reported.

- Twenty Four-Seven (covering, H&F, Westminster and RBKC are experiencing some stock issues, however there is confidence that the provider will deliver on the contract.

- Provide (covering Brent and Harrow) continue to only provide urgent and emergency equipment and no specials orders. There are some concerns being raised regarding the ability of this provider to deliver a good standard in the future. This is currently being monitored by the LA contract team.

North Central London
Integrated Care Board

North West London

North Central London ICB and North West London ICB
Board of Members Meeting in Common
4 December 2025

Report Title	Combined Board Assurance Framework ('BAF') Report	**Date of report**	26 November 2025	**Agenda Item**	2.4
Lead Director / Manager	Sarah Morgan, Chief People Officer- NCL and NWL ICBs.	**Email / Tel**		Sarahlouise.morgan@nhs.net	
Board Member Sponsor	Frances O'Callaghan, Chief Executive Officer- NCL and NWL ICBs.				
Report Author	Andrew Spicer, Assistant Director of Governance, Risk and Legal Services- NCL ICB Martyn Schofield, Company Secretary- NWL ICB	**Email / Tel**		andrew.spicer1@nhs.net martyn.schofield1@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** Each BAF assists the respective ICBs to manage their most significant financial risks.			

Report Summary	NHS North Central London Integrated Care Board (NCL ICB) and NHS North West London Integrated Care Board (NWL ICB) are scheduled to merge and form a new organisation on 1 April 2026. Until then, they are working closely together and will hold their first Board meeting in common on 4 December 2025. However, both remain separate statutory bodies and are individually accountable for their respective functions.
	
	To support this, the following combined report presents the Board Assurance Framework ('BAF') for each ICB's Board of Members. Each BAF captures the most serious risks that have been identified as threatening the achievement of the respective 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 each Board's attention;
	• BAF Risk Overview Report. This is a strategic snapshot of each BAF risk including risk scores, strategic updates and movement over the previous four Board reports:
	  ○ North Central London ('NCL') ICB's report is at Appendix 1;
	  ○ North West London ('NWL') ICB's report is at Appendix 2;				

- 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, evidence of controls/assurances, gaps in controls and actions);
    - The full version of the NCL ICB BAF risk register is here.
    - The full version of the NWL ICB BAF risk register is here.

North Central London ICB Risk Overview

There are 4 risks on the BAF:

- 3 are system risks (COMM32, PERF34 and COMM22);
- 1 is an ICB only risks (CS26)
- 3 of the 4 risks are below the BAF threshold but included for information (see below);

There is 1 new risk:

- CS26- ICB Merger (Threat). This risk is scored at 8.

One risk has closed:

- FIN39- Insufficient ICS Capital Allocation to Deliver ICS Strategic Priorities and Address Issues with Key Infrastructure (Threat). This risk has closed as there is sufficient in year capital allocation to address the in-year operational needs. From Financial Year 26/27 capital allocation been delegated nationally to Trusts and Foundation Trusts so the ICB will lose its current system capital allocator role. The ICB's role will be to continue to hold providers to account via the usual means. Consequently, system capital allocation will no longer be the ICB's risk.

One risk has decreased and is removed from the BAF:

- PERF28- Increased and undifferentiated demand, and variation in general practice access models (Threat). This risk was previously below the BAF threshold but was included for oversight. Due to further mitigations being put into place this risk has reduced from 9 to 6 and so removed from the BAF. It will continue to be monitored by the Chief Transformation Officer.

Three risks are below the BAF threshold but included for oversight:

- COMM32- Failure to provide adequate Child and Adolescent Mental Health Services ('CAMHS') (Threat);
- PERF34- Failure to deliver compliance with national operational standards across elective, urgent, and mental health care pathways (Threat);
- CS26- ICB Merger (Threat).

North West London ICB Risk Overview

There are 9 risks on the BAF:

- 3 are system risks (BAF4, BAF5 and BAF7)
- 6 are ICB only risks (BAF1, BAF2, BAF3, BAF6, BAF8 and BAF9);
- The new NCL ICB risk on merger can be considered within BAF9;The risk appetite levels contained in the BAF will be reviewed in due course in light of the move to being a strategic commissioner, the organisational transition and the change of Executive leadership. Work has also begun in close collaboration with NCL ICB and NWL ICB colleagues to develop the approach to risk appetite and risk tolerance for the new organisation.

Two risks have decreased- with all other current risk scores remaining the same:

- BAF1: This risk has reduced from 20 to 16 due to the ICB's HR team having additional dedicated resources in place to manage both business as usual activities and transition arrangements, with increased capacity through investment in the core team and support from NCL ICB;

- BAF9: This risk has reduced from 20 to 12 due to the work being undertaken to become a strategic commissioner. Please see 'Key Highlights' below.

Key Highlights

Key Highlights to bring to each Board's attention are:

Merger and Organisational Redesign

With NHS England approving the proposals to merge North Central London ('NCL') Integrated Care Board and North West London ('NWL') Integrated Care Board from 1 April 2026 work is underway to ensure all of the necessary arrangements are in place to ensure the new West and North London ICB can effectively operate and discharge its functions from 1st April 2026. This includes the new Executive Director of Transition being appointed and the establishment of a joint NCL/NWL Transition Committee to oversee the transition work.

In addition, HM Treasury has now provided permission for ICBs nationally to consult with staff on the proposed staff structures for the new organisation and has approved a national Voluntary Redundancy Scheme. This is timely as NHS England has confirmed that it expects ICBs to operate within their new running cost allowance from 1 April 2026. Failure to do so may increase the cost pressure on the ICB in Financial Year 26-27 and additional savings may need to be found.

The ICB will meaningfully consult with staff on the proposed new ICB staff structure and will endeavour to operate within its new running cost allowance as soon as practicable. The proposed new staff structure will support the ICB as it pivots to become a strategic commissioner.

A new risk on merger has been added to the NCL ICB BAF at CS26. This risk can be considered within the NWL ICB BAF within BAF9. A new risk on organisational redesign is being developed with ownership by the Chief People Officer.

Children and Adolescent Mental Health Services

Children's mental health services remain a significant risk across North West and North Central London, driven by rising demand, increasing complexity and long waits for neurodevelopmental assessments. This is a priority area for strategic commissioning, with opportunities under the new operating model to align approaches and leverage synergies across both systems.

In North West London, a three-year Children and Young People ('CYP') Mental Health, Learning Disability and Autism Strategy is in development for early 2026. Co-designed with young people, families, and partners, it will address pandemic-related impacts and wider determinants of health. The strategy will focus on resilience and emotional wellbeing, early intervention, community-based support, outreach to vulnerable groups, and redesign of neurodevelopmental and crisis pathways. It will also set out investment priorities and service redesign to meet emerging needs.

As North West London ICB and North Central London ICB comes together to form the new West and North London ICB we will be considering strategic alignment across the mental health programmes, our commissioning intentions and how we best serve our residents and patients.

NWL has already invested significantly this year in reducing neurodevelopmental waiting lists, piloting digital assessment tools to improve access and efficiency and core Children and Adolescent Mental Health Services ('CAMHS') waiting lists initiatives to reduce all 18 week wait Referral To Treatment ('RTT') assessments and clock stops.

	In NCL a somewhat fragmented provider landscape and increasing demand for children's mental health services has meant that it has been identified as a risk on the BAF. Over the last year the NCL Board have taken a series of updates and approved the strategic direction of travel to move to a lead provider model and work is progressing at pace to move to this new arrangement from 1 April 2026, with North London Foundation Trust identified as the lead (subject to appropriate contractual approvals). Informed by engagement with parents and young people, and in preparation for the new arrangements, a comprehensive strategic needs assessment has been produced to identify areas of focus. A business case is being co-produced with providers that will outline the case for change and inform the priorities for service development. Priority areas are Neurodevelopmental disorder ('NDD') pathways, crisis, consistency in core community CAMHS and establishing an integrated front door in all boroughs. Alongside a focus on standardising and improving data quality and consistency. Once formally established the NCL Community CAMHS Provider Collaborative will work closely with the North Central East London Provider Collaborative ('NCEL') which provides Tier 4 CAMHS provision both informally and through the established governance routes. Like NWL, NCL has made considerable investment into NDD and core CAMHS services over both 2024/25 and 2025/26. This includes a digital 'waiting well' offer for those waiting for assessment and treatment, although the pace of demand continues to increase. Through the NCL Community CAMHS Provider Collaborative there are opportunities to make best use of the investment that has gone into services, reduce fragmentation and some duplication and standardise service offers – with any productivity savings to be reinvested into service delivery.
Recommendation	The NCL and NWL ICB Boards are 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	Each 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 each 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 in each ICB helps to support this by providing monitoring, guidance and advice.
Engagement	The BAF report is presented to each Board of Members meeting. Risk discussions continue at the Executive Management Team and the Audit Committee.
Equality Impact Analysis	The BAF report is presented to each Board of Members meeting. Risk discussions continue at h the Executive Management Team and the Audit Committee.
Report History and Key Decisions	The Board Assurance Framework report is presented to each ICB's Board of Members meeting.

	Risks are kept under review by the risk owners and by the relevant 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 robust oversights of the ICB's key risks and new emerging issues; • To consider the development of the new ICB's approach to risk with the relevant Non-Executive Members and Executive Directors.
Appendices	The following documents are included: • Appendix 1- NCL BAF Risks Overview Report • Appendix 2- NWL BAF Risks Overview Report • Appendix 3- NCL BAF Register • Appendix 4- NWL BAF Register.

North Central London ICB BAF Risks - Oversight Report

Risk ID	Risk Title	Risk Owner	Committee	Risk description	Strategic update	2025 Current Risk Score MAR	MAY	JUL	NOV	Movement From Last Report	Target Risk Score
System Risks											
COMM32	Failure to provide adequate Child and Adolescent Mental Health Services ('CAMHS') (Threat).	Sarah McDonnell-Davies - Chief Transformation Officer	Population Health Strategic Commissioning Committee	**CAUSE:** If the ICB fails to respond to the significantly increased need for Child and Adolescent Mental Health Services (CAMHS) services, **EFFECT:** There is a risk that local children and young people ('CYP') with mental health conditions do not access the timely, good quality mental health care they need. **IMPACT:** This may result in the deterioration of CYP's' mental health and national targets not being met by the ICB and create a long term population health impact.	In April 2024 the Strategy and Development Committee asked that commissioning options to improve cohesion and reduce fragmentation within Child and Adolescent Mental Health Services ('CAMHS') provision to increase the pace of improvement on outcomes and better meet rising need are considered. Following discussions with the NHS CAMHS providers all parties have agreed with the proposal to establish a community CAMHS provider collaborative in NCL. 2025/26 will be a year of preparatory work to enable formal Board approval in the autumn/winter for the proposal that North London Foundation Trust ('NLFT') become the lead provider within this proposed arrangement (with the agreement of all NHS CAMHS providers). The ICB is now working with NLFT and the partners who will form the Community CAMHS Provider Collaborative to enable mobilisation of the arrangements from 2026/27, working through areas such as governance, contracts and service development. An assurance methodology is being confirmed to set up regular check ins through 2025/26 to monitor progress, deal with issues as they arise and support transition to the new arrangements, using 2025/26 as a year of shadow operation. It is anticipated that once the Community CAMHS provider collaborative is fully established it will reduce variation in services across the NCL footprint, and this would deliver improvements in access, experience and outcomes for children and young people (and their families / carers). This is also anticipated to increase the level of the controls sufficiently that the risk rating is lowered from 16 to 12. The strategic commissioning programme on the Voluntary, Community and Social Enterprise CAMHS contracts held by the ICB has now been completed. Recommendations for renewal / termination of these contracts are being shared with EMT in November / December 2025 as part of the 2026/27 contracting process. All proposals align with the Thrive model that underpins the strategic direction of travel for Children and Young People Mental Health ('MH') services in NCL as well as provide alignment with the operational arrangements established as part of the NCL Community CAMHS Provider Collaborative. In addition to this, MH Joint Service Performance Group meetings have been established, providing a bi-Monthly forum for providers and the ICB to meet. The focus is understanding drivers of challenge for CAMHS and to jointly develop and monitor delivery of improvement plans. This is particularly focussed on the Neuro Developmental Diagnostic pathway as well as the waiting times for access to CAMHS Services.	16	16	16	16	→	12
System Risks - below BAF threshold, but included for oversight											
PERF34	Failure to deliver compliance with national operational standards across elective, urgent, and mental health care pathways (Threat).	Stephen Bloomer - Chief Finance Officer and Deputy CEO	Population Health Strategic Commissioning Committee	**CAUSE:** If the ICB and system partners fail to ensure adequate capacity and resilience across urgent, elective, cancer, and mental health pathways, **EFFECT:** there is a risk that patients may face treatment delays, breaching national standards. **IMPACT:** This may result in a negative impact on patient outcomes and experience, increased system backlogs, and adversely affect the ICB's performance and oversight rating.	There remains a significant risk that North Central London ICB and its providers will not consistently meet national standards across urgent and emergency care, elective, cancer, and mental health pathways. This reflects ongoing pressures including increased demand, workforce constraints, winter pressures, the potential breakdown in provider collaboration and sustained challenges across mental health, children's and young people, and learning disability and autism services ('LDA'). The ICB and system partners are working to address these challenges through a range of actions, including the submission of 2025/26 delivery plans, enhanced oversight via performance review forums, targeted recovery plans in cancer and elective care, and strengthened mental health service commissioning. In cancer, Referral to Treatment, and urgent care, regular system-wide meetings and NHS England engagement are supporting improved trajectory management and mutual aid. Mental health pressures are being tackled through inpatient flow improvement plans, out-of-area placement reduction efforts, and pathway redesign to reduce delays in discharge. Targeted service improvement plans are also in place for Talking Therapies, children and young people's mental health services and LDA pathways to improve access and sustainability. Despite these mitigating actions, sustained system-wide pressures continue to pose a risk to national standards delivery and may impact the ICB's System Oversight Framework segmentation and overall reputation. NCL ICB will continue at pace, to refine and progress the urgent and emergency care priorities, with particular focus on: • Expanding mental health crisis assessment to the north of NCL (Chase Farm) • Enhancing the ICC Hub to integrate with Same Day Emergency Care and Urgent Community Response ('UCR') alongside implementing the 'call before convey' principle across NCL • Closer integration between Integrated Coordination Centre and UCR teams, with a phased approach, starting with Barnet		12	12	12	→	12
COMM22	Failure of the Integrated Care Board to effectively and safely manage the specialist services devolution, impacting on the delivery of population health improvements (Threat).	Stephen Bloomer - Chief Finance Officer and Deputy CEO	Population Health Strategic Commissioning 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.	We continue to await formal details about the proposed transition of all remaining directly commissioned services from NHS England to ICBs which has been proposed to happen by March 2027. This includes Armed Forces Health, Health & Justic Services, Section 7A Services and the remaining (retained) Specialised Services. The transition of these services will be accompanied by the transition of the staff supporting them and there exists a significant piece of work to be done to progress this transition which is yet to start. There is a real risk this transition will be delayed further with reports indicating that it will not occur until Summer 2027 at the earliest but this is still to be confirmed. We continue to work effectively with NHS England, London region, on agreeing Indicative Activity Plans for our NHS Providers and trying to determine the risk arising from the Elective Recovery Fund as part of the management of overall system risk which has now been quantified as part of our overall risk. We had hoped to be able to agree the distribution of recurrent NHS England funds to support Sickle Cell, Renal and HIV Services in September for 2026/27 but the decisions on this have been delayed and we await confirmation. This is creating additional uncertainty for providers around arrangements for 2026/27 and we therefore hope to resolve this shortly. Our work on Dental Service Transformation continues to gain national recognition with NCL being asked to present to leaders within the Chief Dental Officers' Directorate and we have also been shortlisted for a HSJ Award and we await the awards ceremony in late November 2025 to determine if NCL has won the award.	12	12	12	12	→	9
New ICB Only Risk - below BAF threshold, but included for oversight											
CS26	ICB Merger (Threat).	Ian Porter - Executive Director of Transition	Joint Transition Committee	**CAUSE:** If the ICBs fail to put the necessary arrangements in place to: a) ensure the new West and North London ICB can effectively operate and discharge its functions from 1st April 2026, and b) provide NHSE with the appropriate assurance of this; **EFFECT:** There is a risk that either a) NHSE will not approve the Establishment Order so delaying the creation of the new ICB by a year, or b) the new ICB will not have a 'safe landing', its operations are significantly disrupted and/or it does not have appropriate oversight of its functions; **IMPACT:** This may result in the 25/26 merger consultation being invalidated, delays to the ICB's business, wasted time, energy and effort, a negative impact on staff morale and partnership reputation, a lack of organisational assurance and an increased risk of legal challenges.	This is a new risk. With the new executive structure now in place including the Executive Director of Transition ('EDoT'), full focus is now on the extensive programme requirements to successfully and safely deliver the merger of NCL and NWL ICBs and maximising all opportunities to contribute to the £19 per head national target. Regular assurance checks and reports will be provided through multiple forums including to the Board of Members in Common. Workstreams are in place across multiple disciplines and are reporting in to the programme working group (chaired by EDoT) on a weekly basis. We will continue to ensure the provision of regular and timely updates to staff, board members and key external stakeholders.				8	→	4

Risk Key

Risk Improving ↓

Risk Worsening ↑

Risk neither improving nor worsening but working towards target →

North West London ICB BAF Risks - Oversight Report

Risk ID	Risk Title	Risk Owner	Committee	Risk description	Strategic update	2025 Current Risk Score FEB	JUN	AUG	NOV	Movement From Last Report	Target Risk Score
System Risks											
BAF 4 - ICB and ICS Resilience	Failure to ensure we have the ability to respond appropriately, timeously and effectively to foreseeable major risks, events and potential disruptions (e.g. cyber/pandemic)	Sarah Morgan - Chief People Officer	Performance & ICB Finance Committee	**CAUSE:** • Ineffective training / awareness on what to do, where to go • Ineffective scenario testing / resilience with partners • Physical security not fit for purpose • IT security arrangements not robust **EFFECT:** • Disruption to or complete failure of business as usual / communities affected • Loss of systems / data • Reputational and brand damage • Unexpected costs i.e. fines, the replacement of infrastructure etc. • Injury or loss of life - significant impact on all involved (patients, staff)	North Central London ICB supporting NWL SCC team after staff resignations. Risk is being actively managed but remains vulnerable as the expected winter pressures in the system mount.	16	16	16	16	→	12
BAF 5 - ICS Finance	We are unable to deliver the required levels of activity and quality within a recurrent cost base that ensures long term sustainability for all NWL ICS organisations to allow for the delivery of the NWL ICS strategy and associated plans.	Stephen Bloomer - Chief Finance Officer and Deputy CEO	Performance & ICB Finance Committee	**CAUSE:** • Lower funding level per head of population in NWL compared to other ICBs nationally • Failure to deliver recurrent cost reduction and productivity even if delivering the overall national target and in-year break-even position across all provider organisations and the ICB • Failure of NWL programme strategies to adequately reflect the national and local financial constraints • Failure of the national capital regime to allow for adequate resource limits to be invested in NWL providers creating increased revenue charges for backlog maintenance and reducing the ability to transform services • Failure to have appropriate grip and control across the system to deliver the levels of productivity and value for taxpayers funding • Increase in the levels of patients with no criteria to reside driving inefficiency in bed usage and poor patient experience • Poor productivity in provider organisations with the continuation of a growing workforce without treating higher level of patients **EFFECT:** • Reduction in capital resource levels and cash balances available to invest in capital transformation to deliver the ICS Strategy • Reduction in resources available to invest in wider ICS programme areas e.g. new services, technology, and reducing inequalities • On-going funding challenges in Social Care increasing the level of patients waiting on-going care and placements • Continued unmet need across wider population of NWL and potential increase in health inequalities and differential health outcomes	Commitment given from NHSE that the merged NWL/NCL will receive the same funding as per the separate organisations. Work on ensuring coalition of finance management between NWL and NCL ICB in readiness for the merger on 1 April 2026.	20	20	20	20	→	15
BAF 7 - ICS Performance and Quality	Failure to meet the statutory duty of the ICB to improve quality of services	Dr Jo Sauvage - Chief Medical Officer Jennifer Roye - Chief Nurse Officer	Performance & ICB Finance Committee	**CAUSE:** • Reliance upon the data provided for System Oversight Meetings **EFFECT:** • statutory duty of the ICB to improve quality of services not met • statutory duty of the ICB to have regard to the wider effect of decisions not met	Focus on the development of a total quality management system to understand all aspects of the services provided to patients from the commissioning expectations; the cost; the outcome and how this tallies with what was originally commissioned.	12	12	12	12	→	8
ICB Only Risks											
BAF 1 - ICB People	Failure to recruit, retain and develop the right people with the right skills	Sarah Morgan - Chief People Officer	People & Remuneration Committee	**CAUSE:** • Low workforce morale and wellbeing, change fatigue (multiple restructuring, significant resource reductions, post pandemic health and care pressures on workforce) • National and local recruitment challenges and availability of appropriate skills **EFFECT:** • An adverse effect on creating a fit for purpose ICB within the ICS, delivery of organisational objectives, statutory duties and functional operating model	Focus has been upon embedding new reporting lines with the joint Executive team structures to minimise uncertainty and provide clarity where possible. NWL HR team has additional dedicated support to support both business as usual and transition arrangements with capacity investment both in the NWL core team and support from NCL. Joint communications and acknowledgement of uncertainty and change for all staff. Risk score reduced by joint Chief People Officer on 13 November 2025 due to additional HR team investment.	20	20	20	16	↓	12
BAF 2 - Collaboration and Engagement	Failure of the ICB to hear from, listen to, engage and influence our major stakeholders (residents, patients, staff, and LA, NHS and third sector partners)	Sarah Morgan - Chief People Officer	Strategic Commissioning Committee Performance & ICB Finance Committee	**CAUSE:** • Lack of clear involvement strategy • Poor visibility of who requires to be engaged with, and who will take responsibility for that. • Ambiguity of mandate **EFFECT:** • Loss of confidence in the ICB • Commissioned services do not match local needs • Ill-informed strategy / decision making	Robust working between NCL and NWL communications teams to produce joint communications to staff and partners.	12	12	12	12	→	8
BAF 3 - ICB Strategic Delivery	Failure to develop a prioritised, financially robust and deliverable ICB strategy and associated delivery plans that improve the health and wellbeing of NWL's residents and deliver our statutory duties in an environment where the operating plan of ICBs are being revised and the structure of the NHS is undergoing significant upheaval.	Richard Dale - Chief Strategy Officer	Strategic Commissioning Committee	**CAUSE:** • Limited capability & capacity with leadership team (given short term pressures) • Balance of resource between longer term planning and near term delivery • Availability of supporting guidance and tools • Increasing complexity of the system and resulting ambiguity of roles • Constraints on levers available to the ICB • Insufficient or inappropriate deployment of evidence, modelling and/ or assumptions • Lack of join up between strategic aims and financial and workforce realities • Inability to land difficult decisions • Inability to recruit and retain workforce (primary care) to ensure sufficient levels of capacity • Misunderstanding and dissatisfaction with the new model of care amongst patients (primary care) **EFFECT:** • Loss of confidence in ICB • Failure to commission appropriate services for users • Failure to transform services to deliver longer term improvement and sustainability • Unable to provide consistent high quality services for the registered population across NW London (primary care) • Failure to achieve intended outcomes for equity of access (primary care) • Increased pressure upon other areas of the system where patients are accessing other services inappropriately (primary care)	Later in 2025/26 the operating model of the ICB will be known and therefore an understanding of what can be achieved by when. An initial target rating of 12 is reasonable as a starting point considering the uncertainty.	16	16	16	16	→	12
BAF 6 - ICB Governance	Failure to ensure that the governance arrangements in place are fit for purpose and provide line of sight across the operating model	Sarah Morgan - Chief People Officer	Audit & Risk Committee	**CAUSE:** • Ineffective / inconsistent policies; procedures, terms of reference • Inability to provide accurate and timely data for decision making • Composition of Board and Committees (experience, skills, numbers) **EFFECT:** • Decisions based on inaccurate / outdated information • Confidence in ICB leadership questioned • Long term vision and strategy are undeliverable • Ineffective oversight/ or lack of visibility of key issues/risks/concerns meaning the ICB are blindsided	Robust and cohesive transition governance preparation underway including use of 'in common' Board and committees where possible. Significant work on policy, SoRD and risk management to be completed.	12	12	12	12	→	8
BAF 8 - Contract Management	Failure to effectively manage contracts	Stephen Bloomer - Chief Finance Officer and Deputy CEO	Performance & ICB Finance Committee	**CAUSE:** • Change in procurement legislation (Provider Selection Regime) • Failure to follow the operating model to ensure that contracts are managed by programmes and not boroughs • Failure to complete the small contract review • Failure to complete the Better Care Fund and pooled budget review • Failure to assess quality and activity within sub-acute and small contracts **EFFECT:** • Increase in contract breaches • Increase in need for short term contracting waivers • Lack of oversight on the quality of smaller contracts (see BAF 7 ICS Performance) • Reported over performance on sub-acute contracts • Increase in legal cases about how procurement is managed • Decreased productivity and increased cost	Focussed training with contract leads and the embedding of the Business Case Review Group will help embed improved efficiencies in the contract process.	12	12	12	12	→	6
BAF 9 - Organisation Re-design	Failure to effectively engage with/manage the multiple risks associated with the requirement to reduce running and programme costs by 50% as well as the agreement to merge with North Central London by 1 April 2026. Failure to develop a robust and sustainable operating model that complies with national funding envelopes and enables delivery of the revised role and responsibilities of ICBs ensuring effective strategic commissioning for the population of North West London.	Ian Porter - Executive Director of Transition	People & Remuneration Committee Transition Committee	**CAUSE:** • Multiple changes to the landscape of the NHS within a very short time frame (6-12 months) • Cultural shift and integration between NWL and NCL **EFFECT:** • Increased anxiety for staff due to the uncertainty over their future purpose in the merged NCL/NWL ICB and job prospects within the wider NHS • Difficulties maintaining the current legal requirements of the ICB statutory duties due to staff turnover/increased stress and anxiety; less engagement from providers and wider stakeholders due to lack of clarity over the role of the ICS • Failure to maintain the current legal requirements of the ICB and forward momentum of the ICB work to date (strategy development; programme transformation; integrated neighbourhood team preparation)	Significant reduction in risk score due to alignment with NCL transition risk and the work achieved to date on becoming a strategic commissioner (approvals for voluntary redundancies in 25/26; Joint Executive Team in place). Fixed term (April 27) Executive Director of Transition in post and leading the transition processes.		20	20	12	↓	8

Risk Key

Risk Improving ↓

Risk Worsening ↑

Risk neither improving nor worsening but working towards target →

North Central London
Integrated Care Board

North West London

North Central London ICB and North West London ICB
Board of Members Meeting in Common
4 December 2025

Report Title	Chief Executive Officer's Report	**Date of report**	27 November 2025	**Agenda Item**	2.5
Lead Director / Manager	Not applicable.	**Email / Tel**		Not applicable.	
Board Member Sponsor	Frances O'Callaghan Chief Executive, NCL ICB and NWL ICB				
Report Author	Frances O'Callaghan	**Email / Tel**		Frances.o'callaghan@nhs.net	
Name of Authorising Finance Lead	Not applicable.	**Summary of Financial Implications** None.			
Report Summary	The Chief Executive's Report shares highlights from the work of NCL and NWL ICBs and their partners and key issues for Board Members' consideration that are not covered elsewhere on the agenda.				
Recommendation	The NCL and NWL ICB Boards are asked to **NOTE** the content of this 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 ICBs.				
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.

Chief Executive Officer's Report

NHS Change

The national NHS reform programme continues to move at pace and, further to the issuing earlier this year of the 'model ICB', national guidance has recently been released setting out the future regional delivery model. In addition, the future Strategic Commissioning Framework has been issued – setting out NHS England's expectations for ICBs as a strategic commissioner.

Work continues at pace to meet the requirement that all ICBs reduce their running costs to a maximum of £19 per head of population from 1 April 2026. To help mitigate the risks of this significant reduction to running costs, in July 2025 the Boards of both North Central London and North West London ICBs agreed to merge from 1 April 2026; a progress report on the transition work and merger preparations is included in these Board papers.

After several months of uncertainty for staff, NHS England has now confirmed that a national voluntary redundancy (VR) scheme will be available for ICBs as part of implementing the required reductions. We are now working to offer this scheme to staff in 2025/26 – and are continuing our dialogue with staff and trade unions. We remain committed to doing all we can to support staff during this difficult time.

The nationally driven requirements confirm the context in which we are taking forward our transition to the new operating model. We will need to deliver the substantial reductions in running costs whilst safeguarding statutory functions, supporting delivery of our improvement priorities and honouring our responsibilities as a fair employer. The local design, consultation and equality impact assessment work will determine how this is applied in practice.

Over the coming months we will continue to work with staff, trade union colleagues and partners across our system to sequence organisational change carefully, minimise compulsory redundancies where possible, and ensure that the future structure of the ICB is sustainable, affordable and aligned with the requirements of the model ICB.

Recent Industrial Action

As with previous periods of industrial action, the priority for both ICBs has been to safeguard patient and staff safety, whilst ensuring continuity of essential services.

Our system-wide planning centred on maintaining critical services, monitoring capacity through daily surge and senior officer calls, and ensuring strong executive oversight across both in-hours and out-of-hours operations. In advance of, and during, the industrial action, the ICBs worked closely with providers to identify risks, support mutual aid arrangements, and complete NHS England's assurance processes. Although no Patient Safety Mitigation (PSM) requests were submitted, the framework remained in place to support rapid escalation if required.

Operationally, the system focused on improving discharge processes - including the use of MADE - reducing admissions through Urgent Community Response pathways and strengthening primary care bridging services to increase borough-level capacity. Throughout the strike period, the Systems Operations Centre provided real-time coordination across both systems, supported by daily ICS touchpoints and twice-daily updates with the NHSE regional team. Now that industrial action has concluded, the ICB will undertake a review of the impacts and lessons learned to inform and strengthen future resilience planning.

Board Governance

On 3 November 2025 the North Central London ICB Board took a virtual decision to approve updates to the relevant committees' Terms of Reference and the Standing Financial Instructions – with the updates reflecting the new Executive Management Team structure and portfolios.

Launching Health Data for London

London has now formally launched Health Data for London, marking a major milestone in the scale-up of the London Secure Data Environment (SDE) across the capital. At the launch event senior leaders, researchers and industry partners confirmed a unified commitment to transform how health data is governed, accessed and used, with the Minister for Health Innovation describing London's SDE as *"an exemplar"* for the country.

The SDE will scale to cover 10 million Londoners by April 2026, supported by a dedicated Research Service to guide users through feasibility, approvals and secure access. Three driver programmes - heart health, children and young people's mental health, and antimicrobial resistance - will demonstrate how connected and securely used data can drive better care, innovation and population-level insights. The programme also builds on the capital's world-leading public deliberations, ensuring data is used transparently, ethically and for clear public benefit.

For NCL and NWL, the impact is significant. The scale-up of the London SDE will give our systems timely, secure and friction-free access to linked data across acute, primary, mental health and community care, strengthening our ability to deliver proactive, equitable and neighbourhood-focused models of care. It also provides a major platform for our research-active providers, supporting inclusive research that reflects London's diversity and accelerates discovery in areas such as cardiac disease and children & young people mental health, both priority areas for our populations.

As OneLondon moves to implementation, NCL and NWL will play a central role in shaping governance, supporting local adoption and ensuring our residents benefit directly from one of the most connected and trusted health data ecosystems in the world.

NWL Emergency Preparedness, Resilience and Response (EPRR) Assurance Compliance

NWL ICB has been confirmed as fully compliant with all NHS Core Standards for EPRR following its formal annual assurance review. Under the NHS Act 2006, NHS England

requires all NHS organisations to evidence compliance through a national assurance process – including the submission of a detailed self-assessment. Regional teams validate ICB submissions, promote shared learning, and will submit consolidated assurance outcomes to the NHS Resilience Team by 31 December 2025.

As part of this process, boards remain responsible for EPRR performance and hold the Accountable Emergency Officer to account. NHS England carried out the NWL ICB assurance review on 16 October 2025 and confirmed full compliance, supported by a formal letter from the London Region and the completed self-assessment tool.

NCL ICB is currently completing the same annual assurance process – and we are expecting a similar positive outcome.

Transformation and Change Programme in the ICB

The Transformation and Change Training Programme, which is run by our Transformation Unit, has been recognised nationally, winning the People and Leadership category at the Management Consultancies Association (MCA) Awards in November 2025.

This award reflects the programme's significant impact on developing leadership capability and driving transformation across our organisation. It is also notable given the strong competition from partnerships between Ernst & Young and the Civil Service, KPMG and a major retailer, and Capgemini and the Government.

Interest in the programme continues to grow. Our next training cohort, launching in January 2026, was fully booked within a week, and is open to colleagues from across NCL and NWL. This achievement is a testament to the team's ongoing commitment to excellence and their contribution to building strong leadership and change capability across the system.

HSJ Awards

The HSJ Awards last week saw national recognition for some of our, and our system partners', work. The awards celebrate best practice, excellence and innovation in health and care.

Mark Eaton, NCL Director of Strategic & Delegated Commissioning, and his team, together with system partners, won the HSJ Award for Reducing Inequalities and Improving Outcomes for Children and Young People for their impressive project to improve dental care and outcomes in underserved communities. This is a great example of the impact we are having by knowing our populations, working collaboratively with partners to focus locally, in a targeted way, to successfully tackle longstanding health inequalities.